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HEALTH SAVINGS ACCOUNTS: THE EXPERIENCE SO FAR

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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HEALTH SAVINGS ACCOUNTS: THE EXPERIENCE SO FAR

TUESDAY, SEPTEMBER 26, 2006

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:35 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the subcommittee) presiding.

Present: Senator Rockefeller.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator HATCH. Well, we will call the committee meeting to order.

I have been a strong advocate of individuals taking personal responsibility for their lives. The Federal Government does not always have the right answer or the appropriate solution for everyone, and all of us can admit that, oftentimes, the Federal Government's solutions are inflexible and unyielding.

That is the beauty of health savings accounts, or HSAs. HSAs give the individual the ability to take responsibility for his or her own health care needs. Who knows best, the Federal Government or the person needing the care? I believe that the answer is fairly obvious.

I know that some are uncomfortable with the HSA approach, but I believe that today's hearing will help answer many of the valid questions surrounding the details of HSAs.*

Both our subcommittee Ranking Minority Member, Senator Rockefeller, and I want to take the time to address this important issue and ask very relevant questions regarding HSAs.

It is always a pleasure to be with my friend, Jay Rockefeller. In fact, I could get used to this, couldn't you?

Senator ROCKEFELLER. Yes. Not necessarily——

Senator HATCH. Right away?

Senator ROCKEFELLER. Well, just the position of the seats. [Laughter.]

Senator HATCH. Well, we will just switch seats every once in a while. How is that? [Laughter.]

* For additional information on this subject, *see also,* "Present Law and Analysis Relating to the Tax Treatment of Health Savings Accounts and Other Health Expenses," Joint Committee on Taxation staff report, September 25, 2006 (JCX–45–06).

Oftentimes in the Senate it is difficult even to agree on the existence of a problem. That is not the case when it comes to our Nation's health care system. Everyone in this institution understands the frustration of ordinary Americans, insured and uninsured, who have to navigate our health care system.

As is evident in the report released yesterday by the Citizens Health Care Working Group, which I worked on with my good friend and Finance Committee colleague Senator Ron Wyden, Americans want an improved health care delivery system with better access for those who cannot afford care.

They are tired of insurance that is too expensive, benefits that are too difficult to decipher, a bureaucracy that many times lacks the human touch, and a system that is too unresponsive for a mobile 21st-century workforce.

The administration believes, and a number of our Congressional colleagues and I concur, that health savings accounts are part of the answer. By combining lower premiums with higher deductibles, they have the potential to make health care costs more manageable for individuals and for employers.

The idea is easy to grasp. When individuals are more responsible for their own health care, they will make better, and more cost-conscious, health care decisions. When someone else is paying the whole bill there is no incentive to monitor one's own spending. It is no wonder that the yearly premiums for traditional first-dollar coverage have exploded.

By making health care more affordable, these plans will provide affordable insurance to those who are currently uninsured or under-insured and reduce the Nation's health care expenditures as well. That, at least, is the theory.

Today, we hope to hear how these plans work in practice. One thing does seem certain to me: HSAs are here to stay. Their growth has been remarkable. They were only created in 2003 through the Medicare Modernization Act. I served as a member of that House/Senate Conference Committee, and to this day believe that the creation of HSAs was probably one of the most important aspects of that particular legislation.

By March 2005, 1 million individuals had health savings accounts. Only 9 months later, that number had grown to 3.2 million. Not only are individuals and small businesses turning toward HSAs, but some of the giants of American industry and retail are as well.

Now, these plans do appear to be gaining popularity. They are definitely growing. I think it is incumbent upon us to take the task of improving them as seriously as we can. For me, just picking up the newspaper in the last few weeks confirms their promise and shows the way forward.

The GAO has released its latest in a series of studies demonstrating that both HSA-eligible plans and high-premium plans cover similar services, including preventive services, and that for many people there are substantial savings associated with participation in these plans.

Now, the decision by one prominent company to offer almost 300 generic prescription drugs at $4 for a 30-day supply for those living in Tampa, FL, is an important step in the right direction.

Let us hope that this decision will be expanded to other parts of the country, because it will have a significant impact for HSA participants who may have to pay for some prescription drugs out of pocket.

As more individuals and businesses elect HSA-eligible plans, I do not doubt that private consumer pressure will correct some plan deficiencies on their own. At the same time, I believe that Congress has an opportunity to improve HSAs for those already participating in them. HSAs are still in their infancy. The evidence is starting to come in, however, and our excellent panel should help us to navigate through some of these critical issues.

[The prepared statement of Senator Hatch appears in the appendix.]

So with that, I will turn to my dear friend, Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman.

You notice, the Chairman and I are setting a new example in how to sit, or on what to sit. This is a first in our history of the Finance Committee. Right?

Senator HATCH. I am not sure it is that important, however. [Laughter.]

Senator ROCKEFELLER. It is to me.

Senator HATCH. It is to me, also.

Senator ROCKEFELLER. Health insurance makes a substantial difference in the amount and kind of health care people are able to obtain. We had a two-hour meeting of a foundation I set up about 15 years ago, co-chaired by Bill Frist and myself, yesterday on the whole question of why it is we have stopped talking about the really big picture, which is universal health care, with these new statistics out.

It was very interesting. We decided that, frankly, we had all become too timid, too incremental, looking at little ways to incrementally do this or that, not looking at the effect on the large picture or affecting the large picture.

The consequences of not getting needed medical care are not trivial and can result in unnecessary hospitalizations and serious health problems, not to mention the effect it can have on a person's, or a family's, finances.

According to the Census Bureau, over 46 million Americans were uninsured in 2005, including 8.3 million children. That was the first time that number had gone up since 1998, which has something, I think, to do with our Children's Health Insurance Program.

The weak economy, unemployment, and the increasing cost of health care all made it harder last year for American workers and their families to obtain affordable, comprehensive health care insurance. The growing uninsured problem in this country deserves immediate attention by the Congress. It has not gotten it, really, for about 10 years or so.

If it is not going to get it in this Congress, which it is not because of the time, then we have to do it next year. We should get started before the recess this year. Unfortunately, I do not think the health savings accounts, HSAs, are the answer, and I remain concerned,

unlike my esteemed colleague, that these tax-preferred accounts continue to be pushed by the administration as a meaningful health insurance option.

We know that the majority of uninsured Americans are in working families with low to moderate incomes. Research indicates that 71 percent of the uninsured are in a 10-percent or lower income bracket, and that more than half—that being 55 percent—of the uninsured have no income tax liability at all.

This means they would benefit very little from health savings accounts. According to the GAO, the vast majority of people who purchase HSA policies are healthy, affluent workers, with an average adjusted gross income of $133,000, in 2004 figures. That is not the folks that I deal with in West Virginia, and I suspect it is not typical in Utah, Montana, and a lot of other places.

These individuals are betting on not getting sick, or if they are getting sick, they are probably not going to do anything about it because they do not know whether that would have any effect, or what it would cost, or they become passive in their own health care, which is dangerous.

Furthermore, the use of HSAs could significantly undermine the employer-based insurance on which most people, 60 percent of workers, rely. As healthier, more affluent workers shift to HSAs, older and sicker workers will be left in traditional employer-sponsored policies.

This type of adverse selection will drive up premiums for traditional employer-based coverage, further encourage firms to provide less desirable coverage or to drop health care coverage altogether, all of which happens.

Indeed, some research even concluded that if the savings limits for HSAs were increased, they would also undermine employer-provided retirement savings programs. This perverse incentive would be very dangerous, obviously; as small business owners have the option of saving more money, tax-preferred, in an HSA, they would have less incentive to provide 401(k) accounts to their employees.

We need to do more to encourage small business to provide retirement and health care benefits. Our experience with the Trade Adjustment Assistance Health Care Tax Credit is, in this instance, instructive regarding the limitations of trying to use the tax code to expand coverage.

Even with a tax break, health insurance is still too expense for many, if not most, people to purchase. Therefore, the take-up rate on the Health Care Tax Credit has been very low, worthy of attention. I believe the HSAs present the same problems. Many people will not be able to afford health insurance in the private market, even if they receive some tax subsidy.

Finally, a note about the ability of HSAs to encourage consumer responsibility. Patients generally lack both the medical expertise and complete information about costs and quality that would be necessary to comparison-shop, as we are accustomed to doing for other goods and services.

What patients are doing, instead, is cost-avoidance, or personal peril avoidance. Many HSA enrollees are avoiding needed care because they cannot afford the high deductibles. Anyone who knows

anything about health care knows that this will lead to greater costs to our health care system down the road.

If current purchasers of HSAs would not recommend these plans to people who have chronic conditions, have children, are on medication management, or cannot afford the high deductible, then why should we proceed with a strong tax advantage? These are characteristics of most uninsured Americans. We have to find a better solution.

I will just end with a story, Mr. Chairman, which you have probably heard me say before. But I was a Vista volunteer 40-plus years ago in West Virginia. There was one thing which was rammed into my head and will never leave. I was in a small, southern coal community. Nobody had any health insurance, jobs, did not go to school, lots of problems. Wonderful people.

One thing I found that I could do was to get a Pap smear van from the county. They would send that out, and that was important, so I went around the community on that. The van came, nobody showed up. I figured I had done something wrong. So as a social worker, I went to work and tried to do better. The van came again a month later, and nobody showed up. I went to work again. The van came on the third month, and two people showed up.

Lesson: when people are poor, when they are discouraged, or when they are living in adverse circumstances, they have enough bad news in their life, they are not sure they want to go to a place or take a test which may give them news that is even worse.

Now, you could say, well, it is their responsibility to do so. But human nature is human nature. We need to deal with that and we have to be sensitive about that if we want people to have health care available to them.

Thank you, Mr. Chairman.

Senator HATCH. Well, thank you, Senator Rockefeller.

[The prepared statement of Senator Rockefeller appears in the appendix.]

Senator HATCH. I have to run down to Judiciary to make a quorum, if you can take care of the hearing until I get back. But let me just introduce everybody here. We have a distinguished panel of witnesses here today. You will have to forgive me for being absent for a few minutes.

Robert Carroll, Deputy Assistant Secretary for Tax Analysis at the Department of the Treasury will testify for the administration. Dr. Carroll has been a visiting scholar with the Congressional Budget Office and served as a Senior Economist on the President's Council of Economic Advisors.

I want to thank you for being here. We appreciate you being willing to be on this one-panel format, because ordinarily we would have you go first by yourself.

John Dicken, Director for Health Care Issues for the U.S. Government Accountability Office. He has served as a Senior Analyst for the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, and is a Legislative Fellow with the Senate Committee on Labor and Human Resources.

I am especially happy to welcome Joe Knight, from Ogden, UT. It is always a pleasure to have a fellow citizen of the Beehive State testifying.

Mr. Knight is CFO of Setpoint Systems, a family-owned business with 34 full-time employees. Setpoint offers an HSA-eligible health plan to its employees. So, Joe, we are really pleased to have you here, and I am looking forward to hearing about your company's reasons for offering such a plan, and the experiences of both employees and management with this plan.

Sara R. Collins is the assistant vice president for the Program for the Future of Health Insurance for The Commonwealth Fund, where she has written extensively on health policy. We are grateful to have you here as well.

John Goodman is the founder, president, and CEO of the National Center for Policy Analysis. He is the author of nine books on health care and economic policy, and holds a Ph.D. in Economics from Columbia University.

Finally, Eric Beittel is a certified financial planner with Enders Insurance Associates in Harrisburg, PA. He has worked in the financial services industry for over 7 years, assisting dozens of small businesses and hundreds of individuals with health savings accounts. Furthermore, he owns an HSA himself to manage the health care needs of his young family.

Now, I understand that your great uncle has accompanied you here today, so we are happy to welcome him as well.

We are happy to have all of you here today. If you will excuse me for just a short period of time, I will go down and make that quorum. In these last few days, it is tough to do that. I will be right back.

We will start with you, Dr. Carroll. Senator Rockefeller will take good care of all of you, and we will reserve our questions until the end.

Senator ROCKEFELLER. Dr. Carroll?

STATEMENT OF DR. ROBERT CARROLL, DEPUTY ASSISTANT SECRETARY FOR TAX ANALYSIS, U.S. DEPARTMENT OF THE TREASURY, WASHINGTON, DC

Dr. CARROLL. Thank you, Ranking Member Rockefeller and distinguished members of the subcommittee. I appreciate the opportunity to discuss with you today health savings accounts and the President's initiative to expand upon HSAs, as included in the fiscal year 2007 budget.

The initiative will help make health care more accessible, affordable, and portable, thus better enabling Americans to obtain health care and to retain their health care when they change employment.

I will focus my remarks on the problems in health care and how the President's proposals help address these problems by building upon the early success of HSAs.

By way of background, health care costs continue to rise rapidly in the United States. Growth in health care costs has been exceeding GDP growth by 2 percentage points since 1940, comprising 16 percent of GDP in 2004, and is projected to grow to nearly 20 percent of GDP by 2015.

Higher insurance premiums pose a challenge for employers and burden workers. The burden of rising health care costs is particularly problematic for small businesses, who often end up choosing not to offer any health insurance to their employees.

At the same time health care costs are rising, the number of uninsured also continues to grow. As health care costs grow faster than incomes, an increasing number of individuals are unable to purchase health insurance.

Also, those higher, ever-rising costs mean that the self-employed and employees of small businesses are far less likely to have coverage. A significant number of the uninsured work for small businesses.

A substantial portion of rising health care costs is due to the effects of our insurance system itself. Health insurance gives people valuable protection and peace of mind that they will have help paying their medical bills should a major illness arise.

However, the tax system stacks the deck against insurance that gives the individual a greater role in health care decisions. First-dollar coverage, in effect, dulls the incentives for consumers to shop carefully for cost-effective care.

The tax bias that favors this coverage that encourages individuals to purchase pre-paid health care in the form of employer-provided insurance is an important piece of the puzzle, explaining the rapid growth in health care costs.

When consumers have more at stake, when they have more exposure to the price of health care, when they have more "skin in the game," they can be expected to make better decisions. Greater reliance on competition and greater exposure to market prices will help lead to more efficient use of resources and help stem the excessive rise in health care costs.

With the appropriate reforms, the U.S. health care system can become more efficient at supplying cost-effective health care to consumers, while continuing to lead in innovation. The President's Health Care Initiative would address rising health care costs through a series of proposals designed to improve the functioning of the health care market.

At the core of this initiative is a set of tax proposals that puts the health care consumer more in control of his or her health care, that removes the tax disincentive to purchase high-deductible health plans and the tax bias for first-dollar coverage.

Fundamentally, the initiative places health care purchases directly by individuals with high-deductible health plans on an equal footing with employer-provided health insurance.

The President's Health Care Initiative allows those with high-deductible health plans to deduct insurance premiums and out-of-pocket expenses and to claim refundable tax credits to cover payroll taxes paid on these premiums and out-of-pocket expenses.

The initiative also includes a refundable tax credit to cover the cost of high-deductible health plan insurance premiums that is targeted to the lowest-income Americans. The result is a policy that provides the same tax advantage available to those with employer-provided insurance as health care purchased by all Americans with high-deductible health plans.

Providing consumers with a larger role in health care decisions will help bring market forces to health care. Where market forces are prevalent, there is evidence that health care costs have grown slower, or in some cases even decreased.

The President's initiative also helps make health insurance more portable. In today's economy, employees frequently change jobs, and these changes are often for the better. Each year, some 56 million employees are hired, while 53 million leave their jobs.

Our dynamic labor markets make an important contribution to our economic growth and higher living standards. Tying employees' health insurance to their workplace, however, is a source of job lock and an impediment to fluid and flexible labor markets.

HSAs have the distinct advantage of being owned by individuals, regardless of their employer. When workers change jobs, they take their HSAs with them.

Just a couple of years after the enactment of HSAs, some 3.2 million people are now covered by high-deductible health plans. Moreover, there is broad use of these plans by important segments of the population. Early evidence indicates that over 40 percent of those covered by these plans have incomes below $50,000, and roughly 50 percent are age 40 or over.

The President's Health Care Initiative builds on the early success of HSAs by removing the tax disincentive to purchase a high-deductible health plan. Treasury projects that, in the absence of the tax bias against high-deductible health plans, the number of HSAs will rise by 50 percent.

The President's Health Care Initiative also reorients HSAs—and in many circumstances lower-income Americans would receive a larger tax subsidy than those with higher incomes—and is in stark contrast to current law, where lower-income Americans often receive little benefit from the existing subsidy for health care.

Thank you for the opportunity to testify before the committee today, and I look forward to your questions.

Senator ROCKEFELLER. Thank you. Dr. Carroll.

[The prepared statement of Dr. Carroll appears in the appendix.]

Senator ROCKEFELLER. Mr. Dicken?

STATEMENT OF JOHN DICKEN, DIRECTOR, HEALTH CARE ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. DICKEN. Mr. Chairman, Ranking Member Rockefeller, and members of the subcommittee, I am pleased to be here today to discuss GAO's recent report entitled "Consumer Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans."

As Dr. Carroll indicated, HSAs were introduced in 2004, and HSA-eligible plans are a small, but growing, share of the private health insurance market, with about 3 million Americans covered in these plans as of January of 2006.

These consumer-directed health plans have three components. First is a deductible significantly higher than typical with more common preferred provider organizations or other traditional plans.

Second is the actual HSA, a tax-advantaged account for paying medical expenses and accumulating savings.

Third is a decision support tool to provide enrollees with standardized information on the cost and quality of health care providers and services.

My written statement, based on our recent report, provides information on HSA-eligible plans, including their financial features, characteristics of enrollees, HSA funding and use, and enrollees' experiences. My remarks today will briefly highlight several key points from my written statement.

First, the financial features of HSA-eligible plans differ from those of traditional plans. As detailed in our report, enrollees typically pay lower premiums for HSA-eligible plans than for traditional plans.

However, depending on their use of health care services, enrollees in HSA-eligible plans can also pay more when obtaining care due to higher deductibles and out-of-pocket spending limits.

To give real-world illustrations, we estimated total annual costs for enrollees at three large employers, offering both an HSA-eligible plan and a PPO. For these employers, an enrollee with low to moderate use of health care, such as six doctor visits in a year, could pay 48 to 58 percent lower annual costs in the HSA-eligible plan than in the PPO plan.

In contrast, an enrollee with extensive use of health care, such as a hospital stay costing $20,000, could pay 47 to 83 percent higher annual costs in the HSA-eligible plan than in the PPO plan.

Second, HSA-eligible plan enrollees generally had higher incomes than comparison groups. Specifically, 51 percent of tax filers who reported HSA contributions in 2004 had an adjusted gross income of $75,000 or more. This was nearly three times the percentage of all tax filers under 65 years old with adjusted gross incomes of $75,000 or more.

Similarly, data from the Federal Employees Health Benefit Program, two large employers, and a national broker of health insurance showed that HSA-eligible plan enrollees had higher incomes than traditional plan enrollees in 2005.

Third, regarding the use and funding of HSAs, it is striking that, in 2004, just over 55 percent of those with an eligible plan contributed to an HSA. Of those reporting that they contributed to an HSA in 2004, about 45 percent also withdrew funds, which were mainly used to pay medical expenses.

Fourth, to discuss their early experiences with HSA-eligible plans, we conducted focus groups with enrollees at three large employers. Many focus group participants liked the ability to accumulate savings and the tax advantages of the HSA. Participants also reported few problems obtaining care. Many participants reenrolled in the HSA-eligible plan when offered the choice.

However, participants noted certain aspects that they did not like. Some participants said that they would prefer being able to contribute more to the HSA, while others said they would be willing to pay higher premiums for plans with lower deductibles.

Most participants would recommend their HSA-eligible plans to healthy consumers, but not to those who have a chronic condition or may not have the funds to meet the high deductible.

In closing, these early experiences underscore two important lessons. When offered the choice of enrolling in an HSA-eligible plan, individuals will likely weigh the potential savings and financial risks in relationship to their own health care needs and financial circumstances.

If healthier individuals anticipate incurring lower costs, they may be more likely to select an HSA-eligible plan than would less healthy individuals. This stresses the importance of monitoring enrollment and assessing the cost of health coverage for enrollees in both HSA-eligible and traditional plans.

Finally, an increase in health care consumerism is key to cost reductions that may occur under these plans, but few participants in our focus groups researched costs before obtaining health care.

This may be due in part to consumers' reluctance to question health care providers about costs and the dearth of readily available, standardized provider-specific information. Overcoming these barriers will likely require time, education, and improved tools to provide enrollees with better information about the costs and quality of their health care.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Senator HATCH. Well, thank you, Mr. Dicken.

[The prepared statement of Mr. Dicken appears in the appendix.]

Senator HATCH. Mr. Knight, we look forward to hearing your testimony.

STATEMENT OF JOSEPH V. KNIGHT, CHIEF FINANCIAL OFFICER, SETPOINT SYSTEMS, OGDEN, UT

Mr. KNIGHT. Thank you. Thank you, Chairman Hatch, Ranking Member Rockefeller, and members of the subcommittee, who seem to be on break.

I am Joe Knight, chief financial officer and co-owner of Setpoint Companies, a small manufacturing company comprised of six subdivisions. Three major businesses that I own are manufacturing automation—we help companies manufacture in the United States rather than in China—roller coaster manufacturing, and precision machining through a company we call Leanwerks.

I am here on behalf of the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing more than 3 million businesses and organizations of every size, sector, and region.

Setpoint, originally founded in 1992 after operating out of a garage, has grown to a company with revenues of over $15 million. A fast-growing company, our overall organization has grown, in 2000, from 20 employees, to now a total of 60.

I am also pleased to tell you that our company was voted as one of the best companies to work for in *Utah* magazine. We were recognized as an INC 500 company. For 4 consecutive years, we were one of Utah's 100 fastest-growing companies in the State.

We have grown this company without outside investment and with our own personal savings and sweat, between my partners and I.

One of the challenges we have is, we are a high-tech company and we have employees that, on average, make about $20 an hour in salary. One of the most important things these employees look for in employment is benefits, including health care benefits.

Our strategy is to provide benefits that large companies offer as well and match those benefits. This strategy has served us well, be-

cause we have been able to attract top engineering talent. We have always paid 100 percent of single coverage and 75 percent of family coverage for our full-time employees when it comes to health care.

To recruit and keep these top employees, we need to have, and keep, all of our benefits competitive. Starting in 2003, this became a serious challenge with our health care coverage. One employee had a wife with cancer, and another had some serious health issues with a child. Unfortunately, in a small group like Setpoint's, these issues can be disastrous.

In 2004, our PPO premium increased 20 percent, with a higher deductible and co-pay. Then in 2005, we were hit with a 49-percent increase in our plan. The 49-percent increase was especially devastating to our business, because our health care costs were much higher than the large employers in our area. Consequently, the employee portion of health care and the level of coverage was not competitive, and we had trouble recruiting talent.

After considering several options for the 2005 plan, my agent informed me about the new health savings account high-deductible plan alternative. After looking at this option, we found that we could offer a plan with a $3,500 deductible for singles, and $7,000 for families, through United Healthcare. These plans allowed us to avoid the 49-percent increase in premiums and allowed 100-percent coverage for preventive medicine.

Now, I am a finance guy, so I started looking at the alternatives and the options and started calculating comparative data to see which plan I deemed would be best for my employees, and also for our company. I was surprised to find that the HSA option was far better financially for all of my people, especially those employees who had serious health issues.

We rolled out the new plan with a lot of education, because initially some of our employees were skeptical. This included one-on-one discussions, modeling medical costs, and offering comparative analysis on the different plans.

Now that we are nearly through our second year with the HSA, everyone is happy with the change. As an employer, we are able to use our savings in the HSA premium to increase our contributions, which are now $1,200 per family per year, and $600 for individuals. Consequently, all of our savings and premiums as an employer went directly to the employee's HSA accounts.

On a personal level, I am very pleased with this type of coverage. I have seven children, ranging in age from 18 to 4. Consequently, my wife is a very good budgeter and is very careful with our money. The HSA has made my wife a real shopper when it comes to health care.

When we needed a minor surgery for one of my children, my wife shopped for doctors and the costs that she would be comfortable with. She was able to save on our health care costs by managing that use.

Whether it is finding the right doctor or asking for generic medication when possible, she is in control of our spending with the HSA. If the doctors are aware that you have an HSA and are willing to pay cash, they often offer a cash discount beyond the UHC discount we are already provided.

I think this new type of plan is putting decisions back into the hands of the consumer, and this will lead to more prudent utilization and ultimately help to control the increasing health care costs.

Both my employees and I are delighted with the health savings accounts that allow us to benefit from our health care spending decisions and the use of pre-tax dollars. When the health care plans are paired with these HSAs, it puts the consumer in charge.

There are ways to make these HSAs more appealing to employees and employers, many of which are contained in Senator Hatch's bill and mentioned in my written testimony.

On behalf of Setpoint Systems and our employees, I would like to thank this committee for the work you have done in enacting this legislation into law and considering the possible improvements.

Having health savings accounts as a viable health care option has allowed Setpoint to curb the increases in our health care premiums, while enhancing our ability to hire and retain employees.

Thank you.

Senator HATCH. Thank you, Mr. Knight.

[The prepared statement of Mr. Knight appears in the appendix.]

Senator HATCH. Dr. Collins, we will take your testimony.

STATEMENT OF DR. SARA R. COLLINS, ASSISTANT VICE PRESIDENT, PROGRAM FOR THE FUTURE OF HEALTH INSURANCE, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. COLLINS. Thank you, Mr. Chairman, Ranking Member Rockefeller, members of the subcommittee.

The subcommittee is to be commended for focusing attention on the manifold problems confronting the U.S. health care system: steady growth in the number of uninsured, rising health care costs and premiums, wide variation in the quality and cost of care, and inefficiencies in care delivery and administration.

Some maintain that HSAs, coupled with high-deductible health plans, are an important part of the solution to our health systems problems. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, driving down cost growth and improving the quality of care as providers compete for patients.

The tax incentives associated with HSAs will lure previously uninsured people into the individual market, reducing the numbers of families without health insurance.

While it is comforting to believe that such a simple idea could help solve our health care problems, nearly all evidence gathered to date about HSAs and high-deductible health plans points to the contrary.

Indeed, there is evidence that encouraging people to join such health plans will exacerbate some of the very maladies that undermine our health system's ability to perform at its highest level. Americans already pay far more out-of-pocket for their health care than residents of other industrialized countries.

The Commonwealth Fund's Biennial Health Insurance Survey found that, in 2005, 60 percent of privately insured adults with annual household incomes of under $40,000 spent 5 percent or more

of their income on out-of-pocket expenses and their premiums, and 40 percent spent 10 percent or more.

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care that they need. There is also evidence that rising cost exposure leads people to accumulate medical debt, take on credit card debt, and reduce their savings.

The Employee Benefit Research Institute and The Commonwealth Fund Consumerism in Health Care Survey found, in 2005, that people enrolled in HSA-eligible high-deductible health plans were much less satisfied with many aspects of their health care than adults in more comprehensive plans. People in the plans allocate substantial amounts of income to their health care, particularly those who have poor health and low incomes.

Adults in the plans are far more likely to delay or avoid getting needed care or to skip medications because of the costs. Problems are particularly pronounced among those with poorer health or lower incomes.

Few Americans in any health plan have the cost and quality information they need to make decisions, but patients' use of information alone is not likely to dramatically reduce health care costs or improve quality. Most health care costs are incurred by people who are very ill, often in emergencies.

Payors, Federal and State governments, accrediting organizations, and professional societies are much better positioned to insist on high quality and efficiency.

HSAs will not solve our uninsured problem. Fewer than a million currently uninsured Americans are expected to gain coverage as a result of HSAs. This is primarily because, as Senator Rockefeller pointed out, 71 percent of uninsured are in the 10-percent or lower income tax bracket, and thus would benefit little from the tax savings associated with HSAs.

The individual insurance market is not an efficient or equitable solution to the uninsured problem. The Commonwealth Fund survey found that nearly 90 percent of adults who sought coverage in the individual insurance market in the last 3 years never ended up buying a plan.

Nearly 3 of 5 adults who sought coverage found it very difficult or impossible to find a plan they could afford. The problem was particularly acute among people with health problems or who had low incomes.

The administrative costs of individual coverage consume an estimated 25 to 40 percent of each premium dollar, compared to 10 percent for group coverage. We as a Nation should focus on more promising strategies for expanding coverage and improving affordability, quality, and efficiency.

These strategies include: expanding group forms of insurance coverage, like employer-based coverage; eliminating Medicare's 2-year waiting period for coverage of the disabled, letting older adults buy into Medicare; building on Medicaid and the State Children's Health Insurance Program to cover greater numbers of people; ensuring affordable coverage for families by placing limits on health care costs as a percent of income; greater transparency with regard to provider quality and the total cost of care; pay-for-performance

incentives to reward health care providers that deliver high quality and high efficiency; development of value networks of high-performing providers under Medicare, Medicaid, and private insurance; better management of chronic health conditions; improved access to primary care and preventive services; and investment in health information technology.

Thank you.

Senator HATCH. Thank you.

[The prepared statement of Dr. Collins appears in the appendix.]

Senator HATCH. Dr. Goodman?

STATEMENT OF DR. JOHN C. GOODMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL CENTER FOR POLICY ANALYSIS, WASHINGTON, DC

Dr. GOODMAN. Thank you, Mr. Chairman, Senator Rockefeller.

Professor Kotlikoff and his colleagues at Boston University are predicting that, in just 5 decades, government at all levels will be spending a third of the GDP on health care.

Yet government spending today for all purposes is a third of the GDP, so the path we are on is for health care to crowd out, literally, everything else that government does.

If the private sector keeps pace with the government, and it has for the past 30 years, then by mid-century health care will crowd out every other form of consumption. We will have no food, no clothing, no housing. We will have only health care.

Now, this, of course, is an impossible path, yet it is the path we are on. We cannot get off of this path unless someone chooses between health care and other uses of money.

The question is, who will that someone be? Too often, the critics of health savings accounts are given a free pass. They do not want patients to make these decisions, but only a few years ago some of these very same people were irate when employers and insurance companies were making these decisions. They would probably be equally irate if government made them.

We cannot have a serious conversation about health care unless we address how we are going to choose between health care and other uses of money. For my part, I want as many of these choices as possible to be made by patients, in consultation with doctors, rather than by impersonal bureaucracies.

This is not an unusual idea. Twelve billion times a year, Americans buy over-the-counter drugs. Before they engage in these acts of self-medication, why do they not seek professional advice from a physician? Presumably because they do not want to incur the time or the expense.

Yet in making these decisions 12 billion times a year, Americans are choosing between physician care and other uses of time and money. That is a good thing, not a bad thing, because, if they all went to the doctor on all these occasions, we would need 25 times the number of primary care physicians we have in this country.

Do people always make good decisions? No. Do their mistakes sometimes have tragic consequences? Of course. But the answer there is not to discourage choice, it is to help people make better choices.

From the large to the small, Americans have shown a willingness and an ability to trade off health care dollars against other uses of money. To help them make these choices, individual self-insurance through health accounts and third-party insurance should be on a level playing field under the tax law.

When does it make sense to have individuals manage their own health care dollars, and when does it make sense to have those dollars managed by third parties? These are decisions that should be made in the marketplace and not by Congressional committees.

We have more than a decade of experience with health accounts in South Africa, where two-thirds of the private marketplace now is in a health savings account plan. We have 7 years' experience with the MSA pilot program, 3 years with HSAs, and 4½ years with HRAs.

As a result of all this, we know a lot more than some of you may think. The GAO study we heard about looked at three companies for 1 year, and the companies were not typical. But AHIP has looked at thousands of companies, covering 2.3 million people.

On top of that, we have dozens of reports and studies done by companies in the industry, independent analysts, think tanks, and many more coming forth every day. Here is the thrust of what the great bulk of these studies find: that when people manage their own health care they do common-sense things.

They cut back on unnecessary doctor visits. They cut back on drugs they were not planning to take anyway. They switch from brand-name drugs to generic drugs. There is no real evidence that they are skimping on preventive medicine. Even the worst studies do not find any harm to the health care of any people in these plans.

People enrolled in these plans represent a broad cross-section of people by age, income, and health. One-third of them were previously uninsured. I do not know why some people making $75,000 a year would not recommend one of these plans to other people, but I can introduce that high-income person to literally thousands of Medicaid disabled patients who today are managing their own health care dollars in the Cash and Counsel program. The satisfaction rates among these Medicaid patients are almost 100 percent.

As good as all these results are, we have barely begun to take advantage of these accounts. What we need for the future is flexibility, especially for the chronically ill, because this is where our greatest opportunity lies. For the healthy person, the HSA is, for the moment, a savings account. But for the chronic patient, this is an opportunity to manage their own health care.

Self-management of care will be the next great wave of change in the health care marketplace. We now have devices that allow diabetics to monitor their own glucose level. Asthmatics can monitor their own peak air flow. Parents can buy devices that tell them whether their child's sore throat is a strep infection. Another device tells them whether the child's ear ache is an infection.

New products are coming on the market every day. But to make all of this work, the patient who manages his own care must also manage the funds that pay for that care. That will be the promise of health savings accounts in the future.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Goodman appears in the appendix.]

Senator HATCH. Thank you.

Mr. Beittel, you will be our concluding witness.

STATEMENT OF ERIC C. BEITTEL, ENDERS INSURANCE ASSOCIATES, HARRISBURG, PA

Mr. BEITTEL. Chairman Hatch, Ranking Member Rockefeller, and members of the committee, thank you for the honor to address you today.

My name is Eric Beittel, and I am a self-employed Certified Financial Planner and insurance producer from central Pennsylvania.

My father always said to speak from the heart and your audience will hear you. I could advise you financially about the many fine cost-saving attributes of the health savings accounts, or I could tell you about the various small businesses that I have helped implement HSAs as a way to continue offering employees high-quality benefits while costs continue to rise.

But those stories, though very meaningful to me, are not entirely from my heart. Instead, I am going to tell you about my family's health savings account and how it has allowed us to live out a few of our biggest dreams by giving us a financially sensible avenue to health care.

In the summer of 2003, my wife Jennifer and I had our second child. Though Jen had a job she loved as a public high school teacher, she wanted to stay home with our children, knowing firsthand just how important parental involvement is.

But we had a problem. While we figured we could tighten the belt and live without her income, we could not live without her health insurance coverage—our health insurance coverage—particularly with two young children.

As a self-employed financial advisor, I did not think that we could afford the high cost of individual health insurance on one income. When I looked for coverage, I discovered it would cost about $800 to $1,000 a month, and that coverage did not really compare to the rich benefits my wife had under her health insurance plan in her school district.

I then learned about medical savings accounts and the new HSAs coming in 2004, and I was hooked. We could get insurance for $200 to $250 a month. The monthly savings in cost of coverage would more than make up for the high deductible.

Although there would be some initial risk in having a large deductible, it gave me an extraordinary opportunity, an opportunity for my wife to be home with our children: priceless. We still have an HSA today, and my wife is still at home, now with three children.

Though our family has had a few health bumps in the road, including a gall bladder removal, ear tubes for the baby, and Lyme disease, we would never switch back to our old insurance. Despite our high out-of-pocket health costs—we hit our deductible the last 2 years—today we are far more in tune with our health, and we are savvy consumers.

We research treatments, compare costs, and really consider our lifestyle choices as part of the complete picture. We have saved a

ton of money, which only encourages us to continue weighing in the many different health and lifestyle options available for our family.

Here is a great example of our newfound attention to detail. My wife had to take our oldest child to the emergency room while visiting her parents in rural Pennsylvania because he fell and split open his chin.

Alone on this trip, she frantically called me to check on our insurance. But I told her not to worry, and to give them our insurance card and to get our son the care he needed. Fortunately, our son did not require stitches. The physician assistant who saw our son sealed his chin with Dermabond™ and kept it closed with strips.

It took all of about two minutes. About a month later, we got the bill from the hospital. The total charge was about $630. While it is difficult to walk into an ER and not accrue such charges, I found two interesting items on the itemized bill. First, there was a fee for a specialist physician when my son was seen by a PA; second, was for sutures, which my son definitely did not receive.

I made one very patient call to the hospital to discuss these charges. The hospital took a day or two to research my concern, that I was charged for services my son did not receive. When they called me back they stated the charges were incorrect and our bill would be adjusted.

The end result? Our bill was adjusted from $630 to $304. In the day of our old health insurance, we never would have read the itemized section of the bill or explanation of benefits. We would have just read the "insured responsibility" section to verify our co-pay and deductible.

Additionally, after this experience in the ER, my wife added the over-the-counter Steristrips™ and Dermabond™ to the first aid kit she carries. [Laughter.] If there is a next time, she will be ready.

But what really do our experiences with our health savings accounts have to do with living our dreams? It is my wife's dream to be at home with our kids while they are young, and there she is, loving nearly every minute of it. It allows me to concentrate on growing my business instead of juggling a family life with two working parents and three young children.

The quality of family time that we have because one parent can fully devote her time and energy to our children and our household is an amazing blessing that should be achievable for any family in America. I speak from the heart about health savings accounts.

They have helped our family live out many of our dreams, and they can help many more Americans do the same. My family has had an HSA for nearly 3 years, and I have helped hundreds of people in dozens of businesses evaluate and implement HSAs. I have seen it all.

However, until last week I had no idea there were any bills proposing improvements to HSAs. I was pleased to learn about many valuable improvements proposed in legislation sponsored by Senator Hatch, Representatives Kantor and Ryan, and other members of the Congress.

In particular, as policy makers look to improve HSAs, I believe the following changes would go a long way to expand access to HSAs for those who need them most: increase the limit on HSA

contributions, especially for those with high health costs, and permit those who enroll in a high-deductible health plan mid-year and are subject to the full annual deductible to be able to make that full annual contribution to their HSA.

Thank you for the honor of addressing you today. I would be happy to answer any questions the members of the committee have for me.

[The prepared statement of Mr. Beittel appears in the appendix.]

Senator HATCH. Well, thank you, Mr. Beittel. We appreciate the testimony of all of you. We are really interested in trying to find the best ways we can to help our country and to help each individual citizen.

Dr. Carroll, you have listened to all of the testimony here today. Would you care to comment on any of it, in light of what your findings are?

Dr. CARROLL. I think, listening to the testimony, HSAs clearly do provide more options to individuals. They give individuals a greater stake in their health care decisions, and I think it is the case that when individuals have more at stake in their health care decisions, they will tend to make better decisions, more informed decisions. I think HSAs are certainly an important part of the health care solution to help control health care costs.

Senator HATCH. What about some of the issues Dr. Collins has raised?

Dr. CARROLL. She raised a number of issues. One issue is, who is benefitting from HSAs? I think the early evidence on HSAs, which is still fairly early, indicates that a fairly broad spectrum of the population is benefitting from HSAs.

The statistics that I have seen suggest that roughly 42 percent of those with HSAs have incomes below $50,000, indicating that HSAs are being used by lower-income and moderate-income individuals, and I think that is very, very significant.

The data that I have seen suggest that roughly half of those individuals with HSAs are 40 or over, suggesting that a portion of the older population, as well as the younger population, is taking advantage of HSAs.

It was mentioned earlier that for those purchasing HSAs in the non-group market, industry data suggest that perhaps as many as one-third of those individuals were previously uninsured, again suggesting that, in terms of addressing the uninsured problem, HSAs are a significant part of the solution.

Senator HATCH. You testified that data showed that about one-third of those who purchased HSA-eligible health plans in the non-group market were previously uninsured. I do not know if we have any data on what percentage of those in the group market were previously uninsured. But would we not expect it to be even higher?

Let me ask one other thing. After all, is it not one of the goals of health savings accounts to make insurance more affordable to those who do not have it? Therefore, even if only one-third of HSA owners were previously uninsured, do you not agree with me that this is really a significant factor?

Dr. CARROLL. I think that is a very significant finding. It is fairly early evidence. I think as time goes on and we have a better expe-

rience with HSAs, I think that is something that we want to continue to look at very carefully, the number of folks who have HSAs who were previously uninsured.

Senator HATCH. All right.

Mr. Knight, in your small business case, what were the largest challenges in connection with offering health savings accounts? What did you find to be the biggest challenge?

Mr. KNIGHT. Well, the largest challenge for us was educating the employees and helping them understand the differences between the plans. In 2006, the case was so compelling that what I actually did was offer an evening session, with pizza, for employees and their spouses to come and go over the traditional plan versus the HSA plan, and look at the financial ramifications.

I have heard some of the testimony here. I can only speak to my specific plan. But financially, my $4,000-deductible family plan, when you take into account the savings in premiums, as well as the contribution we made as an employer into that plan, there was no possible scenario I could come up with that would make the employee worse off at any income level with the traditional plan.

So once I got through that information and presented it to my employees and they understood that, it really overcame a lot of obstacles. But I think the biggest challenge with these plans, offering it to a company with employees who are used to more traditional plans, is education and helping them understand the difference in the plans and the way an HSA works.

Another thing that occurs to me, Senator Hatch, is that we are looking at the first year here. As employees build up money into that account, these accounts can greatly exceed the amount of the deductible, which means that our employees or the people that work in my company will be 100-percent covered in the future as these plans accumulate.

Finally, by far, the people who are best off financially when I modeled it were those who had the most chronic and serious health care problems, and that is primarily because the co-pays do not count towards deductibles.

Since the PPO plan we were forced to go on because of our health problems had a high deductible and high co-pays, that created a situation where their out-of-pocket was greatly increased because of their severe health care problems, when compared to an HSA.

Senator HATCH. Could I ask one more question before I turn to you?

Senator ROCKEFELLER. Sure.

Senator HATCH. My question is, why do you offer health insurance at all to your employees? The reason I ask this is that there seems to be an unstated assumption among some HSA critics that these plans are the first step towards doing away with employer-provided health insurance altogether. What benefits do you get as a company from providing health insurance to your employees?

Mr. KNIGHT. As a company? Well, first of all, I would argue exactly the opposite. Having an HSA option made it more likely that I could offer health care to my employees and made it possible for me to keep the coverage with the same amount of funding that I could have handled otherwise.

That 49 percent increase would eat into my profits, but it is also something the employees had to handle, Senator Hatch. So offering the plan to my employees and having employees have health care not only is critical and made possible through the HSA, but, if I did not offer that, I would lose employees at every level of my company.

We have a lot of blue collar employees, and we also have some professionals that work in engineering, and they expect to have health care coverage. You take that away, and I cannot compete with some of my competitors who are able to offer coverage.

So I never thought of not offering health care coverage as an option in my business because of the types of people we hire, and the fact that it is so important to retain employees in a technology-based business, that you cannot handle the turnover that comes with offering limited benefits and not offering insurance.

Senator HATCH. Well, thank you.

Senator Rockefeller? Then I will have some more questions.

Senator ROCKEFELLER. Yes. I think, there just being two of us here, we should be able to proceed.

Senator HATCH. Keep going?

Senator ROCKEFELLER. Yes.

Senator HATCH. Go ahead.

Senator ROCKEFELLER. Dr. Carroll, the President's fiscal year 2007 budget includes two main proposals allegedly aimed at increasing health insurance coverage, an individual tax credit and expansion of HSAs.

Now, these proposals are not news to us. They have been included in previous budget requests as well. However, there is a question that I have been trying to get for the better part of several years and I have not gotten an answer. I think I can predict your answer that I have a question about.

I asked former Treasury Secretary Snow and current Secretary of Treasury Paulson by letter, and no one was able to answer this question, even though it is fundamental to the analysis of health savings accounts, so, I am hoping you are going to answer my question today.

The question is, how many currently uninsured Americans do you estimate each of these initiatives, health savings accounts and individual tax credits, would cover?

Dr. CARROLL. It is a very, very difficult question. It is very, very difficult to quantify the effects on the number of insured, particularly the way that we do the modeling at Treasury.

First, I should point out that we very much view this as a package. There are actually five different proposals. There are two deductions, one for high-deductible health insurance premiums, one for a higher level of out-of-pocket expenses for high-deductible health plans or HSAs, contributions into HSAs. Then there are three refundable credits: one credit for payroll taxes paid on premiums, another refundable credit for payroll taxes paid on out-of-pocket expenses, and the third credit—which is probably familiar to you having been in a number of budgets, although this year it is focused on high-deductible health plans—a refundable tax credit targeted to the lowest-income individuals to help them afford health care.

We view this very much as a package, and so it is very, very difficult to disentangle the effects of any one particular provision.

Just as an illustration of this, in the blue book that Treasury produced to accompany the budget, we show the revenue effect of the refundable tax credit targeted to low-income individuals to help them better afford health insurance. We estimated that credit to cost in the neighborhood of $22 to $25 billion.

The way we did the estimates, it is stacked after all of the other elements of the package that I described, so it presumes that all of the other elements, for the purposes of the estimate, have already been enacted.

If we were to estimate the effect of that one proposal relative to current law, presuming that none of those other proposals were enacted, instead of costing $22 to $25 billion, it would cost over $50 billion. The interactions between the proposals are very, very important.

Senator ROCKEFELLER. You have made your point on interactions, and therefore not being able to come up with answers. You work for the Treasury Department. You are a highly trained professional. You ought to be able to answer my question. If you cannot, I will for you.

Dr. CARROLL. Again, I do not think we are able to put a specific number on how the proposals would affect the number of uninsured. I think what we can do, and what we have done, is provide a qualitative answer: by controlling the rise in health care costs, the initiative will help increase the number of newly insured. So, that much we can say.

Again, I think the root problem in health care is that health care costs are rising considerably faster than incomes, and, in any country where health care costs continue to rise at 2 percent above GDP for a long period of time, we are always going to have an increasing number of uninsured in terms of an absolute number, or relative to the size of the population.

Senator ROCKEFELLER. May I just interrupt to say that you are not going to answer my question. I am not being—well, I am being a little bit, I guess, abrupt, and I apologize.

I suggest that you look at the number 3.2 million. I think that is what the answer is probably close to being. I would then point out to you that most of those will have been, were previously, already insured.

I would just appreciate, when you are creating public policy, you may be doing it for a whole subject, but the incremental parts of it each are public policy discussions within themselves and ought to have statistical consequences and answers.

So I think that is approximately what you are going to come up with. Then if you come anywhere close to that, the fact that they previously had health insurance, maybe you could respond to me by letter about that problem.

Dr. CARROLL. All right.

Senator ROCKEFELLER. Thank you.

For John Dicken and for Dr. Sara Collins, this has to do with income levels of HSA purchasers.

Mr. Dicken, GAO's findings seem to suggest that higher-income individuals are more likely to enroll in HSA-eligible plans. Your re-

port specifically mentioned that HSA purchasers had an average adjusted gross income of $133,000 in 2004.

Mr. KNIGHT. Yes.

Senator ROCKEFELLER. Now, when you talked about your employees, Mr. Knight, you said they were very happy with the switch to HSA coverage, but you also mentioned that the family deductible under your new plan is $7,000. So that would lead me, I think, inexorably to the question of, what is the average age of your employees? You have, what, 34?

Mr. KNIGHT. Yes, in the plan. The average age is early 40s, probably, mid-40s.

Senator ROCKEFELLER. Early 40s. Would you call that relatively young and relatively healthy?

Mr. KNIGHT. No, I would not. Not my plan.

Senator ROCKEFELLER. You would not?

Mr. KNIGHT. No. Not with the problems we have. Not relatively healthy.

Senator ROCKEFELLER. All right. Do you believe that if one of your lower-wage workers—if you have such; I do not know what your structure is——

Mr. KNIGHT. We do. We have workers in the $7 per hour range. That is where we start.

Senator ROCKEFELLER. All right.

Do you think they would still be pleased, if they experienced a catastrophic new medical problem? Would your lower-income employees have $7,000 in available disposable income to cover that?

Mr. KNIGHT. Yes. Let me answer that. The answer is, they would be better off.

Senator ROCKEFELLER. Do you see what I am getting at?

Mr. KNIGHT. I understand what you are getting at. The answer is, they would be much better off with the HSA, and here is why.

First of all, the plan has two deductibles, a $4,000 and a $7,000. You can decide by premium. The problem is, because of our problems, our PPO plan had a $3,500 deductible.

So, to go from the $3,500 to the $7,000 deductible, that differential was offset by the fact that we put $1,200 in their HSA account, plus they save $100 a month in premium.

When you add the savings together and take that into account, it is actually less of a burden for them to cover the $7,000 than it would have been to cover the $3,500.

In addition to that, the co-pays, for example, when they get a prescription or when they go to a doctor's appointment, do not count towards that $3,500, Senator Rockefeller.

So comparing the two together, my employees that use the plan a lot, even at the lowest income levels, come out better off because of the PPO plan that I was offering to them and the fact that it was a high-cost plan.

Senator ROCKEFELLER. You had a problem before and you consider this to be marginally better.

Mr. KNIGHT. Let me explain further.

Senator ROCKEFELLER. Then, Dr. Collins, I want you to comment.

Mr. KNIGHT. We had a plan that was of typical cost, and then we had two terrible medical situations in our small group. For that reason, the carrier started raising our premiums dramatically. Not

only did they raise our premiums, but they also said we are going to go to a higher co-pay, so instead of $25 for a doctor visit, it is going to be $50; instead of $15 or $25 for a prescription, it is going to be $45. So they raised that.

They also raised our premium as well. So we are at this high-cost PPO plan, whereas if I go to the HSA, the increase in premium came down a little bit, but I still had that high deductible. I had one $7,000 deductible, but the co-pays and everything else went away in the HSA.

However, when that low-income employee starts spending money, every dollar they spend goes towards that $7,000 deductible. Whereas, in the PPO plan, all of those co-pays—which, frankly, I know this is staggering, but for one of my employees, they were spending $900 a month in medical co-pays, on average. That does not count towards the deductible in a PPO plan. It did in the HSA.

So this employee who had a chronic health problem was saving thousands and thousands of dollars by going to a $7,000-deductible plan. Thousands. And that employee was elated by going to an HSA. He had a large family. One of the children had a serious health problem and they needed numerous prescriptions every month.

Senator ROCKEFELLER. Dr. Collins, how would you react to that?

Dr. COLLINS. I do not think that either situation was particularly beneficial, either for the firm or for the employee. It is hard to see how going to yet a higher-deductible plan is better for the employee.

I mean, if you look at the considerable amount of evidence that there is on people's out-of-pocket spending and what it does to their health care behavior, there is incontrovertible evidence that people delay care or do not get care if they have high out-of-pocket costs, including high deductibles. So it is hard to see that this is a much better situation for the employees.

The other thing that high-deductible plans do and high out-of-pocket costs do is, they prevent people from saving, so they are shifting resources into their health care and not saving.

Mr. KNIGHT. Dr. Collins used very general information. I am talking very specifically about my cases. And I am a finance guy. When my employees have more money in their pocket, they are better off, period. That is what happened with the HSAs.

Senator ROCKEFELLER. Well, you are talking about specific cases. We are talking about an entire country.

Mr. KNIGHT. I understand. I understand. I am just talking about my experience with my two or three families that had chronic problems. That is exactly right, Senator. I understand.

Senator ROCKEFELLER. I respect what you say.

Mr. KNIGHT. Fair enough.

Senator ROCKEFELLER. And my time is well over.

Senator HATCH. Well, thank you, Senator.

Let me go to Mr. Dicken here now. Your study drew some comparisons in the income of HSA-eligible plan enrollees and enrollees in traditional health plans.

However, I am troubled by the logic of the comparisons. For example, on page 6 of your testimony you mentioned that "the ad-

justed gross income of the estimated 108,000 tax filers reporting HSA contributions in 2004 was about $133,000, compared with just $51,000 for all tax filers under age 65."

Now, rather than comparing the HSA enrollees to traditional plan enrollees, you are comparing them to all filers. Now, this seems to me to be an invalid comparison. Should we not be comparing the $133,000 figure to the AGI of traditional plan enrollees and not all filers under age 65?

My guess is, the AGI of traditional plan enrollees is also going to be far in excess of the $51,000 average, because many filers do not have health insurance at all.

Now, the report makes the same mistake, in my opinion, on page 7, when you compare the income from the other data sources. This does seem to be a major flaw. What is your response on that?

Mr. DICKEN. Thank you, Mr. Chairman. Certainly we draw a number of different comparisons in looking at credible data that look at the income of people that purchase HSA-eligible plans. The IRS data, as you indicate, do compare those that make contributions to their HSAs to all tax filers. Unfortunately, the IRS data do not allow us to look specifically at those who would have insurance, and we recognize that limitation in our report.

But to bolster that, we make a number of other comparisons, looking at Federal employees who have selected a health savings account compared to others who purchased traditional plans, looking at two employers, and data from a national insurance broker, and they all come to the same conclusion, that these are higher-income people purchasing the HSA-eligible plans than traditional plans or PPOs.

Senator HATCH. Well, Drs. Collins and Goodman, let me throw one to both of you. Could you please describe for me the evidence that HSAs are creating a distortion in the insurance pools that will lead to higher premiums and a greater number of uninsured? And were these not the same charges that were made when we moved toward managed care? Dr. Goodman?

Dr. GOODMAN. Absolutely. And there was some evidence that healthy people joined HMOs. But many of the people who today criticize HSAs on those grounds never had one unkind word to say about the HMO form of delivery, so they are cherry-picking the occasions on which they want to make this allegation.

Probably the best evidence we have on how all this is going to work is, surprisingly enough, South Africa. Because about the time that Nelson Mandela became president, they deregulated their insurance industry.

Virtually every product that we have in the United States competed on a level playing field in South Africa. There were not a lot of government regulations saying what the HSA had to look like. It was pretty much a free market.

Over the next decade, the HSAs captured most of the market. In fact, I think today they have two-thirds of the entire market. But there is no evidence of all the healthy people running one way or all the sick people going the other way. These are plans that, as I said earlier, appeal to a broad cross-section of people.

The problem with the GAO study is, when you see numbers that are just way out of whack with what we know from other experiences, they just chose unrepresentative companies.

If GAO had chosen to survey Whole Foods, they would have discovered there are tens of thousands of employees making $20,000 a year who are in HSA accounts. And not only that, but at Whole Foods the employees get to vote on whether they want to switch back to the old health plan. Eighty-five percent of those employees voted to stay with their health savings account product.

So I would say that GAO study, the answers they got, are simply a function of which companies they chose and are not representative of the market as a whole.

Senator HATCH. Dr. Collins?

Dr. COLLINS. I think the experience of the FEBHP, the Federal Employees Health Benefit Program, product shows that in an employer group plan, people who are offered a high-deductible health plan HSA product and choose to go into the product tend to be younger. So if you look at just an employer-based plan, enrollees do tend to be younger, they do tend to be higher-income.

So if you put that experience in a small employer firm context so that a small employer offers an HSA product and a lower-deductible product, the HSA/high-deductible product will probably attract a younger and more affluent member of the company.

To the extent that the youngest and healthiest workers go into that product, leaving the older and less wealthy and sicker employees in the other product, you could have a situation where the premiums become so expensive in the other product, the lower-deductible product, that it is no longer a viable insurance product.

To the extent that a small employer only offers a high-deductible plan, it would surely benefit their higher-income employees, their healthier employees over their lower-income and sicker employees, leaving few options for that group of employees.

Senator HATCH. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Goodman, a question for you. In your testimony you made a very interesting comparison. You stated that "HSAs are like Medicaid Cash and Counseling." I strongly disagree with you.

I think that comparing HSAs to Medicaid Cash and Counseling is an apples to oranges comparison at best. Individuals with diabetes who participate in Cash and Counseling have a personal care manager to help them plan their health care budgets.

Are you suggesting that every HSA enrollee in America has access to a personal care manager to plan their budgets? This is the argument in this so-called 4 to 2 panel, 4 in favor, 2 with questions.

I do not think this is the case. Prima facie, it is not the case because the argument is that the individuals can make the best choice themselves and do not need to have these personal counselors.

Also, Cash and Counseling is for personal care only in your example, not health care. Personal care is washing, feeding, transportation to the doctor's office, et cetera. So do you not think it is somewhat of an overstatement to say that these two are alike?

Dr. GOODMAN. No. But that is an interesting metaphor that you used, the apples and oranges, because that is what has been happening up and down the table throughout this hearing. We keep talking about these plans as though they are all alike, and they are not all alike.

At my organization, the National Center for Policy Analysis, we fully fund our health savings account; at Mr. Knight's place of employment, they do not. So these are two completely different plans, even though both involve patients managing their own money.

Now, there are health savings account plans out there where the diabetics do have a counselor in the private sector. What I meant to say in my testimony is we have not taken advantage of how to use these accounts. In the Medicaid program, you are right, it started out as custodial care.

I have been told by HHS that now they have moved into real health care dollars, so in many of these experiments it is more than just custodial care. If I am wrong about that, then I stand corrected, but I have been told that it now involves more than just that.

In any event, the principle is the same, that you empower patients, you give them the opportunity to manage their own money, where it is appropriate for them to do it. We have not made enough of a distinction here. We do not want patients to make every decision.

If you are unconscious on the gurney, you are not in the right place to be making health care choices. But on how to handle a lot of diabetic problems, on what drug to take for relief from arthritic pain, those are cases where patients can manage their own care and make a lot of their own decisions.

Senator ROCKEFELLER. Dr. Collins?

Dr. COLLINS. The thing that is hard to understand when we talk about diabetic care and chronic care in the framework of these plans is that the law is explicit about not covering prescription drugs that would take care of those very chronic conditions, so I do not understand the logic about this being good for people who have chronic health conditions.

If you look at the data, when people with chronic health problems face high out-of-pocket costs, face caps on their drug benefits in the case of Medicare beneficiaries, certain studies have shown this, that people tend not to get the drugs that they need to take care of diabetes, to take care of heart disease, and it ends up costing the health system more down the line. So again, it is hard to understand that logic.

Senator ROCKEFELLER. Mr. Chairman, my time is over.

Senator HATCH. Well, thank you.

Let me go to you again, Dr. Collins. You cite the RAND Health Insurance Experiment as evidence that greater cost-sharing reduced the amount of health care that people obtained.

Now, what did this study, or any other subsequent studies, reveal about the subsequent health outcomes of those people with greater cost-sharing as compared to those who participate in low-deductible health insurance plans?

Dr. COLLINS. There are a couple of recent studies, one by John Hsu at Kaiser-Permanente that looked at capping the Medicare

drug benefit and the effect that it would have on Medicare beneficiaries' use of prescription drugs.

They do find a statistically significant and substantial reduction in the use of chronic care medications that led to adverse health events for those Medicare beneficiaries, who reduced their use of prescription drugs, ending up in the hospital, not being able to control their blood pressure, trips to the emergency room. There was another study in Canada that looked at the effect of higher deductibles on prescription drugs and found similar evidence.

Senator HATCH. Dr. Carroll, let me just ask you this. Would you care to comment on that first?

Dr. CARROLL. Yes, I would. If you go back to the RAND study, as I understand it, they did not find any statistical difference in the outcomes.

Senator HATCH. That is right.

Dr. CARROLL. But they did find that plans with no cost-sharing spend 45 percent overall on health care than individuals in plans that had a high degree of co-insurance, which was very substantial.

I did want to mention one other point that is related to a number of comments that have been made about preventive care. There is what appears to be some fairly recent research that finds that HDHPs, high-deductible health plans, may in fact encourage preventive care. Preventive care can be covered under a high-deductible plan, of course.

This is a very important finding. A recent study found that 5 percent more individuals sought preventive care with an HDHP than with a traditional PPO. The intuition behind that actually makes some sense.

For somebody who has a stake, who has to pay out-of-pocket for their medical care, they actually have a self-interest in receiving and obtaining preventive care in order to lower their future health care costs.

This is exactly the sort of market efficiency, if you will, that we want to encourage through HSAs. Some early evidence suggests that preventive care may actually be sought more frequently under those with HSAs than those with traditional PPOs.

Senator HATCH. Let me ask you, at Treasury, what efforts are you making through regulation to make these plans better?

Dr. CARROLL. We have been very aggressive. The approach we have taken is to issue regulatory guidance early and often, as we say. The regulatory guidance is really handled more on the legal side of the office as opposed to the economic side that I head up.

But one good example is preventive care. Early on there were some questions about what type of preventive care could be covered under high-deductible plans that would qualify for HSA contributions, and we worked very, very quickly to provide clarification of that through regulatory guidance.

Senator HATCH. Let me ask you this, Mr. Beittel. We have kind of ignored you here, but we have not meant to ignore you. We just had a lot of these technical questions to ask folks.

But I would like to ask you a question that is pretty practical in nature. That is, among the principal charges against HSAs plans is that they are only for the wealthy, or they mostly benefit the wealthy.

Also, the unstated assumption is that somehow they are sub-par plans that do not cover anything and that do not include employer contributions for the deductible. Now, do these charges jibe with your experience?

Mr. BEITTEL. Not at all. Employers are very concerned about still giving quality benefits with the lowest cost to the employee as possible. I have many companies which have tailor-made their HSA contribution to be similar to the type of resource contribution they had made to their previous health care plan.

I think Dr. Goodman made a great point, that comparing one HSA plan to another HSA plan is kind of like comparing apples to oranges. Of course, if an employer does not add any money to it, it is disappointing, to say the least, but most employers add quite a bit.

I had one employer fully fund it, and it still resulted in about an 8 percent savings overall to their previous plan. So, everybody won in that situation. The employees paid less, the employer paid less, and still high-quality care was there. For me personally, to take on $2,400 for my family, I saved roughly $3,600 a year in insurance premiums.

Senator HATCH. That is pretty impressive.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you.

Dr. Carroll, I just want to make an observation. You know, there is no question, I am a Democrat, he is a Republican, we are very good friends. We agree, and we have created some amazing programs together here in Congress.

But there is no question that one of the problems is that the administration's focus, to our way of thinking, on high-income people, particularly through the tax cuts, which are incomprehensible to me—Senator Hatch will have a very different view, and I understand that—so that it seems like over the recent years we have been through a series of situations which continue to help those that are either younger, healthier, or have higher incomes. I think this is another example.

Now, you said something very interesting, which I want to explore, not with you but with my staff. That is that HSAs encourage wellness or prevention of illness as opposed to curing of illness, or both.

But the wellness factor, prevention factor, is enormous, in my mind, how that can get done, how we can get people to do that. So, one of the things I am just going to say to you that we are going to do, is to look at what you said with respect to that wellness factor. If you are right, that is very significant, and I need to take that into account. All right.

Mr. Beittel, I do not want this to come out wrong, and it is going to, so forgive me for that. I am glad you are here. I am glad you are telling us about your experience with HSAs. It is valuable for us to hear from somebody like you who participates in an HSA.

A couple of questions, however. You are an insurance salesman, working for Enders Insurance Associates, are you not?

Mr. BEITTEL. Yes.

Senator ROCKEFELLER. And could you please tell the committee whether you sell HSA products?

Mr. BEITTEL. I sell the high-deductible health plans that go along with the health savings accounts. Yes.

Senator ROCKEFELLER. That just needs to be said, without prejudice. Your answer needs to be heard. It becomes a little bit more difficult for you to tackle your own product.

Mr. BEITTEL. Have you ever tried to sell health insurance or manage it?

Senator ROCKEFELLER. No.

Mr. BEITTEL. It is no fun.

Senator ROCKEFELLER. I do not expect you to have a fun-filled life.

Mr. BEITTEL. I would truly rather be working in other fields of my expertise.

Senator ROCKEFELLER. I understand. But you are not. One of the things you are doing is selling HSAs. I just want that on the record, without any prejudice to you. You have a right to do anything you want in life. But you are before this committee testifying on HSAs, and that needs to be said.

Dr. GOODMAN. May I say something about that? If he was a normal insurance agent, his commission is lower on the health savings account plans than on any other insurance he sells. Is that not right?

Mr. BEITTEL. For most companies, that is correct. When the insurance premium is 30 percent less, that means I generally make 30 percent less.

Senator ROCKEFELLER. That does not change my point of view. I appreciate the intervention. I do not appreciate the use of my time, but fair enough. Whether you make more or less is not a concern to me. It is the fact that you sell the product and that you are here before us, and I think that is valid.

I have a question, again, for Dr. Carroll. Although more than 3 years have passed since the trade adjustment assistance, the TAA Health Coverage Tax Credit that began in late 2003, I think, the program still serves very few—in fact, less than 10 percent—of the displaced workers and early retirees who receive notices of potential eligibility. So, let us look at that for a second.

I think, Dr. Carroll, that the HCTC program is a good example of what happens when you use the tax code to try to expand health insurance coverage. People do not get the health care they need. The nature of a tax deduction is that it is more valuable to people who pay higher taxes at a marginal tax rate. I do not think that is disputable.

The value of deduction to a high-income worker is, as I think you indicated, more than three times the value to a low-income worker. Or maybe that was Dr. Collins who indicated that. It seems to me to be a bad public policy to offer large subsidies to more affluent people, those who need less subsidy, to afford health insurance in general.

So my question is, if a person does not have enough income to be liable for any Federal income tax—and I addressed that in my opening statement—then are the HSA tax benefits of any value to that worker?

Dr. CARROLL. Well, I would focus on two different points.

Senator ROCKEFELLER. And I am assuming that 55 percent of uninsured Americans do not make enough income to pay Federal income tax. Right?

Dr. CARROLL. I think the average family of four begins paying income taxes when they have about $41,000, $42,000 of income, which I think is consistent with your comments.

HSAs not only provide tax advantages, they also provide more flexibility to workers. As I mentioned in my opening statement and in more detail in my written remarks, one of the features of HSAs is that they are portable.

An individual owns the HSA, as distinct from FSAs and HRAs. When an individual leaves a job, they take the HSA with them, so that affords more flexibility to workers, where over time in this economy we have had an increasing number of workers who have switched jobs.

HSAs also provide the opportunity for some savings. We have heard a number of individuals on the panel talk about the lower premiums that result from HSAs. There is an actuarial relationship between the higher deductible and lower premiums under HSAs, as well as the employer contributions that are often made into HSAs.

I would just remark that Mr. Knight's experience for his firm is actually fairly close to the average for the economy. The numbers I have seen suggest that, for singles, employers, on average, contribute $580; for families, employers, on average, contribute $1,092.

So to summarize, HSAs provide, I think, a broader set of benefits than just the tax advantages. What is interesting about the IRS data from 2004 that Mr. Dicken has in the GAO report is that a significant number of lower-income taxpayers have HSAs, even though they may in fact have no income tax liability. So, that might be an indication that there are non-tax benefits associated with HSAs that individuals benefit from.

The second point I want to mention is, the President's initiative really does realign HSAs in an effort to reduce or eliminate the tax disincentive for high-deductible plans or tax incentive for first dollar coverage.

It tries to create a level playing field, if you will, between insurance purchased through employers and insurance or health care purchased directly by individuals.

It does so for those with high-deductible plans, but through a series of credits and deductions, eliminating the income taxes, as well as the payroll taxes. Because it is eliminating the payroll taxes, one of the benefits of the proposal, if you will, is that it realigns the distributional effects of HSAs.

There is a table in my written testimony on page 14 that illustrates for a typical family of four with high and low medical expenses the tax benefits that a typical couple could expect to receive under the President's initiative.

What you see is, for an individual with typical medical expenses, lower-income individuals will actually receive a higher dollar tax benefit than higher-income individuals. When you look at the person with higher expenses, you cannot exactly say that.

You cannot say that the lower-income individual will receive a higher dollar benefit. But the relationship is not very different. The

lower-income individual receives almost as much in terms of a dollar benefit as a higher-income individual.

The point of all that is that, because of the payroll tax credits or the tax credits for payroll taxes paid on premiums, out-of-pocket, and the targeted tax credit for lower-income Americans, the initiative really does realign the distributional effects of HSAs, I think, in an important way.

Senator ROCKEFELLER. Mr. Chairman, can I ask one more question of Dr. Collins?

Senator HATCH. Sure.

Senator ROCKEFELLER. Thank you.

I would like to explore a very important argument that HSA folks say, and that is that their HSA accounts would drive down the cost of health care by having consumers be more price sensitive. I would like to have you comment on this.

It has been argued that patients will be more careful about what health care they receive if they personally must pay the bills as part of a high-deductible plan. I personally am skeptical of this, for several reasons.

I understand that 70 percent of all health care costs are paid by the sickest 10 percent of Americans. People who have chronic conditions or a catastrophic medical event will quickly exceed their deductible, even in plans with high deductibles.

So my question to you is, will the HSA model actually impose any pricing pressure for those patients who already have exceeded their deductible? If the data is correct, that 70 percent of the costs are incurred by a small share of the total patient population, then is it realistic to expect that price pressure will affect more than one-third of health care expenditures?

And Mr. Knight, I have a written question which I will send to you.

[The question and answer appear in the appendix.]

Dr. COLLINS. The EBRI Commonwealth Fund survey does show that people in high-deductible health plans are somewhat more cost-conscious. They tend to talk over treatment options with their physicians, and are more likely to ask for lower-cost drugs.

We also show in the survey that only 14 to 16 percent of people have any cost or quality information available to them to use, so, even if people wanted information about the cost of their physicians, they would not be able to find it because it is simply not provided by their health plans.

But even if people had full information about prices and quality, it is unreasonable to expect, given the point that you make about the large share of health care costs that are borne by very sick people, that high-deductible health plans, health savings accounts, would have a transformational impact on the health care cost problems that we currently have and on the quality problem we have.

Increased transparency, both on prices and quality, is very good policy for the health system in the United States. We want people to know more about the cost of their health care. We want employers to know more about the cost of their health care.

We want buyers and purchasers to know more about the cost of health care, and we want people to know more about the quality of the providers that they are going to. But research has shown

that public information on quality is more often used by the providers who are required to provide information about the quality of their care to improve quality of care, rather than patients. Focusing on provider use of quality of care information and cost information will have the most important impact on quality and costs in the health care system. Patients are really in the weakest position to demand high quality and efficiency from their providers.

Senator ROCKEFELLER. I thank you.

Thank you, Mr. Chairman.

Senator HATCH. Thank you, Senator Rockefeller.

Dr. Goodman, would you care to respond to that? Then my last question to you is, are these plans working?

Dr. GOODMAN. I think Senator Rockefeller's question is very interesting. We have a market in which physicians do not really compete for patients on the basis of price or quality, nor do hospitals.

The reason is because the third parties have all the money and pay all the bills. Basically we ration the physicians' time by waiting in this country, the same way Canadians ration it. Although we like to think our system is very different, it really is not.

If we empower the patient, I expect, eventually, radical changes. However, only about 20 percent of those changes are going to occur because patients have changed. Eighty percent of the change is going to come on the provider side.

Once you let the diabetic control his own dollars, then you are going to find physicians who say, "Oh, by the way, I know none of my colleagues will talk to you on the phone or talk to you by e-mail, but I will do that. I know my colleagues do not keep your records on computer and they do not electronically order your prescriptions, but I am going to do that and you will get safer care, and you will be getting better care."

You will actually have a market in which people compete for the business of diabetics, whereas, in today's market they run away from them. No one wants the sickest patients. But with consumer-driven health care, you could have a real market for sick people.

We are beginning to see right now, Senator Hatch, the beginnings of a change on the supply side, I think, in response to patients controlling more dollars. The Minute Clinics in the upper midwest, the Call-a-Docs where you can pay to talk to a doctor on the phone, Wal-Mart offering generic drugs at $4, all of the new innovations in medical tourism, I think all of this is a response to consumers controlling more dollars.

I think we are going to fast approach a tipping point where you get huge changes on the supply side, and the medical marketplace will begin to look more like other markets instead of the bureaucratic market that it now is.

Senator HATCH. That is great.

Now, Mr. Beittel, do not feel badly that Senator Rockefeller pointed out how you work. Every one on this panel works in their own special way. Dr. Goodman, of course, is president and chief executive officer of the National Center for Policy Analysis.

Dr. Collins, just to mention one other, is Assistant Vice President of the Program for the Future of Health Insurance. So you are all experts in your own field, and that is why we have you here. You

have added a particularly interesting element to this hearing, so we are very appreciative of it.

I would just like to ask one other question, and I will start with you, Dr. Goodman, but I would like all of you to respond to this question if you could.

I was intrigued by your suggestion that the participation of the chronically ill in the HSA would have the broadest impact on national health care savings. But we have also heard today that the chronically ill might not see the benefits of an HSA. You would, as I understand it, overcome this difficulty by allowing greater health care contributions by employers for chronically ill employees.

I would like to know what you have to say about that. Then I would like to know what the rest of the panel thinks about this. Is there evidence to suggest that persons with preexisting conditions are finding it more difficult to get into a low-cost, high-deductible health plan? There are two questions there, and maybe more than two.

Dr. GOODMAN. To the point of what needs to be done for the chronically ill, I think someone has said that the chronic patients spend 70 percent of the health care dollars, so, if you want to take full advantage of the account, you want to make the account work for the patients who are spending all of that money.

Now, the basic design of the health savings account, and I was involved in helping design it, did not have the chronic patient in mind, quite frankly. This is just one way to start out with a health savings account.

But if you want the chronic patient to benefit and use intelligently these accounts, it seems to me you have to make different deposits to the accounts of different employees. If one employee is spending a lot more money than another employee, the third party insurance money is not the same for the two employees, so why should the deposit to the account be the same for the two employees?

It seems to me what we need to do is have special accounts for people with different chronic problems. There is a lot of literature that shows that diabetics can manage their own health care and get as good or better results than in traditional care, the same for asthmatics and other chronic conditions. So, we know that patients are willing and able to do this.

If you want them to do it well, you need to empower them. When they make decisions, they need to financially benefit from their good decisions and bear costs when they make bad ones. I think there is a tremendous opportunity here. I think you would find these accounts would be welcomed in the chronic community.

A chronic patient in the individual market is going to have a hard time getting low-cost insurance because you have individual underwriting in most States, whereas, in the employer market he cannot be discriminated against.

But in my ideal health insurance world, we not only want doctors competing for the sick patient, we want insurers competing for them as well. If you create a system in which people have perverse incentives to avoid the sick person, then they are going to run from them. But if insurers and doctors can profit from solving the prob-

lems of people who are ill, then they will compete vigorously for their business, and that should be our end goal.

Senator HATCH. Thank you.

Mr. Beittel? Then we will go to Dr. Collins, on across that way.

Mr. BEITTEL. I was born and raised in Lancaster County, which has a large Amish and Mennonite population. My father was a pediatrician who treated many of them. He said that they operated a little bit differently than the rest of us when it came to their health care. They wanted the most affordable, effective treatment. People with traditional health insurance usually do not care about affordable.

But with the Amish and the Mennonite, there are limitations as far as insurance because of their religion and they are much more of a self-pay. They were concerned about those things and they would take much better care of following treatments because their money was on the line. I think the same thing goes with HSAs.

Senator HATCH. Thank you.

Dr. Collins? By the way, I appreciate that because that is a perfect illustration of when people are taking care of themselves and doing everything they can to have great health care, and it is because they are personally concerned about every dime that is involved. The more we get people concerned about that, the better off we are all going to be. Naturally, Senator Rockefeller and I want to make sure everybody has——

Senator ROCKEFELLER. And would that we could all be Amish or Mennonite. [Laughter.]

Senator HATCH. Well, I am still hoping for you, I will tell you. [Laughter.]

Dr. Collins?

Dr. COLLINS. Just to address the point about buying high-deductible health plans in the individual insurance market, and people with chronic health conditions. A report based on the Commonwealth Fund Biennial Health Insurance survey that the Commonwealth Fund released a couple of weeks ago questioned people who had ever sought health insurance in the individual market over the last 3 years, and 70 percent of people who had health problems said they found it very difficult or impossible to find a plan in this market that was affordable.

AHIP, the trade association for health insurance plans, found in just a subset of their membership, 30 percent of people were either denied health care because of a preexisting condition, or were charged a higher premium, or had a condition excluded because of a preexisting condition.

So they found about 100,000 people in their sample over a given year were denied coverage in the individual insurance market, so it is not a particularly good market for people who have chronic health conditions.

In terms of getting employers to add more dollars to the accounts of people with chronic health conditions, you are still allowing this to be a voluntary contribution. About 37 percent of employers now do not contribute to people's health savings accounts.

Those that do, the savings, I think was mentioned earlier today, is about $689, on average, about a third of the average deductible in these plans. So, just telling employers that they are allowed to

contribute dollars for employees with chronic health conditions does not guarantee that people with chronic health conditions will have adequate access to the health care that the need.

Senator HATCH. All right.

Mr. Knight?

Mr. KNIGHT. I have a point of clarification. I think, Dr. Carroll, you said it was about $1,000, right?

Dr. CARROLL. Yes. It is $1,092 for families, roughly $600 for singles.

Mr. KNIGHT. Right. Right.

Senator HATCH. So your testimony is very important because you are living it every day.

Mr. KNIGHT. Yes.

Senator HATCH. And your business depends on how you handle it.

Mr. KNIGHT. Yes. I will just make a quick comment on this issue, if I could. Sadly, the employee that I mentioned had a wife with cancer. His wife passed away this year. This employee went through about 3 years of very, very difficult times, obviously.

It was difficult to watch him go through that. Perhaps if we had an option to fully fund his HSA account or put more money in beyond what the limit was, we would have chosen to do that, simply to take the stress off of him and to get him through that.

Now, I do not want you to believe that I am completely just trying to take care of people and love people. I do, but I am also a businessman. When you have a business with technical people—and this particular person was a CAD designer that did very high-end design for us—you need their mind in the game. You need their long-term commitment.

So, I feel like taking care of people at that level in these kinds of businesses that we have is good for business in the long run, and making profit. So, having that option, with special cases with employees, is actually a benefit to me as a business person in helping to keep my business strong and vibrant, not just this year, but in the long run. So, I think it would be a nice option to have.

Senator HATCH. Thank you.

Mr. Dicken?

Mr. DICKEN. As we talked to participants that have high-deductible health plans and talked to industry experts, there were cautions about recommending these to individuals with chronic illness, and there are several aspects that may, under current law and current IRS guidelines, limit the attractiveness to those with chronic illness.

One is what you have identified, which is that currently employers are not able to contribute more to those individuals with chronic illness. Another issue is that of maintenance medications.

Prescription drugs cannot be covered under the deductible, and so people may be on maintenance medications. They are not considered preventive, and they may not be able to get those covered until they have reached their deductible or they are paying fully out-of-pocket.

So, certainly we did hear from experts and from individuals that those were the types of things that they would look for to try to improve the attractiveness for those with chronic illness.

The other comment I think both Dr. Goodman and Dr. Collins mentioned is that certainly, in the first year of HSA, most of these accounts were in the individual insurance market. Over time, enrollment has increasingly been in the employer market. Certainly there are issues about those with chronic illness being underwritten in individual markets to get the high-deductible health plans.

Senator HATCH. Thank you.

Dr. Carroll, you are the last one.

Dr. CARROLL. Yes. The comments by Mr. Dicken are exactly right. The current comparability rules prevent employers from distinguishing between their HSA contributions. They have to provide the same percentage, the same amount of HSA contributions to all employees, with comparable high-deductible health plan coverage.

The President's proposal would change that and allow employers of individuals who are chronically ill to contribute at a higher level, so I think that is an important feature of the President's proposal.

I think, by and large, many employers do want to provide more HSA funds to employees who have higher expenses because of chronic illness. I think that change would help make HSAs more attractive.

Another point I wanted to mention is the statistic that we have heard on the panel, that a very large fraction of the health care expenditures are borne by a very small group of people. The statistic I have heard is that 20 percent of the population pays 80 percent of the health care expenses.

I think there are a couple of points to make about that statistic. One point is, first, a significant portion of health care spending occurs below the HSA out-of-pocket maximum, so even if that statistic were accurate, there would still be significant cost-sharing. There would be significant exposure to price for people below the HSA out-of-pocket maximum under, let us say, the President's initiative.

The second point to make, I think, is really important. Many people will not be able to predict at the beginning of the year that they will be over the HSA limit, so, when you start off at the beginning of the year, you have to evaluate whether HSAs will increase price sensitivity.

It is really those people who know, at the beginning of the year, that they are going to be over the limit—that is where you would think there would be less sensitivity as opposed to more. Those people who cannot forecast it, and have an extraordinarily high level of expenses, that is where you would think you would have greater sensitivity.

Based on the Medical Expenditure Panel Survey, and this is a very interesting statistic, of those with spending over the HSA out-of-pocket maximum in 1 year, only 21 percent had spending that exceeded that limit in the prior year.

So, empirically, I think it may well be the case that the 20 percent who pay 80 percent of the health care expenses, more often than not, are simply not the same people year after year.

Senator HATCH. Well, like Senator Rockefeller, I have a lot more questions. We will submit them in writing.

[The questions appear in the appendix.]

Senator HATCH. But let me just say, I think both of us feel that this panel has been an excellent one in trying to help us understand these issues and to sift through them. I, for one, am very appreciative of having you all here.

Senator ROCKEFELLER. And I, for two. We do not do enough of this. Actually, it is kind of a joy when you do not have everybody here so we can just sit and ask the questions we want. You have been excellent. Some of you have come long distances. I think both Senator Hatch and I appreciate that. I think it has been a very, very good hearing.

Senator HATCH. All right. Thank you so much. We appreciate all of you.

With that, we will end this hearing. Thank you again for being here. We appreciate all of your testimony.

[Whereupon, at 4:25 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony

United States Senate
Committee on Finance

Regarding

Health Savings Accounts: The Experience So Far

September 26, 2006

Mr. Eric C. Beittel , CFP
Enders Insurance Associates

Chairman Grassley, Ranking Member Baucus, Senator Hatch, Senator Rockefeller, and Members of the Committee, thank you for the honor to address you today. My name is Eric Beittel, and I am a self-employed Certified Financial Planner and insurance producer from Central Pennsylvania.

My father always said to speak from the heart and your audience will hear you. I could advise you financially about the many fine cost-saving attributes of Health Savings Accounts. Or I could tell you about the various small businesses that I have helped implement HSAs as a way to continue offering employees high quality benefits while costs continue to rise. But those stories, though very meaningful to me, are not entirely from my heart. Instead, I am going to tell you about how my family's Health Savings Account has allowed us to live out a few of our biggest dreams by giving us a financially sensible avenue to health care.

In the summer of 2003, my wife Jennifer and I had our second child. Though Jen had a job she loved as a public high school teacher, she wanted to stay home with our children, knowing first-hand just how important parental involvement is. But we had a problem. While we figured we could tighten the belt and live without her income, we could not live without our health insurance coverage, particularly with two young children. As a self-employed financial advisor, I did not think we could afford the high cost of individual health insurance on one income.

When I looked for coverage, I discovered it would cost about $800 - $1,000 a month, and that coverage did not really compare to the rich benefits my wife had under her health insurance plan in her school district. I then learned about Medical Savings Accounts (MSAs) and the new HSAs coming in 2004, and I was hooked. We could get insurance for $200 - $250 a month. The monthly savings in cost of coverage would more than make up for the high deductible. Although

there would be some initial risk in having a large deductible, it gave us an extraordinary opportunity…an opportunity for my wife to be home with our children. Priceless.

We still have an HSA today, and my wife is still at home, now with three children. Though our family has had a few health bumps in the road, including a gall bladder removal, ear tubes for the baby, and Lyme disease…we would never switch back to our "old insurance," despite our high out-of-pocket health costs (we hit our deductible the last two years). Today we are far more in tune with our health, and we are savvy consumers. We research treatments, compare costs, and really consider our lifestyle choices as part of the complete picture. And we have saved a ton of money, which only encourages us to continue weighing in the many different health and lifestyle options available for our family.

Here's a great example of our new-found attention to detail. My wife had to take our oldest child to the ER while visiting her parents in rural Pennsylvania because he fell and split open his chin. Alone on this trip, she frantically called me to check on our insurance, but I told her not to worry and to just give them our insurance card and to get our son the care he needed. Fortunately, our son did not require stitches. The physician assistant who saw our son sealed his chin with derma bond and kept it closed with steri strips. It took all of two minutes. About one month later, we got the bill from the hospital…the total charge was about $630. While it is difficult to walk into an ER and not accrue such charges, I found two interesting items on the itemized bill. First, there was a fee for a "specialist" physician (when my son saw a P.A.), and the second was for sutures (which my son did not receive). I made one very patient call to the hospital to discuss these charges. The hospital took a day or two to research my concern that I was charged for services my son did not receive. When they called me back, they stated the charges were incorrect and our bill would be adjusted. The end result: our bill was adjusted from

$630 to $304. In the days of our old health insurance, we never would have read the itemized section of the bill or "explanation of benefits," we would have just read the "insured responsibility" section to verify our co- pay or deductible. Additionally, after this experience in the ER, my wife added over-the-counter steri strips and derma bond to the first aid kit she carries in the van. If there is a next time, she'll be ready.

But what, really, do our experiences with our Health Savings Account have to do with living our dreams? It is my wife's dream to be at home with our kids while they are young, and there she is, loving nearly every minute of it. It allows me to concentrate on growing my business instead of juggling a family life with two working parents and three young children. The quality of family time that we have because one parent can fully devote her time and energy to our children and our household is an amazing blessing that should be achievable for any family in America. I speak from the heart about Health Savings Accounts. They have helped our family live out many of our dreams, and they can help many more Americans do the same.

My family has had an HSA for nearly three years, and I have helped hundreds of people and dozens of businesses evaluate and implement HSAs. I have seen it all. However, until last week, I had no idea there were any bills proposing improvements to HSAs. I was pleased to learn about many valuable improvements proposed in legislation sponsored by Senator Hatch, Representatives Cantor and Ryan, and other Members of Congress. In particular, as policymakers look to improve HSAs, I believe the following changes would go along way to expand access to HSAs for those who need them most:

- Increase the limit on HSA contributions, especially for those with high health costs.

- Permit those who enroll in a High Deductible Health Plan (HDHP) mid-year and are subject to the full annual deductible to be able make the full annual contribution to their HSA.

Thank you for the honor of addressing you today. I would be happy to answer any questions the members of the committee have for me.

Questions for the Record for Mr. Eric Beittel
September 26, 2006

From Senator Hatch:

Mr. Beittel, with the advent of HSAs have plan providers been driven to offer a more flexible array of plans in order to attract a more selective employer? If so, could you give this subcommittee an example of one particular feature in a high premium plan that we may not have seen before the onset of consumer-directed health plans?

Answer: In my market, employers are pushing plan providers for plans with lower premiums. Insurance companies have responded with plans that have higher deductibles and higher co-pays. So, in a sense, employers are pushing for Health Savings Accounts . . . high deductible plans that allow a management of costs for both individuals and employers while still providing rich coverage.

Mr. Beittel, in your experience how well are insurance providers responding to the needs and questions of employers and employees who are new participants in HAS-eligible plans?

Answer: In my experience, insurance providers are responding poorly at best (to the needs and questions of employers and employees who are new participants in H.S.A.-eligible plans).

From Senator Rockefeller:

1. Mr. Beittel as an insurance salesman, are you familiar with the concept of pooling risks? Would you say that it is important for an insurance pool to include people who have a range of risk?

Answer: Senator Rockefeller, I am a Certified Financial Planner. While I do, indeed, sell insurance, my primary role and approach is not the "sale," but rather, how I can help businesses and individuals meet their particular needs in a way that is financially sound. I am not product-driven, I am client-driven. I think it is important to make this distinction because the label "saleman" traditionally refers to one who sells a product...for the product's sake and for the revenue gained in its selling. I help people devise strategies, not sell products. My career, unarguably, is the source of my livelihood. However, I will undermine my own success the moment I think any product, insurance, provider, investment, etc. is the beat-all-end-all product great for everyone. Each client I serve has different needs and desires, just as each and every one of us has different health needs and desires. How could it benefit any individual to be treated the same as the next,

given the same product as the next, regardless of need and desire? We are best served in a marketplace of difference, not universalities.

Yes, I am familiar of the concept of pooling risks. No, it is not important for an insurance pool to include people that have a *range* of risk. Rather, it is more important to have the largest pool possible and to spread the risk. One of the fundamental problems with health insurance today is that the rising cost of coverage has led some people to choose not to be covered, thereby diminishing the pool. Often, these are healthy, younger people who do not understand the need for health insurance.

2. Are you concerned that HSAs appeal primarily to individuals who do not have children and who are healthy enough that they do not anticipate needing much health care?

Answer: No, I am not concerned. When an individual or family considers whether or not an H.S.A. is right for them, it should be done on the basis of savings versus risk. How does the premium savings compare to the deductible risk? With escalating insurance costs, my concern is that individuals who do not have children and who do not anticipate needing much health care choose no insurance at all, thus reducing the risk pool. H.S.A. plans have provided an alternative to keep insurance at a far lower cost, making them more attractive to the young, childless, and healthy. At the same time, H.S.A.'s provide those with high health bills the same tax advantages of richer health plans.

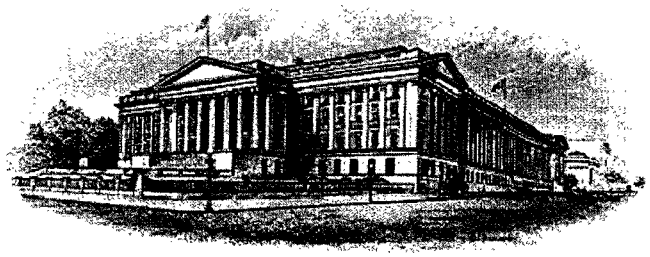
On September 25th, the *Wall Street Journal* had an article entitled "New Premium: When Employees Pay for Health Care, The Boss Pays Too-Questions Besiege Mr. Bond As Workers Try to Scrimp In High-Deductible Plan," which discussed the experience of an employer who provides HSAs to his employees. The article pointed out that since instituting HSAs his employees have shared a lot more information about their medical conditions with him. In particular, many of his employees do not have internet access, or do not know how to investigate cheaper treatment options, and they have been coming to him with questions. This employer has spent a great deal of time researching treatment options for his employees, from suitable generic drugs to cheaper hospitals for some procedures.

He expressed unease about so much detailed medical information about his employees, because if he ever let an employee go, they may claim he had done so as a result of some information he had about their health.

3. Do you have any concerns about employers having so much medical information, recognizing that there may be some employers who would use it in inappropriate ways?

Answer: Yes, I am concerned about employers having so much health information about employees. What concerns me more, however, is that the employees referenced in the *WSJ* article did not feel empowered to make such decisions on their own . . . that the employees did not know where to turn to find answers to

the questions that they had. It troubles me deeply that every time health care in our country is discussed, we dumb down Americans. The core: Americans are too feeble-minded to take an active role in their own health care; Americans lack the brains to consider treatment options or maximize their own health dollars. I refuse to believe that my society is composed of a majority of addled people, particularly when it comes to their own health. If we truly believe that Americans cannot more actively manage their own health and health care, perhaps we should take a much closer look at how we have set them up for this failure.



DEPARTMENT OF THE TREASURY
OFFICE OF PUBLIC AFFAIRS

TESTIMONY OF ROBERT J. CARROLL
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)
UNITED STATES DEPARTMENT OF THE TREASURY

HEARING ON HEALTH SAVINGS ACCOUNTS: THE EXPERIENCE SO FAR
SENATE FINANCE SUBCOMMITTEE ON HEALTH
SEPTEMBER 26, 2006

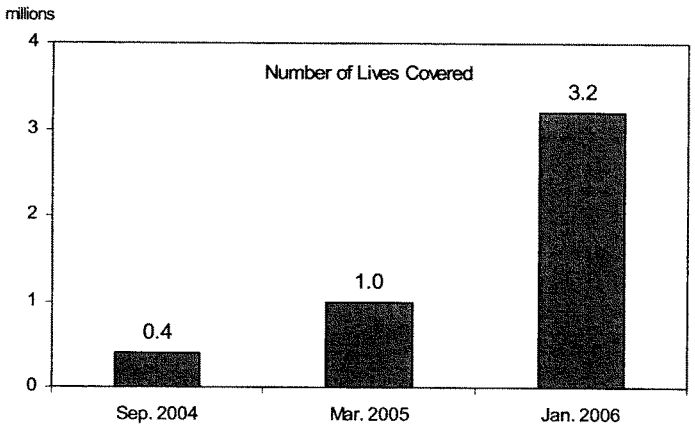
Chairman Hatch, Ranking Member Rockefeller, and distinguished Members of the Subcommittee, I appreciate the opportunity to discuss with you today the health savings accounts (HSAs) and the health care initiative included in the President's FY 2007 Budget. I will focus my remarks on both the problems in health care and how the President's proposals to expand HSAs help address these problems.

The Experience So Far with HSAs

The growth in high deductible health plans (HDHPs) since their inception has been dramatic. Enrollment in HSA-qualified HDHPs has grown to nearly 3.2 million individuals in January 2006, according to the latest estimates from America's Health Insurance Plans (AHIP). As shown in Chart 1, this is triple the number reported in 2005,

which in turn was double the number reported in 2004, the first full year in which HSAs were available.

Chart 1: The number of HDHP/HSA-type plans has grown rapidly



Source: America's Health Insurance Plans, Center for Policy Research

Importantly, HSAs appear to have helped the uninsured and are being used by many lower income and older Americans. AHIP data also show roughly one-third of those who purchased HSA-eligible HDHPs in the non-group market were previously uninsured, and about 50 percent are age 40 or over. Other research shows that over 40 percent of those who purchased HSA-eligible plans in 2005 have incomes below $50,000.[1] HSAs provide an additional option to individuals, which helps reduce the number of uninsured and helps lower income and older individuals.

The Broad Objectives of the President's Health Care Initiative

The President's initiative on health care is aimed at making health care more accessible, affordable, and portable, thus better enabling Americans to obtain health care and to retain their health care when they change employment.

[1] From Health Savings Accounts: The First Six Months of 2005," eHealthInsurance, July 27, 2005.

Health insurance should be more accessible, regardless of where people work. Individuals and families should have access to a variety of health plans from which they can choose based on their individual needs and preferences. Ideally, health insurance options at a reasonable cost would be available in all types of employment settings , not just for those who work at large firms that are capable of offering economical group health coverage to all of their employees. Employees of smaller firms, the self-employed, and those outside of the workforce should have similar choices at similar prices. One goal of the President's health care initiative is to remove the tax disincentive for individuals to purchase health care directly. It is simply unfair for individuals without access to health care through their employer to be denied the tax advantages given to those with access to employer-provided health insurance.

A key focus of the President's health care initiative is to put the consumer at the center of his or her own health care decisions. Empowering consumers is essential to improving value and affordability in American health care. When individuals are allowed to take greater control of their own health care decisions, we can expect those decisions to be better ones. Removing the tax disincentive against high deductible health plans (HDHPs) will help encourage the more efficient use of health care resources. Information about the range, price, and quality of health care options should also be readily available and easy to use. Purchasing decisions should be made by consumers, rather than surrogates, such as employers, insurers, or the government.

The President's health care initiative also recognizes that health insurance should be more affordable. The government has a responsibility to promote access to high quality and affordable health care for the poor. Our federal government also can provide financial assistance to low-income Americans and encourage the states and employers to help the chronically ill to obtain affordable health coverage.

Health insurance should be portable. Individuals should be able to take their health insurance with them when they change jobs, move, become self-employed, or leave the labor force. They should not have to worry about changing doctors, learning a new

insurance company bureaucracy, having their premiums go up, or losing their insurance tax advantage when they move between employment opportunities. The tax system should not impose a relative tax penalty on small employers that makes it difficult to recruit and retain workers.

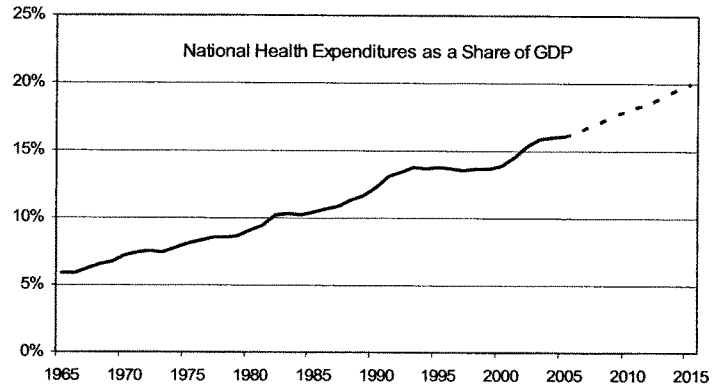
Americans enjoy the best health care facilities and medical professionals in the world, but Americans are concerned about the rising cost of health care, losing their health insurance if they change jobs, and a lack of information about price and quality. These concerns are based on real world observation and are valid. The President's health care initiative attempts to address the root problems that underlie these concerns.

Problems in Health Care

Rising Costs

Health care costs continue to rise rapidly. Growth in health care costs have been exceeding GDP growth by two percentage points annually since 1940. Chart 2 shows both actual and projected growth of national health expenditures as a percentage of GDP from 1965 through 2015. Most recently, growth of national health expenditures as a percentage of GDP rose from 13.8 percent in 2000 to 16 percent in 2004 and is expected to rise to nearly 20 percent by 2015. These rising costs impose a burden on the U.S. economy. Higher spending on public programs like Medicare and Medicaid strains state and Federal budgets. Higher insurance premiums pose a challenge for employers and burden workers with higher health costs and lower wage increases.

Chart 2: National health expenditures continue to rise as a share of GDP



Source: Department of Health and Human Services, Centers for Medicare and Medicaid Services.

The burden of rising health care costs is particularly problematic for small businesses, which often choose not to offer any health insurance to employees. According to the Kaiser Family Foundation's annual survey, nearly 100 percent of firms with 200 or more workers offer health insurance to their employees. Yet only 59 percent of firms with between 3 and 199 workers offer insurance to their employees, a decline of 9 percentage points from 2000.

The Uninsured

At the same time health care costs are rising, the number of uninsured also continues to grow. As health care costs grow faster than incomes, an increasing number of individuals are unable to purchase health insurance. Regardless of how the number of uninsured is measured, millions of Americans are currently uninsured.

Removal of Market Forces from Health Care Purchase Decisions

A substantial portion of rising health care costs is due to the effects of our insurance system itself. Health insurance gives people valuable protection and peace of mind that they will have help paying their medical bills should a major illness arise. However, because third parties such as insurance companies, employers, and the government

finance the vast majority of health care spending, most insured Americans do not know or feel the full cost of the health care services they consume.

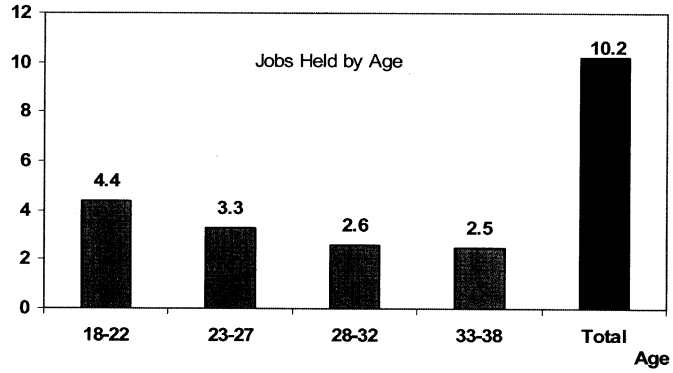
The direct expenditure for health care by an insured person may be only a small portion of his or her total health care costs. This is characteristic of low deductible and first dollar health insurance and the prevalence of this type of insurance is rooted in the tax treatment of health care generally. The tax code reduces the cost of health care when it is "pre-paid" or purchased in advance through employer-provided insurance. This has resulted in health care markets dominated by low deductibles, low coinsurance rates, and pre-paid coverage, all of which dull consumers' incentives to be cost conscious and may lead to the over-consumption of medical care. This over-consumption is the rational response of consumers who do not have to directly pay the entire cost of the medical services they use. A change in the portion of the cost of medical services faced by the consumer so that he or she faces something closer to the true market cost of medical services – the marginal cost of health care – would encourage him or her to make better decisions and examine information on lower-cost alternative treatments. This may slow the steady increase in national health expenditures.

Health Insurance Is Not Directed Towards Today's Dynamic Labor Markets

In today's economy employees frequently change jobs. These changes are often for the better. The dynamism of U.S. labor markets provides important economic benefits by allowing our economy to adapt more quickly to changing economic circumstances. The fluidity and flexibility of our labor markets may generally lead to a better matching of workers to jobs and contribute to skill development and wage growth. Workers might change jobs in pursuit of better pay, to gain more work experience or broaden their skills, or possibly to attain more flexible work arrangements.

According to the Bureau of Labor Statistics' Job Openings and Labor Turnover Survey, in 2005, some 56.1 million employees were hired to fill jobs, while 53.1 million employees left their former positions, and this was a typical year for labor turnover. As

Chart 3: Job turnover is an important part of dynamic labor markets in the U.S.

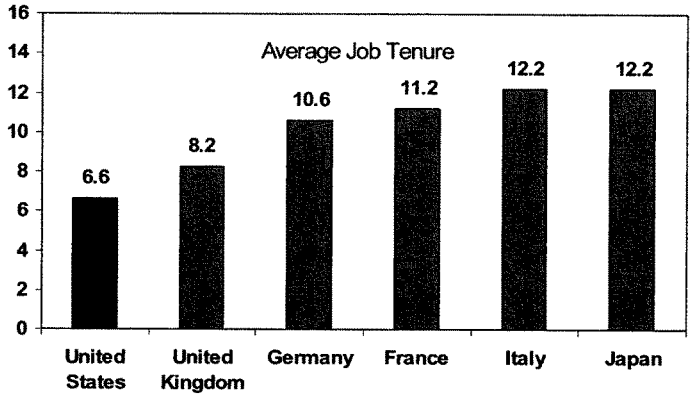


Source: Bureau of Labor Statistics, "Number of Jobs Held, Labor Market Activity, and Earnings Growth among Younger Baby Boomers: Recent Results from a Longitudinal Survey," August 25, 2004.

shown in Chart 3, the average American between the ages of 18 and 38 has held 10.2 jobs and the young are more apt to change jobs than those who are older. About two-thirds of lifetime wage growth occurs within the first 10 years of labor market experience. Seeking out and testing different jobs appears to be an important aspect of our labor markets and an important component of the economic progress for younger workers.

The high degree of job mobility and its role in building labor market experience and skills undoubtedly contributes to our economic vitality. As shown in Chart 4, Americans tend to change jobs much more frequently than workers in other major industrialized nations, in some cases nearly twice as often. The better matching of workers to jobs associated with the high degree of labor force dynamics contributes to economic growth and living standards by increasing the productivity of labor.

Chart 4: Labor markets in the U.S. are characterized by greater flexibility than our major trading partners



Source: International Labor Organization, "World Employment Report 2004-05," December 2004.

Tying employees' health insurance to their workplace, however, is an impediment to a dynamic labor market. Approximately 73 percent of insured Americans obtain their insurance in whole or in part through their employers. Employer-based health insurance is usually not portable when employees change jobs or stop working. People changing jobs usually must change insurance policies to receive any health benefits from their new employer. Lack of portability results in "job lock" – if anyone in the family is in poor or questionable health status, workers become hesitant to leave their jobs to work for an employer who does not offer insurance, work for themselves, or retire. Job lock has the effect of reducing the fluidity and flexibility of our labor markets and is a drag on economic growth.

How Does The President's Health Care Initiative Address the Problems

Major Parts of the Initiative

With the appropriate reforms, the U.S. health care system can become more efficient at supplying cost-effective health care to consumers while continuing to lead in innovation and the development of cutting edge medicines. The President's initiative would address

the rising costs of health care spending through a series of initiatives designed to encourage more efficient use of health care resources by improving consumer incentives. At the core of this initiative is a set of tax proposals that remove the tax disincentives to purchase high deductible health plans (HDHPs) and purchase health care directly. These changes put the health care consumer more in control of his or her health care and could result in lower health expenditures and lower health insurance premiums.

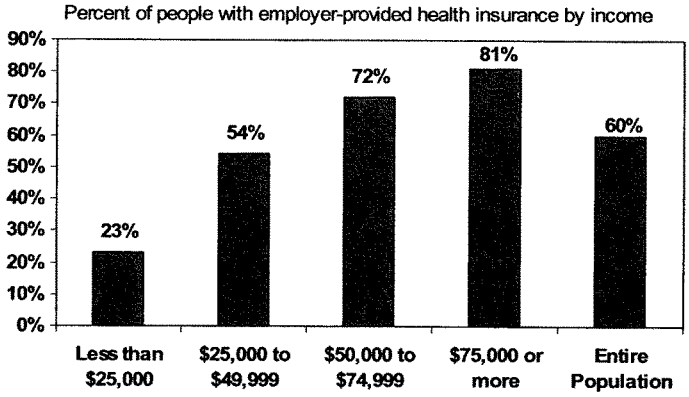
Currently, health insurance purchased through an employer is subject to neither income nor payroll taxes. While an individual purchasing health care on his or her own might pay one dollar for a dollar's worth of health care, an individual who obtains health care through an employer-provided insurance plan pays considerably less. Consider, for example, a taxpayer who is in the 15 percent income tax bracket and also pays 15.3 percent in Social Security and Medicare taxes (including both the employee and employer shares). For the last dollar of wages received, this taxpayer would pay 30.3 cents in income and payroll taxes. Thus, for every dollar of wages received, this individual could purchase only 69.7 cents of most consumption items. In the case of health care financed through an employer, however, the individual can purchase a dollar of "pre-paid" health care through a health insurance policy for every dollar of wages received. Thus, the current tax system builds in a large tax subsidy for "pre-paid" health care in the form of employer-provided health insurance.

Smaller firms are comparatively disadvantaged by this system. As already mentioned, many small businesses cannot afford to offer insurance and their workers are often among the uninsured. But those who work for larger companies currently receive a significant tax advantage: they pay neither income taxes nor payroll taxes on their health insurance premiums. In contrast, those who purchase insurance directly – perhaps because they work for a small business that does not offer insurance – pay for insurance after paying income and payroll taxes.

The President's proposals would also reduce the possibility of job lock. HSAs are owned by individuals regardless of their employer. When workers change jobs, they take their

HSAs with them, reducing the possibility of job lock. An individual could seek the best job possible regardless of whether the employer offers insurance coverage, or become self-employed and still have the opportunity to take advantage of the tax benefits provided by the President's proposals.

Chart 5: Low-income families often aren't covered by employer-provided health insurance.



Source: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, March 2005

Moreover, as shown in Chart 5, lower income individuals are less likely to be covered by employer-provided insurance. Policies that make health insurance more accessible and affordable to all Americans by extending the tax advantages enjoyed by those receiving their insurance through their employers would be particularly helpful to these lower income individuals.

There are several parts to the proposal. First, all taxpayers could either deduct or exclude for income tax purposes health insurance premiums for high deductible health care plans (HDHP). In addition, individuals would receive a refundable income tax credit for payroll taxes paid on those premiums. These two provisions effectively place insurance purchased directly by individuals on an equal footing with insurance purchased through an employer, provided the insurance purchased is an HDHP.

Next, all taxpayers that have an HDHP could deduct a higher level of out-of-pocket expenses for income tax purposes through the use of an HSA than under current law. Also, taxpayers could claim a tax credit for payroll taxes paid on out-of-pocket expenses through the use of that same HSA. The amount of out-of-pocket expenses that could be deducted would be equal to the amount of out-of pocket exposure allowed for a qualifying HDHP. These two proposals have the effect of placing out-of-pocket expenses for those with an HDHP on an equal footing with "pre-paid" health insurance.

Once a taxpayer decides to purchase an HDHP, he or she would effectively receive the same tax advantages on his or her health care expenditures -- insurance and out-of-pocket -- as those who finance all their health care through an employer-provided health plan. The initiative eliminates the current tax disincentive to purchase of HDHPs and removes the tax bias that makes health care cheaper when purchased through pre-paid insurance, more attractive, than out-of-pocket payments.

The third major piece of the initiative is a refundable health insurance tax credit (HITC) for lower-income individuals for the purchase of an HDHP. The credit would be refundable and cover up to 90 percent of the cost of the health insurance up to $1,000 for singles and up to $3,000 for families. This provision would make health care more affordable to lower-income individuals and encourage those currently uncovered to obtain health insurance.

Giving Consumers a Greater Stake in Health Care Decisions – Slowing the Growth in Health Care Costs

An HDHP gives consumers a greater stake in their health care decisions. There is considerable evidence that the consumption of health care is sensitive to prices and that removing the tax bias for first dollar coverage can have an effect on health care spending. Currently, an insured individual with an HDHP has responsibility for payment of at least the first $1,050 (with no more than a total $5,250 out-of-pocket exposure) of medical

costs.[2] The President's initiative, by increasing the HSA contribution limits to the out-of-pocket maximum ($10,500 for families) ensures that individuals purchasing health care via an HSA-eligible HDHP receive the same tax treatment as employer-provided coverage up to the limits of their potential out-of-pocket costs. . It has been estimated that individuals who switch from traditional first dollar insurance to HSAs with spending below the out-of-pocket maximum would reduce their spending by 21 percent.[3] Overall, it has been estimated health care spending would fall by 1.2 percent because of the greater exposure people who switch from traditional health insurance to HSAs would face under the President's initiative

Health care spending also has the potential to grow more slowly over time as individuals become more cost-conscious and bear a larger share of the financial responsibility for their health care decisions. In health care markets where market forces are prevalent, health care costs have grown more slowly or, in some cases, even decreased. Markets such as the laser eye surgery market and the in vitro fertilization markets, where there is significant competition, have experienced price decreases. To put this into perspective, if greater cost consciousness through the President's initiative were able to lower the growth in health care costs by just 0.5 percent, the effects on health care spending over time could be dramatic. In just ten years, this decline in the growth rate would lower health care spending by 5 percent and would be an entire percent point lower as a fraction of GDP in 2015 (e.g., $162 billion).

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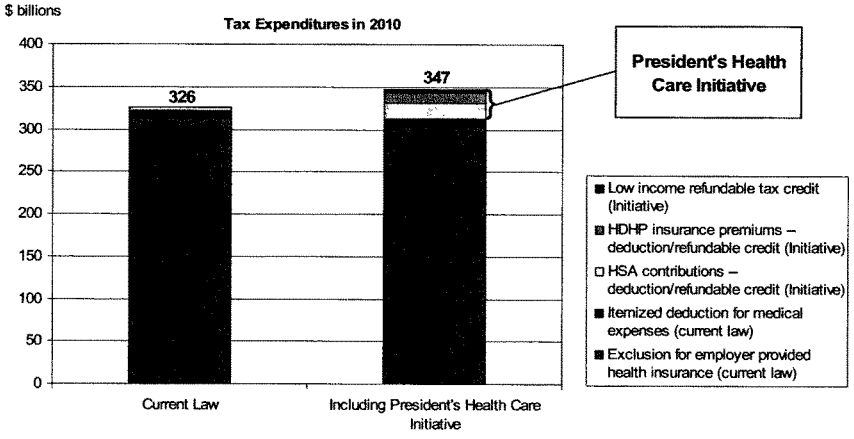
[2] These are the 2006 levels of the required deductible and total out-of-pocket exposure. These levels are indexed by the CPI-U. The required deductible and total out-of-pocket exposure for family coverage are $2,100 and $10,500, respectively.

[3] These estimates are from Katherine Baicker, William Dow and Jonathan Wolfson, "Health Savings Accounts: Implications for Health Spending," *National Tax Journal*, forthcoming.

What is the Cost of the President's Initiative?

Chart 6 shows the health care tax expenditures under current law and under the President's health care initiatives for fiscal year 2010 for both income and payroll taxes. As can be seen, the current tax subsidy for the employee exclusion for employer-provided health insurance constitutes the major portion of the health care tax expenditure, either currently or under the President's initiative. As a result of the President's health care initiative, total health tax expenditures would increase by about $21 billion or somewhat over 6 percent in 2010.

Chart 6: President's Health Care Initiative complements already existing health care tax expenditures



Note: The estimates include the tax expenditure related to both income and payroll taxes. The estimates also include the effects on outlays.

Source: U.S. Department of the Treasury, Office of Tax Analysis.

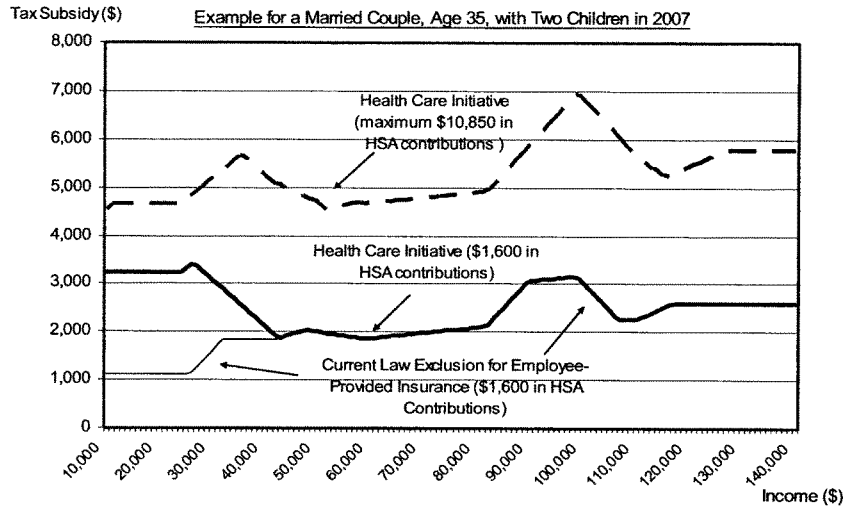
Where Does the Presidents Health Care Initiative Take Us?

The President's health care initiative levels the playing field between employer-provided insurance and HDHP insurance purchased directly by an individual and also levels the playing field between out-of pocket expenditures and insurance premiums for those with

an HDHP. A key benefit of the initiative is that it reduces the tax bias towards lower deductible and first dollar health insurance. As discussed above, first dollar insurance dulls the incentives for consumers to shop carefully for cost-effective health care. Placing the consumer at the center of health care decisions helps slow the growth in health care spending. Greater reliance on health insurance purchased directly by individuals, and on HSAs generally, will also increase portability and reduce the harmful effects of job lock.

The initiative also makes HSAs more progressive. Lower income Americans receive a larger tax subsidy through the refundable health insurance tax credit targeted to low income individuals and through the set of refundable tax credits for Social Security and Medicare taxes. The latter set of credits is reduced once an individual reaches the taxable wage cap for Social Security taxes. Chart 7 compares the tax subsidy from the health care tax provisions under current law to those received under the President's health care initiative for a couple at age 35 with two children. When the family's income exceeds roughly $45,000, the President's health care initiative provides the same tax subsidy for a family purchasing health care directly as it does for a family purchasing their insurance through their employer under current law. Also, the tax subsidy under the President's health care initiative is higher for lower income families than under current law. For those with the lowest incomes, the President's initiative would provide a subsidy for more than half of a family's insurance premiums.

Chart 7: Health Care Tax Subsidy Under Current Law and the President's Health Care Initiative



Note: The family is assumed to pay a health insurance premium of $6,200 and make an HSA contribution of $1,600, except as noted above. The maximum HSA contribution under the proposal is $10,850 (in 2007). The taxpayer is assumed to receive all income from wages.

Source: U.S. Department of the Treasury, Office of Tax Analysis.

As shown in Chart 7, there is a significant tax benefit from contributing the maximum amount to an HSA under the President's initiative, with the tax subsidy initially increasing with income because of the graduated income tax rates. The tax subsidy declines once the taxable wage cap for Social Security taxes is reached. Thus, there is a limit on the tax benefit from the payroll tax credit for higher-income earners.

The maximum tax benefit provided by the HITC targeted to lower income individuals is available for single individuals with incomes below $15,000 and is completely phased out when a single individual's income reaches $25,000. For families, the maximum tax benefit provided by the HITC is available for incomes below $25,000 and completely phased out when a family's income reaches $60,000.

The President's initiative makes HSAs significantly more attractive to both the uninsured and to lower-income individuals. The Treasury Department estimates that the President's initiative would increase the number of HSAs by some 50 percent by 2010. This initiative would also help control the growth in national health expenditures by encouraging the use of HSAs and HDHPs.

Conclusion

It is also important to consider these tax provisions as part of the President's broader initiative. The broader initiative outlined by the President includes: new national Portable HSA insurance plans; a proposal to permit the purchase of health insurance policies across state lines; a proposal to allow associations of small businesses to band together to purchase health insurance; medical liability reform; and a series of health information technology actions.

I thank you for the opportunity to testify before the Subcommittee and look forward to your questions.

Senate Finance Committee Hearing:
"Health Savings Accounts: The Experience So Far"
Tuesday, September 26, 2006

Questions for the Record for
Dr. Robert J. Carroll
Deputy Assistant Secretary (Tax Analysis)
United States Department of the Treasury

From Senator Hatch:

Question 1

Dr. Carroll, some critics maintain that HSAs allow employers to shift the cost of health benefits to workers, but most economists agree that the cost of heath care benefits is already borne by workers. Please explain whether the administration agrees that HSAs are unable to shift costs to workers that workers already bear?

Answer

An employee's total compensation is comprised of his wages and fringe benefits including health insurance benefits. A widely held view among economists is that employee compensation is ultimately the result of market forces and related to worker productivity. The mix of compensation is also the result of market forces, but influenced by its tax treatment. When one component of compensation changes, it should be expected that another component will also change in a manner that keeps total compensation roughly constant. Again, this is because total compensation is determined in the give and take of labor markets and is heavily influenced by labor productivity.

If the employer's cost of health care benefits falls because, for example, employees enroll in lower cost, high deductible plans with HSAs, we can expect wages or other benefits to increase to keep total compensation constant. Preliminary evidence from the HSAs experience suggests that employers are passing much of the savings from high deductible plans to employees in the form of employer contributions to HSAs. The average employer contribution to employees' HSAs was roughly $1,100 for families and $600 for individuals in 2005.

Question 2

Dr. Carroll, many in the business community are finding that HSA-eligible plans provide cost savings, even after taking into account employer contributions to the deductible. In estimating the cost of HSA-expansion, has the Administration considered the revenue impact of businesses claiming fewer deductions through adoption of these lower premium plans?

Answer

Since both wages and fringe benefits are deductible by the employer, a reduction in the cost of health benefits would only engender an increase in wages (or an increase in some other fringe benefit) and would not change the total deduction for compensation or the employer's tax bill. However, if wages increase so will payroll and individual income tax revenues.

Question 3

Dr. Carroll, some critics have expressed concern about the lack of full enrollment in HSAs by those participating in HDHPs. They have attempted to make much of the fact that more than 3 million individuals are now covered by HSAs, but that in 2004—the latest data available—fewer than 200,000 took the tax deduction for HSA contributions. The suggestion is that most of those covered under HDHPs cannot afford HSA contributions. First, is it safe to assume that when the 2005 data is made available there will be a substantially larger number of persons claiming the contribution deduction? Second, is this comparison of covered individuals to deductions fair? Because there are many more people covered under HDHPs than there are individual policies, wouldn't it be more fruitful to compare the number of HSA deductions to the number of HSA-eligible policies?

Answer

Yes, these statistics are not a good measure of the fraction of HDHP-covered individuals who make contributions to HSAs. First, the number of covered lives is considerably more than the number of plans, because several people can be covered under a single family policy. Therefore, HDHP-covered lives, as reported by America's Health Insurance Plans (AHIP), is not exactly appropriate for determining the fraction of eligible plans with associated HSAs. Secondly, we do not yet have reliable information on the total number of accounts open in a given year.

The tax return data on which the Department of the Treasury and Joint Committee on Taxation rely include the number of tax returns that claim an individual income tax deduction for HSA contributions. However, this provides an incomplete picture of the total number of HSAs open in a given year. Many employers make contributions on behalf of their employees that are not reported as a deduction on the employee's tax return. Employer HSA contributions also include contributions made pursuant to an employee's salary reduction agreement under a cafeteria plan. Also, preliminary analyses indicate that a significant number of lower income taxpayers without any income tax liability have HDHPs. These taxpayers may be making contributions to their HSA, perhaps because HSAs are portable, but might not claim a deduction when filing their return because the deduction would have no tax consequences. Finally, an individual might have an open account, but not make a contribution so that, again, no deduction would be reported on the taxpayer's tax return.

Complete tax return data for tax year 2005 that includes not only individual tax filings but various information returns related to HSAs will become available to the Office of Tax Analysis in the summer of 2007. We expect to release a detailed analysis of HSAs that captures both individual and employer contributions after analyzing these data.

Question 4

Dr. Carroll, in addition to data on the number of individuals claiming the HSA deduction, does Treasury have data on the number of HSA-eligible plans to which employees contribute?

Answer

As indicated above, the Department of the Treasury expects to have a detailed analysis of HSAs for tax year 2005 completed during the summer of 2007. It is not until the Office of Tax Analysis has both employee and employer contributions to HSAs that it will be in a position to provide a comprehensive view of how many individuals contribute to HSAs. Preliminary analysis has made it clear that employer contributions to HSAs are an important way in which HSAs are funded.

Question 5

Dr. Carroll, assuming that health care coverage is a part of an employee's total compensation, would a reduction in health care costs lead to greater personal income?

Answer

Since total compensation is included in personal income, a change in health benefits would not generally affect total personal income. However, a reduction in tax-preferred health benefit costs might increase taxable personal income. In addition, greater use of HSAs, which can provide greater tax benefits, could increase disposable incomes for taxpayers.

Question 6

Dr. Carroll, Joseph Antos of the American Enterprise Institute reports that HSAs, flexible spending accounts, and the itemized deduction for medical expenses combine for less than 5 percent of the total tax expenditure amount for health care. This indicates that the marginal costs absorbed by the government for an HSA vis-à-vis a traditional employer-provided plan are inconsequential. Does Treasury support this view?

Answer

The analysis you reference in your question is an extremely important point and one that is highlighted in my written testimony. Currently, the total tax expenditure for health care tax subsidies totals $326 billion (in 2010). The single most important tax subsidy is the employee exclusion for employer-provided health insurance, which accounts for nearly 90 percent of all health tax subsidies. As you point out, HSAs account for only a tiny fraction of the total health care subsidies. Moreover, the President's health care initiative, which dramatically alters economic incentives by extending the favorable tax subsidy for employer-provided health insurance to all health care, provided an individual purchases an HDHP, increases the total tax subsidy for health care by only $21 billion or six percent.

Question 7

Dr. Carroll, you mentioned the importance of fluidity and flexibility in our labor markets and explained that job lock due to non-portability of health insurance can reduce these dynamics in our economy. How large a role has job mobility played in the U.S. economy's out-performance of most of our trading partners over the past few years?

Answer

As I describe in my written testimony, in today's economy employees frequently change jobs and these changes are often for the better. The dynamism of U.S. labor markets provides important economic benefits by allowing our economy to adapt more quickly to changing economic circumstances. The fluidity and flexibility of our labor markets may generally lead to a better matching of workers to jobs and contribute to skill development and wage growth. Workers might change jobs in pursuit of better pay, to gain more work experience or broaden their skills, or possibly to attain more flexible work arrangements.

Technological change and innovation inevitably lead to the restructuring of an economy as resources – labor and capital – are allocated towards new and more productive uses. Some industries benefit disproportionately from such changes. The challenge is to maintain the dynamic character of the economy as reflected by the flexibility and fluidity of our labor markets while providing all workers with the meaningful insurance against economic losses -- insurance for unemployment, health, and retirement security.

Tying health insurance to an employee's workplace, however, may impair a dynamic labor market. Approximately 73 percent of insured Americans obtain their insurance in whole or in part through their employers. Employer-based health insurance is typically not fully portable and this lack of portability may result in "job lock" where workers become less likely to leave their job when a family member is in poor or questionable health status.

HSAs help reduce job lock because they are owned by workers, not employers, and when workers change jobs, they take their HSAs with them. HSAs, together with deductibility for individually-purchased HDHPs, better enable individuals to seek the best job possible regardless of the employer.

Different explanations have been offered for the recent acceleration of U.S. productivity growth and deceleration of productivity growth in the European Union (EU). A common explanation for the slowdown in the EU is that institutional and legal barriers limit flexibility. An example of the type of barriers that restrict growth are the zoning laws that prevent large retailers (e.g., Wal-Mart and Target) from establishing and expanding the use of more efficient distribution systems in Europe, while the incorporation of these distribution innovations in the U.S. may have contributed to higher U.S. labor productivity.

Recent research by Gordon and Dew-Becker[1] offer a different explanation. The labor market reforms enacted in the mid-1990s in many EU countries have actually had a negative, albeit perhaps temporary, effect on productivity growth. These researchers suggest that by relaxing rigid work rules and high wage floors EU employers could hire more low-wage, low-productivity workers and substitute away from high-skill workers and capital. Average productivity was, in effect, pulled down from the less stringent regulatory environment enacted by some EU countries in the mid-1990s as these economies adjust to the new composition of their workforces.

From Senator Bunning:

Question 1

Current HSA rules prohibit an individual from carrying health insurance that provides first dollar coverage, which according to the IRS, includes VA healthcare. There is proposed legislation, S 3655, that would amend the Internal Revenue Code to allow individuals eligible for Veteran's health benefits to establish and contribute to health savings accounts. Can you comment on this issue and on S. 3655?

Answer

First, we would like to clarify the current treatment of VA health benefits for purposes of HSA contribution eligibility. Under the guidance issued by Treasury and the IRS, it is not eligibility, but actual receipt of health care from the VA that results in a reduction in the HSA contribution for the year. This interpretation is in keeping with our understanding of the intent of Congress that tax deductible HSA contributions are limited to individuals who have coverage by a high deductible health plan (HDHP) and generally no other health coverage, and that the HSA benefits were provided to offset the costs of covering expenses below the high deductible. Given the nature of VA health benefits, Treasury and the IRS determined that, rather than disqualify individuals who were merely eligible for the benefits, a better rule would be a reduction in the HSA contribution related to the actual utilization of the benefits.

S. 3655, if enacted, would allow individuals eligible for VA benefits to receive unlimited VA health benefits and still make the maximum HSA contribution allowed based on their HDHP coverage. While current law allows certain limited health benefits in addition to HDHP coverage, this change would allow individuals receiving significant health benefits other than HDHP coverage to contribute to HSAs, and generally protect them from having to use the HSA to cover the expenses below the deductible. Consequently it raises questions about whether other individuals who have health coverage other than HDHP should also be allowed the tax preference of HSA contributions notwithstanding their other coverage.

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[1] Gordon, Robert, and Ian Dew-Becker. "Why Did Europe's Productivity Catch-up Sputter Out? A Tale of Tigers and Tortoises and Textbook Labor Economics." Presented at the NBER Summer Institute, August 2006.

Question 2

Do you think opening HSAs to all Americans, regardless of age or health insurance status, would encourage more Americans to budget for their own health needs?

Answer

Currently, HSAs are available to all Americans who purchase a High Deductible Health Plan (HDHP). The purpose of combining an HSA with the purchase of an HDHP is to encourage the individual to purchase a health care plan that provides the insured with an increased financial responsibility for a portion of his or her health care costs. With an HDHP, the insured has responsibility for payment of at least the first $1,050 (with no more than a total $5,250 out-of-pocket exposure in 2006) of medical costs. The higher deductibles under HDHPs ensure greater price exposure for health care consumers. When consumers have more at stake or "skin in the game" they can be expected to make better decisions. Greater reliance on competition and greater exposure to market prices will help lead to the more efficient use of resources and help stem the excessive rise in health care costs.

Question 3

In your testimony, you outline a proposal by the President to increase annual contribution limits to the out-of-pocket maximum. With the fiscal crisis facing Medicare in the coming decades, why are initiatives such as this so crucial to encouraging Americans to save as much as possible for their health needs?

Answer

Under current law contributions to an HSA are limited by statutory amounts ($2,700 for self-only and $5,450 for family coverage in 2006). The President's FY 2007 Budget proposal would expand the amount that could be contributed to an HSA to the HDHP's out-of-pocket limit (up to $5,250 for a self-only policy and $10,500 for a family policy in 2006).

These higher contribution limits are important because they make high-deductible HSA-qualified plans more attractive and affordable. These changes would be particularly important for the chronically ill who have a higher probability of out-of-pocket spending above their deductible.

The current tax code reduces the cost of health care when it is "pre-paid" or purchased in advance through employer-provided insurance. This has resulted in a health care market dominated by low deductibles, low coinsurance rates, and pre-paid coverage. This type of coverage dulls consumers' incentives to be cost conscious and may lead to the over-consumption of medical care. This over-consumption is a rational response of consumers who do not have to directly pay the entire cost of the medical services they use.

Increasing the price exposure that health care consumers face through higher deductible coverage will give them a greater stake in their health care decisions. When consumers have a greater stake in their decisions, we can expect those decisions to be better ones. Removal of the current

tax bias that favors first dollar coverage or the pre-payment of health care through employer-provided insurance can have a significant effect on health care spending. It has been estimated that individuals who switch from traditional first dollar insurance to HDHPs with spending below the deductible would reduce their spending by 21 percent. Overall, it has been estimated that health care spending could fall by 1.2 percent because of the greater exposure people who switch from traditional health insurance to HDHPs as a result of the President's initiative.

Question 4

Can you explain how the refundable health insurance credit would benefit lower income Americans?

Answer

Lower income Americans constitute a majority of the uninsured. The President's health care initiative includes three refundable tax credits: 1) a refundable credit for payroll taxes paid on HDHP premiums, 2) a refundable credit for payroll taxes paid on out-of-pocket expenses for those with HDHPs, and 3) a refundable health insurance tax credit (HITC) targeted to lower income Americans to help make HDHPs more affordable. The HITC would cover up to 90 percent of insurance premiums up to $1,100 for individuals and $3,300 for families. Individuals with incomes below $15,000 and families with incomes below $25,000 would receive the maximum benefit.

The combination of these provisions results in a substantial realignment of the existing tax subsidies for health care for those with HDHPs: a much greater share of the tax subsidy would be targeted to lower income Americans. As indicated in my written testimony, for individuals or families with a typical amount of health care spending, the tax subsidy under the proposal would be higher for lower income Americans than for higher income Americans. For those with above average health care spending, lower income Americans would receive a tax subsidy for health care spending almost as large as higher income Americans. The progressive nature of the President's initiative is in contrast to the current tax code where the tax subsidy typically rises with income and a taxpayer's tax rates.

From Senator Baucus:

Question 1

Does the IRS have data on the number of current HSA holders who were previously uninsured? If not, is this something that IRS could begin tracking through administrative procedures this year?

Answer

No. The IRS is not able to identify whether an individual with an HSA previously had insurance.

From Senator Rockefeller:

Question 1

Dr. Carroll, as we discussed at the hearing, I have been extremely frustrated that the Administration has not released any estimates of the numbers of currently uninsured Americans they would expect to be covered by the President's two main proposals allegedly aimed at increasing health insurance coverage – individual tax credits and the expansion of HSAs.

These proposals have been included in several budget requests. And while I appreciate your claim that the estimates would be complicated by interactions between the various proposals, I believe that if the Administration expects Congress to take seriously these proposals to increase health insurance coverage, then it owes us specific estimates of the number of uninsured people who would gain coverage.

Thus, please tell me: How many currently uninsured Americans do you estimate each of these initiatives — health sayings accounts and individual tax credits — would cover?

Answer

The President's health care initiative is intended to address the rising cost of health care in several ways. First, the initiative gives individuals a greater stake in their health care decisions by emphasizing high deductible health insurance. A fundamental principle underlying the initiative is that when individuals are more involved in their health care decisions, those decisions will be better ones. Putting the health care consumer more in control of health care decisions -- rather than third parties such as insurance companies, employers, and the government -- will help reduce the rise in health care costs.

Second, the initiative fundamentally alters the tax incentives that underlie the current health care system. The current tax treatment of health care provides a tax incentive for individuals to prepay for their health care through employer-provided health insurance. This results in greater use of first dollar coverage and greater reliance on employer-provided insurance simply because of the tax bias. Prepayment of health care through first dollar insurance coverage translates into less price sensitivity by the health care consumers and is a significant factor for why health care costs have risen roughly 2 percent faster than the rate of growth in the economy for many decades.

The President's health care initiative reduces the tax bias for first dollar coverage and the prepayment of health care through employer-provided insurance by extending the tax subsidy available to health care purchased through employer sponsored insurance to health care purchased by individuals whether financed through health insurance or direct out-of-pocket spending, provided they purchase high deductible health plans.

While putting the health care consumer more in control of his or her health care decisions and addressing important tax biases that underlie our current health care system, the initiative only

increases the existing tax subsidy for health care, principally for employer-sponsored insurance, from about $326 billion to $345 billion in 2010 (Treasury Department estimates).

It is important to evaluate this initiative as a package, because the individual provisions work in unison to address the inequity and the uneven treatment of health care in our current system. Accordingly, it is not possible to disaggregate the individual provisions. As a package, the Treasury Department estimates that these proposals will have a substantial effect on the number of HSAs, increasing their number in 2010 by 50 percent. Of course, helping to lower the growth in health care costs is a central objective of the initiative and the anticipated rise in the number of HSAs is important to achieving this objective.

The early evidence on HSAs is very promising. According to a study released by AHIP, by January 2006 there were about 3.2 million people covered by HDHPs. This is up very significantly from the roughly 900,000 people covered by HDHPs reported by AHIP in September 2004. Research by AHIP also indicates that 42 percent of individuals with HDHPs have incomes below $50,000 indicating that a substantial number of lower income individuals are using HDHPs. Similarly, research by E-Health Insurance found that roughly one-third of those with HDHPs in the non-group insurance market were previously uninsured. Also, recent research sponsored by the United Health Group has found that individuals with HDHPs are 5 percent more likely to seek preventive care than individuals with traditional PPO plans. This is important because preventive care may help dampen future growth in health care costs at the same time as improving wellness.

Employers are playing an important role as individuals begin to shift towards HDHPs by making substantial contributions to individuals' HSAs. Recent research by Kaiser/HRET indicates that, on average, employers contribute roughly $600 to HSAs of employees with individual coverage and $1,100 to HSAs of employees with family coverage. These contributions reflect one way that the savings from lower insurance premiums associated with HSAs are passed on to consumers. The important role played by employers in the HDHP market is also reflected in tax return and information reporting data. A preliminary Treasury analysis of these data for 2004, the first year HSAs were in effect, found that nearly one-half of all HSAs were funded exclusively by employer contributions. We expect to have an analysis of HSAs for tax year 2005 completed by the summer of 2007.

Question 2

As I mentioned at the hearing, I think the Trade Adjustment Assistance (TAA) Health Coverage Tax Credit (HCTC) program is a good example of what happens when you use the tax code to try and expand health insurance coverage — people do not get the health coverage they need. What are the Treasury Department's most recent enrollment estimates for the TAA HCTC as well as the source and date of those estimates? Please provide total enrollment as well as individual enrollment figures for displaced workers and early retirees.

Answer

Since the HCTC Program's inception in 2003, the potentially eligible population and the number of enrolled participants in the monthly credit program has grown.

The HCTC Program management office reports that since the inception of the monthly HCTC Program in mid-2003 and as of September 2006, the HCTC Program has approximately:

- 16,000 taxpayers currently enrolled in the monthly HCTC Program (with approximately 10,000 additional family members also receiving the credit). Of these enrolled taxpayers, approximately:
  - 10,100 are PBGC pension benefit recipients, and
  - 5,900 are TAA and ATAA benefit recipients.
- 39,500 taxpayers cumulatively enrolled in the monthly HCTC Program (with approximately 24,000 additional family members also receiving the credit).

The five states with the largest number of taxpayers currently enrolled in the monthly HCTC Program are: North Carolina, Pennsylvania, Ohio, West Virginia and Virginia. Through the monthly credit program, the HCTC Program has paid approximately $307 million to health plans, including more than $196 million paid by the IRS (65 percent portion).

In addition to claiming the credit monthly, individuals can claim the HCTC yearly when they file their Federal tax returns. The tables below represent the number of people who took advantage of the HCTC for each tax year. The "Total Unique Participants" row (Row 4) provides a unique count of people who took advantage of the HCTC Program for each tax year via the monthly option, the yearly option or a combination of both. The first table represents only primary people and does not include any associated family members also benefiting from the program. The second table provides an estimate of the primary participants and their family members.

Table 1: 'Primary' HCTC participants by tax year.

		TY2003	TY2004	TY2005
Row 1	Monthly HCTC Participants:	6,816	18,935	22,040
Row 2	End of Year (EOY) HCTC Recipients:	19,312	14,880	12,000 *
Row 3	Overlap (Received both Monthly and EOY):	(4,621)	(6,700)	(Approx 6,000) *
Row 4	Total Unique Participants:	**21,507**	**27,115**	**Approx 28,000 ***

* TY2005 EOY data is provided as of September 2006. Individuals will continue to file their 2005 returns through December 2006. Therefore, the EOY, Overlap and Total rows for TY2005 will be not final until the end of the year.

Table 2: Estimate of Primary Participants and Their Family Members.

		TY2003	TY2004	TY2005
Row 1	Monthly HCTC Participants:	11,000	30,000	35,000
Row 2	End of Year (EOY) HCTC Recipients:	31,000	24,000	20,000 *
Row 3	Overlap (Received both Monthly and EOY):	(8,000)	(11,000)	(Approx 10,000) *
Row 4	Total Unique Participants:	**34,000**	**43,000**	**Approx 45,000 ***

* TY2005 EOY data is provided as of September 2006. Individuals will continue to file their 2005 returns through December 2006. Therefore, the EOY, Overlap and Total rows for TY2005 will be not final until the end of the year.

Notes on data tables:
- The numbers in table 1 include primary participants only and do not include family members.
- The numbers in table 2 include primary participants and an estimate of their family members.
- The totals are specific to each tax year and do not represent a cumulative participation across tax years.

Anecdotally, the steel, textile, airline and most recently the automobile industries appear to have experienced the most TAA certifications or PBGC pension assumptions since 2003. Additionally, the United Auto Workers reported to the HCTC Program in August 2006 they expect 250,000 workers in Michigan will lose their jobs through the end of calendar year 2007. This population could significantly increase the number of taxpayers receiving the HCTC.

Question 3

How many people does the Treasury Department estimate are eligible for the TAA HCTC? Why does this program continue to benefit a small fraction of the vulnerable workers and their families who qualify for help?

Answer

Because of the HCTC's complex qualification requirements, it is very difficult to know how many people are actually eligible for the HCTC without an extensive audit of those that have been identified as potentially eligible through DOL and PBGC. Consequently the HCTC Program cannot determine a participation rate for the credit. Because of this situation, our focus is on reducing potential barriers to participation among those who have been identified as potentially eligible.

The "potentially eligible" population only represents the individuals for whom the states and the PBGC reported as meeting some of the eligibility requirements for the HCTC. Because of the multiple and varied legislative requirements to be eligible for the credit, a significant portion of the potentially eligible population cannot receive the HCTC. Consequently, this population does not represent the number of individuals who meet all of the eligibility requirements for the HCTC. A significant number of individuals cannot receive the HCTC because of eligibility rules beyond the control of the HCTC Program including:

- The rules for a "Qualified" health plan are complex (such as the rule that a taxpayer must have been covered under an individual plan for 30 days prior to termination of employment in order to be able to the use the credit for that individual plan) and individuals cannot obtain qualified health insurance.
- Individuals were already enrolled in coverage that is not qualified when they became potentially eligible for the HCTC.
- Potentially eligible individuals use their spouse's insurance and they can only claim the credit on their Federal tax return (if at all).
- Potentially eligible individuals do not meet the other HCTC eligibility requirements, such as:
    - Not meeting the age requirements
    - Being entitled to Medicare (which precludes any family members from continuing to receive the credit)
    - Not meeting the training requirements for TAA

Personal finances may also play a role in participation. Taxpayers may be eligible to participate but find the health insurance costs are too high and they cannot afford either to cover the

premium costs and file for the end-of-year credit, or even to enroll in the program and pay the 35 percent share.

Other barriers to participation derive from the length of time between the loss of employment and determination of eligibility for the credit. The HCTC Program Office is working with DOL and PBGC to explore ways to shorten the time it takes for these agencies to identify potentially eligible taxpayers in an effort to make it as easy as possible for eligible taxpayers to obtain the credit.

Question 4

I noticed that the President's budget for Fiscal Year 2007 includes a provision that would allow states to impose a pre-existing condition restriction for a period of up to 12 months? Can you tell many how many HCTC eligible workers would lose coverage because of this proposal?

Answer

The reason the Administration proposed the change in "qualified individuals" to allow up to 12 months of pre-existing condition restrictions is to make the program's requirements consistent with HIPAA's portability rules. Health plan participation in HCTC is voluntary, and in negotiating with plans, we found considerable resistance to participating because of the three month rule. Plans feared adverse selection because of the three month rule, and this requirement proved to be a significant barrier to obtaining plan participation in a number of states. The Administration believes that by making the definition of a qualified individual for HCTC consistent with HIPAA, it will be possible to obtain the participation of more health plans in the program.

There is no data which tells us how much creditable coverage people have. Anecdotally, our experience suggests that people who have three months of creditable coverage have more than 12 months. This is because the workers that become eligible for HCTC, either through the PBGC or TAA programs, typically have been with their businesses a long time, and therefore, if they have had health coverage, they have had it for more than one year.

Question 5

It has come to my attention that the Department of Treasury may be considering a change in its interpretation of IRC § 213 (d) as it relates to the coverage of dietary supplements and meal replacement products under Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and by individuals who deduct medical expenses above 7.5% of their adjusted gross income. If this is indeed the case, I would like to know the parameters of such a change.

As you are probably aware, not all dietary supplements and meal replacement products have approved FDA health claims. I am concerned that blanket approval of all dietary supplements and meal replacement products for preferential tax treatment could he viewed as tacit approval by the federal government of the merits of all these products, including those without an FDA-approved health claim and with known side effects.

Answer

No such change is under consideration.

Question 6

Can you tell me whether or not the Department of Treasury is considering a change in its interpretation of IRC § 213 (d) relative to the coverage of dietary supplements and meal replacement products? If so, are you collaborating with the Food and Drug Administration in this area?

Answer

No such change is under consideration.

Question 7

Would an approved FDA health claim be the basis for tax-preferred coverage under an HSA, FSA or by individuals who deduct medical expenses that exceed 7.5% of their adjusted gross income?

Answer

Under the existing Internal Revenue Code and regulations, an approved FDA health claim, by itself, could not be the basis for a tax excludable distributions from an HSA, coverage under an FSA, or deductibility or by individuals.

Question 8

On September 25th, the *Wall Street Journal* had an article entitled "New Premium: When Employees Pay for Health Care, the Boss Pays Too," which discussed the experience of an employer who provides HSAs to his employees. The article pointed out that since instituting HSAs his employees have shared a lot more information about their medical conditions with him. In particular, many of his employees do not have internet access, or do not know how to investigate cheaper treatment options, and they have been coming to him with questions. This employer has spent a great deal of time researching treatment options for his employees, from suitable generic drugs to cheaper hospitals for some procedures.

He expressed unease about having so much detailed medical information about his employees, because if he ever let an employee go, they may claim that he had done so as a result of some information he had about their health.

Do you have any concerns about employers having so much medical information, recognizing that there may be some employers who would use it in inappropriate ways?

Answer

We share your concern about the privacy of medical information. Our rules for HSAs specifically prohibit employers or HSA trustees from conditioning the availability of HSA funds on the receipt of medical information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions relating to the privacy of certain individually identifiable health information. Those provisions are under the purview of the Department of Health and Human Services.

The employees described in the article voluntarily provided the health information in order to get advice about medical treatments, notwithstanding the fact that nothing in the article indicated the employer in question had any expertise or training relating to health care. Nothing in the HSA rules under the Internal Revenue Code require employees to provide employers with health information, or permit employers to request that information as a condition for accessing HSA funds. While many employers may voluntarily shoulder the burden of assisting employees in obtaining important information about health care, we believe that burden will greatly diminish as transparency in the health care arena increases.

HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS: WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE

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HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS: WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE

Sara R. Collins, Ph.D.

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and insurance premiums, wide variation in the quality and cost of care, and inefficiencies in care delivery and administration.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution to our health system's cost, quality, and insurance problems. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, driving down cost growth and improving the quality of care as providers compete for patients. And the tax incentives associated with HSAs will lure previously uninsured people into the individual market, reducing the numbers of families without health insurance.

But while it is comforting to believe that such a simple idea could help solve our health care problems, nearly all evidence gathered to date about HSAs and HDHPs points to the contrary. Indeed, there is evidence that encouraging people to join such health plans will exacerbate some of the very maladies that undermine our health care system's ability to perform at its highest level.

Many Americans Are Already Burdened by High Health Care Costs

- Americans already pay far more out-of-pocket for their health care than residents of other industrialized countries, and real per capita out-of-pocket spending has been steadily rising since the late 1990s.
- The Commonwealth Fund Biennial Health Insurance Survey found that in 2005, 60 percent of working-age adults with private insurance with annual household incomes of under $40,000 spent 5 percent or more of their income on out-of-pocket expenses and premiums, and 40 percent spent 10 percent or more.

- There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Survey found that 44 percent of privately insured adults with deductibles of $1,000 or more avoided getting necessary health care or prescriptions because of the cost, compared with 25 percent of adults with deductibles under $500.
- There is also evidence that rising cost exposure leads people to accumulate medical debt, take on credit card debt, and reduce their savings. The Commonwealth Fund survey found that 40 percent of privately insured adults with deductibles of $1,000 or more had problems paying medical bills or had accumulated medical debt, compared with 23 percent of adults with deductibles under $500.

Early Experience with HSA-Eligible HDHPs Reveals Low Satisfaction, High Out-of-Pocket Costs, and Cost-Related Access Problems

- The EBRI/Commonwealth Fund Consumerism in Health Care Survey found in 2005 that people enrolled in HSA-eligible HDHPs were much less satisfied with many aspects of their health care than adults in more comprehensive plans.
- People in these plans allocate substantial amounts of income to their health care, especially those who have poorer health or lower incomes.
- Adults in HDHPs are far more likely to delay or avoid getting needed care, or to skip medications, because of the cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- Few Americans in any health plan have the information they need to make decisions. Just 12 to 16 percent of insured adults have information from their health plan about the quality or cost of care provided by their doctors and hospitals.

Patients' Use of Information Alone Is Not Likely to Dramatically Reduce Health Care Costs or Improve Quality

- It is unrealistic to expect that patient financial incentives, even if better information is available, will lead to dramatic improvements in quality and efficiency.
- Most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending.

- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high quality and efficiency.

HSAs Will Not Solve Our Uninsured Problem

- Economists Sherry Glied and Dahlia Remler estimate that under current law, fewer than 1 million currently uninsured Americans are expected to gain coverage as a result of HSAs. This is primarily because 71 percent of the uninsured are in a 10-percent-or-lower income tax bracket—and thus would benefit little from the tax savings associated with HSAs.

The Individual Insurance Market Is Not an Efficient or Equitable Solution to the Uninsured Problem

- The Commonwealth Fund Biennial Health Insurance Survey found that nearly 90 percent of adults who sought coverage in the individual insurance market in the last three years never ended up buying a plan.
- One-third (34%) of those who sought individual market insurance said they found it very difficult or impossible to find a plan with the coverage they needed.
- Nearly three of five (58%) adults who sought individual market insurance found it very difficult or impossible to find a plan they could afford. The problem was particularly acute among people with health problems or low incomes.
- About one-fifth (21%) of adults who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage.
- The individual market is also inefficient: the administrative costs of individual coverage consume an estimated 25 to 40 percent of each premium dollar, compared with 10 percent for group coverage.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and improving quality and efficiency. These strategies include:

- Expanding group insurance coverage, with costs shared among individuals, employers, and government. This could be done by expanding employer-based coverage, eliminating Medicare's two-year waiting period for coverage of the disabled, letting older adults "buy in" to Medicare, and building on Medicaid and the State Children's Health Insurance Program (SCHIP) to cover greater numbers of low-income families, young adults, and single adults.

- Ensuring affordable coverage for families by placing limits on family premium and out-of-pocket costs as a percentage of income (e.g., 5% of income for low-income families).
- Greater transparency with regard to provider quality and the total costs of care.
- Pay-for-performance incentives to reward health care providers that deliver high quality and high efficiency.
- Development of "value networks" of high performing providers under Medicare, Medicaid, and private insurance.
- Better management of high-cost care and chronic health conditions.
- Improved access to primary care and preventive services.
- Investment in health information technology to facilitate the transfer of information among patients, providers, and payers.

HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS: WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE

Sara R. Collins, Ph.D.

Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems currently confronting the U.S. health care system and our collective need to find solutions.

National health care spending is climbing by more than 7 percent per year and is expected to continue to outpace economic growth by a substantial margin.[1] The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped $10,880 last year—more than the average yearly earnings of a full-time worker earning the minimum wage (Figure 1).[2] Many employers, particularly small companies, are coping with rising premiums by passing along more of their costs to employees in the form of higher deductibles and other cost-sharing, or by eliminating coverage altogether (Figures 2 and 3).[3]

Consequently, the number of Americans without health insurance is climbing steadily: in 2005, nearly 47 million people were uninsured, an increase of 7 million over 2000 (Figure 4).[4] An additional 16 million could be considered "underinsured," as a result of their high out-of-pocket costs relative to income.[5] Americans, meanwhile, experience significant variation in the quality and cost of their health care, depending on where they live and where they go for care. Adding to these problems are inefficiencies in the delivery and administration of care. A recent report by the Commonwealth Fund Commission on a High Performance Health System found that across 37 indicators of health system performance, the United States scored an average of 66 out of possible 100

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[1] C. Borger et al., "U.S. Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive (Feb. 22, 2006):W61-W73; C. Smith et al., "National Health Spending in 2004," *Health Affairs* (Jan/Feb 2006): 186-196.

[2] J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24 (Sept./Oct. 2005): 1273–1280.

[3] Ibid.

[4] C. DeNavas-Walt, B. D. Proctor, C. H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports (Washington, D.C.: U.S. Census Bureau) Aug. 2005.

[5] C. Schoen, M. M. Doty, S. R. Collins and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005, W5-289–W5-302.

on a scale based on the best possible care achievable within the country.[6] The study found that the U.S. ranks 15th out of 19 developed nations in deaths that could have been prevented with timely medical care.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution for the cost, quality, and insurance problems that plague the U.S. health care system.[7] Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care. As patients shop around for the cheapest, and best, providers, the market for health care services will ultimately look more like the market for other goods and services, driving down growth in health care costs and improving the quality of care as providers compete for patients. And the tax incentives of HSAs will lure previously uninsured people into the individual market, reducing the number of families without health insurance.

While it might be comforting to believe that such a simple idea could solve our collective health care problems, nearly all evidence gathered to date about HSAs and HDHPs points to the contrary. Indeed, there is evidence that encouraging people to join such health plans might exacerbate some of the very maladies that undermine our health care system's ability to perform at its highest level.

Many Americans Are Already Burdened by High Health Care Costs

Increasing patient cost-sharing is a misguided solution for reining in U.S. health care costs. The claim that Americans spend too much on health care because they are protected from the real cost simply is not borne out by evidence. Americans already pay far more out-of-pocket for their health care than the citizens of other industrialized countries (Figure 5).[8] Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 6).[9]

The Commonwealth Fund Biennial Health Insurance Survey of 2005, a survey of more than 4,000 adults, found that 31 percent of privately insured adults ages 19 to 64 spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical

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[6] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

[7] R. Herzlinger, *Consumer-Driven Health Care: Implications for Providers, Payers and Policy Makers*, Jossey-Bass, 2004.

[8] B. K. Frogner and G.F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Apr. 2006.

[9] C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (Jan./Feb. 2006).

care, prescription drugs, and dental and vision care over a 12-month period (Figure 7).[10] Adults with coverage through the individual insurance market were more likely to have high personal out-of-pocket costs than those with coverage though an employer. The survey found that two of five (41%) adults insured through the individual market spent $1,000 or more out-of-pocket on their personal health care over 12 months, compared with 30 percent of adults with employer coverage.

Adults with HDHPs—whether through the individual market or through employer-based coverage—have higher out-of-pocket costs than adults with lower-deductible plans. The Commonwealth Fund Biennial Health Insurance Survey found that more than half (55%) of adults with deductibles of $1,000 or more per year spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical care, prescription drugs, and dental and vision care over 12 months (Figure 8).[11] In contrast, slightly more than one-quarter (27%) of adults with deductibles under $500 spent that much.

Higher spending on health care, combined with sluggish growth in real income, also means that families are spending increasingly more of their earnings on medical costs. In the Commonwealth Fund Biennial Survey, two of five (40%) adults were in households that spent 5 percent or more of their annual income on premiums and family members' out-of-pocket spending for medical care, prescription drugs, and dental and vision care (Figure 9).[12] One-quarter were in households where at least 10 percent of family income went toward premium payments and health care costs. Those with individual market insurance were more likely to report cost burdens. Nearly two-thirds (65%) of adults with individual market insurance spent 5 percent or more of their household income on premiums and out-of-pocket costs, and more than two of five (43%) spent 10 percent or more. In contrast, one-quarter (24%) of adults with employer-based coverage spent 10 percent or more of their family income on premiums and out-of-pocket expenses.

Privately insured adults with high deductibles also are more likely to spend a large share of their household income on health care costs and premiums than are those with lower deductibles. More than two-thirds (67%) of adults with deductibles of $1,000 or more spent 5 percent or more of their family income on premiums and family

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[10] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006). See appendix to this testimony for survey methodology.

[11] Ibid.

[12] Ibid.

members' out-of-pocket expenses, and more than two of five (43%) spent 10 percent or more (Figure 10). Smaller shares of adults in households with per-person deductibles under $500 spent as much: 36 percent spent 5 percent or more of household income on premiums and out-of-pocket costs, and 22 percent spent 10 percent or more.

The costs of health care and health insurance impose the greatest burden on families with low or moderate incomes. The Commonwealth Fund survey found that over half (57%) of privately insured adults with annual household incomes of less than $20,000 spent 5 percent or more of their income on premiums and family members' out-of-pocket costs, and 42 percent spent 10 percent or more (Figure 11).[13] Middle- and moderate-income families are also greatly burdened by health care costs. Three of five (61%) adults with annual household incomes of $20,000 to $39,999 spent 5 percent or more of income on family out-of-pocket health care costs and premiums, while 40 percent spent 10 percent or more. Of those adults with incomes between $40,000 and $59,999, over one-third (37%) spent 5 percent or more on health care and insurance premiums, and 21 percent spent 10 percent or more. Even many families with higher incomes spend a considerable share of income on health care costs—30 percent of those with incomes of $60,000 or more spent 5 percent or more of their income on family out-of-pocket health care costs and premiums.

Higher Out-of-Pocket Spending Leads People to Avoid Necessary Care

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Health Insurance Survey found that adults with high deductibles are more likely to have problems getting necessary health care than those with lower deductibles. Forty-four percent of adults with deductibles of $1,000 or more reported one of four cost-related access problems: because of cost did not fill a prescription, did not see a specialist when needed, skipped a recommended test, treatment, or follow-up, or had a medical problem but did not see a doctor (Figure 12). In contrast, 25 percent of adults with deductibles under $500 cited similar cost-related access problems.

Other studies confirm these findings. The RAND Health Insurance Experiment, for example, found that greater cost-sharing reduced the use of both essential and less-essential health care.[14] A recent study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer

[13] Ibid.

[14] J. P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, Nov./Dec. 2004.

adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels. Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.[15]

Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room (Figure 13).[16] A review by Thomas Rice and K.Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.[17] Finally, research by Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, revealed that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all.[18]

Adults with High Deductibles Have More Problems Paying Medical Bills

When people who lack adequate financial protection become ill and seek diagnosis and treatment, they may find themselves with medical bills they are unable to pay right away. In the Commonwealth Fund Biennial Health Insurance Survey, one-quarter (26%) of all privately insured adults either had a problem paying a medical bill in the past 12 months or were paying off accrued medical debt.[19] People with annual deductibles of $1,000 or higher were particularly affected by bills and debt: more than two of five (41%) reported bill problems or accrued debt (Figure 14). In contrast, 23 percent of adults with deductibles under $500 reported similar problems.

Confronted with medical bills and debt, many people are forced to make tradeoffs between spending and saving priorities. In the Commonwealth Fund survey, among

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[15] J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

[16] R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *JAMA* 285, no. 4 (2001): 421–429.

[17] T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (Dec. 2004): 415–452.

[18] C. Schoen, M. M. Doty, S.R. Collins, and A. L. Holmgren, "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289–W5-302.

[19] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund) Sept. 2006. Medical bill problems included not being able to pay bills, being contacted by a collection agency about medical bills, or having to change your way of life in order to pay bills. Those who said they were contacted by a collection agency because of a billing mistake—and not because they were unable to pay a bill—were excluded from the total.

privately insured adults, 6 percent said that, because of medical bills, they were unable to pay for basic necessities like food, heat, or rent; 10 percent used all their savings to pay bills; 4 percent took out a mortgage against their home or other loan; and 10 percent took on credit card debt.[20] Adults covered through the individual insurance market, or those who had deductibles of $1,000 or more, were much more likely to say they had accumulated debt on credit cards because of medical bills. Nearly one-quarter (22%) of adults with deductibles of $1,000 or more and 15 percent of those with coverage purchased in the individual market reported that they had taken on credit card debt to pay their bills.

Other research has found that rising out-of-pocket costs are reducing people's ability to save for retirement. The 2005 EBRI Health Confidence Survey found that 29 percent of insured adults under age 65 reported they financed increased health care spending by using up all or most of their savings, while 45 percent had decreased contributions to other savings (Figure 15).[21]

Early Experience with HSA-Eligible HDHPs: Low Enrollment, Low Satisfaction, High Out-of-Pocket Costs, and Cost-Related Access Problems

Given that American families are already spending large shares of their income on health care, it should not be surprising that enrollment in HSA-eligible HDHPs remains low. These health plans currently comprise a very small share of the insurance market. The EBRI/Commonwealth Fund Consumerism in Health Care Survey (2005), a national online survey of adults ages 21 to 64, found that as of October 2005, just 1 percent of the adult population had a HDHP and an HSA or health reimbursement arrangement (HRA) (Figure 16).[22] An additional 9 percent had an HSA-eligible HDHP but had not yet opted to open an account. Other studies have found similarly slow take-up. The General Accountability Office (GAO) found that as of March 2005, only 7,500 federal employees, retirees, and dependents out of 9 million covered lives had opted to enroll in the HDHP/HSA product offered by the Federal Employee Health Benefits Program

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[20] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Sept. 2006.

[21] R. Helman and P. Fronstin, "2005 Health Confidence Survey: Cost and Quality Not Linked," EBRI Notes (Washington, DC: *EBRI*), Nov. 2005, Vol 26, No 11.

[22] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) Dec. 2005. The EBRI/Commonwealth Fund Consumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1,200 adults ages 21-64 and an oversample of those in HSA-eligible HDHPs with and without savings accounts that can be rolled over year to year (both HSAs and Health Reimbursement Arrangements or HRAs). There were 1,061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA. See appendix to this testimony for survey methodology.

(FEHBP) (Figure 17).[23] A recent study by America's Health Insurance Plans, an industry trade group, estimates that there are currently about 3.2 million people enrolled in HSA-eligible HDHPs, though the study did not indicate how many people had opened an account.[24] The U.S. Treasury Department estimates that under current law only 14 million people will ever enroll in HSA-eligible HDHPs—still a relatively small share of the overall market.[25]

Reflecting the fact that people in higher-income tax brackets have the greatest tax benefits associated with HSAs, HDHPs have disproportionately attracted people who have higher incomes. The GAO study of enrollment in FEHBP's HDHP/HSA product found that 43 percent of those enrolled in the HDHP/HSA plans had incomes of $75,000 or more, compared with 23 percent of those in all FEHBP plans (Figure 18).[26] Another recent GAO analysis of consumer-directed health plans found that 51 percent of tax filers who reported contributing to an HSA in 2004 had adjusted gross incomes of $75,000 or more, compared with 18 percent of all tax filers under 65.[27] In addition, higher deductibles have also attracted those who are younger and in better health. Rates of enrollment in the FEHBP HSA/HDHP plans were higher among federal employees under age 54 than among those ages 55 to 64 (Figure 19). In the EBRI/Commonwealth Fund Survey, people with HSA/HDHPs were slightly more likely to be in excellent or very good health than those with more comprehensive insurance.[28]

Yet, unlike federal employees, most workers who were enrolled in HSA-eligible HDHPs in the EBRI/Commonwealth Survey did not have a choice of plans: less than half of those enrolled in the plans had options (Figure 20).[29] Among those in the plans who did have a choice, lower premiums and the ability to open a savings account were the primary reasons for selecting the plan. Workers in comprehensive plans chose them for their low out-of-pocket costs.

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[23] Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf.

[24] America's Health Insurance Plans, *January 2006 Census Shows 3.2 Million People Covered by HSA Plans*, March 9, 2006; C.L. Peterson, *Data on Enrollment, Premiums and Cost-Sharing in HSA-Qualified Health Plans*, Congressional Research Service, CRS Report for Congress, May 13, 2006; E. Park, *Informing the Debate About Health Savings Accounts: An Examination of Some Misunderstood Issues*, Center on Budget and Policy Priorities, June 13, 2006.

[25] U.S. Department of the Treasury, *Fact Sheet: Dramatic Growth of Health Savings Accounts (HSAs).*

[26] Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf.

[27] General Accountability Office, *Consumer-Directed Health Plans: Early Experience with Health Savings Accounts and Eligible Health Plans*, Report to the Ranking Minority Member, Committee on Finance, U.S. Senate, Aug. 2006.

[28] P. Fronstin and S. R. Collins, Dec. 2005; General Accounting Office, 2006.

[29] P. Fronstin and S.R. Collins, Dec. 2005.

Low satisfaction with plans. Few Americans who are currently enrolled in HDHP/HSA plans are satisfied with them. The EBRI/Commonwealth Fund survey found that people with HDHPs, both with and without accounts, were far more likely than people in more comprehensive plans to report dissatisfaction with quality of care, out-of-pocket costs, and overall satisfaction with their plans (Figures 21 and 22).[30] More than half of those in the plans were not satisfied with their out-of-pocket costs. Moreover, one-third of those in the HDHP/HSAs would change plans if they had the opportunity to do so, and only one-third or less would recommend the plan to a friend or co-worker (Figures 23 and 24).

High out-of-pocket costs. The Kaiser Family Foundation/Health Research and Educational Trust (HRET) 2005 Survey of Employer Sponsored Health Benefits, a national survey of 2,013 employers, found that employer costs of HSA/HDHP products are lower relative to other plans offered, but the costs to their employees are higher relative to other plans (Figure 25).[31] According to the survey, employers who offered HSA-eligible plans in 2005 reduced their annual premium contributions for an employee's single coverage on average from $3,413 to $2,270.[32] The average employee premium contribution in HSA-eligible plans was $431 compared with $610 for all plans. But the average deductible in HSA-eligible HDHPs was $1,901, versus $323 in PPO plans. Moreover, employers contributed an average of $553 to employees' HSAs, an amount representing just 30 percent of the deductible. This average contribution includes the 37 percent of workers whose employers contributed nothing. Thus, workers' potential contributions to HSA-eligible HDHPs, including deductibles minus the employer HSA contribution, was $1,779, compared with $933 for all plans.

The majority of those in HDHPs have deductibles substantially above the level required for HSA eligibility. According to the EBRI/Commonwealth Fund survey, nearly three of five adults (59%) who had single-coverage HDHPs with accounts had deductibles of $2,000 or more.[33] Among those with family coverage in HDHPs with accounts, two-thirds (67%) reported a deductible of $3,000 or more; 24 percent had a deductible of at least $5,000.

Although it is legal for employers to exclude preventive services from the deductible of HSA-eligible plans, the KFF/HRET Survey found that in 2005 just 30

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[30] Ibid.

[31] G. Claxton et al., "What High Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* Web Exclusive, Sept. 14, 2005.

[32] Ibid.

[33] P. Fronstin and S.R. Collins, Dec. 2005.

percent of workers covered by an HSA-eligible plan had some preventive services covered within the deductible.[34]

When measured as a share of income, out-of-pocket costs associated with HSA-eligible HDHPs disproportionately burden the most vulnerable—those individuals with low incomes and/or health problems. The EBRI/Commonwealth Fund survey found that two-thirds of adults who are enrolled in a HDHP with an account and who have incomes of less than $50,000 spent 5 percent or more of their income on out-of-pocket costs and premiums—twice the rate of those with similar incomes in more comprehensive plans (Figure 26). People with health problems in HSA-eligible HDHPs, both with and without accounts, were also vulnerable to spending large shares of their income on out-of-pocket costs and premiums: more than half (53%) of those in HDHPs without accounts and 38 percent of those in HDHPs with an account spent 5 percent or more of their income on out-of-pocket costs.[35] People with health problems in comprehensive plans were much better protected by comparison: 17 percent spent 5 percent or more of their income on out-of-pocket costs.

Cost-related access problems. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay or avoid getting needed care, or to skip their medications. The EBRI/Commonwealth Fund survey found that one-third of those in HDHPs with and without accounts had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans (Figure 27). People with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults in HDHP/HSAs with incomes of less than $50,000 reported delaying or avoiding care; this was nearly twice the rate of people in the same income group in more comprehensive plans. People enrolled in HSA-eligible HDHPs without accounts were more likely to skip doses of their medications in order to make them last longer, or to not fill their prescriptions at all. The rates of skipped medications were highest among people with health problems (Figures 28 and 29).

Available Information to Help Patients Make Informed Choices Is Inadequate

The theory most central to the consumerism-in-health-care movement is that prudent choices in the use of health care will drive the health services market to look more like markets for other goods and services, lowering costs and improving quality as providers

[34] G. Claxton et al., Sept. 14, 2005.

[35] Health problem was defined as reporting fair or poor health or one of eight chronic health conditions: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; hypertension, high blood pressure or stroke.

compete for patients. But patients' ability to make informed choices is dependent on the extent to which they have access to useful information.

The EBRI/Commonwealth Fund survey finds that Americans, regardless of the health plan they are in, continue to encounter a yawning gap between the information needed to make decisions based on cost and quality and the information that is actually available. Just 14 to 16 percent of insured adults—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their plan on the quality of care provided by their doctors and hospitals (Figure 30).[36] Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.

There is evidence that people in HSA-eligible HDHPs are more cost-conscious consumers of health care than those in more comprehensive plans. The EBRI/Commonwealth Fund survey finds that three of five of those enrolled in HDHPs, both with and without accounts, said that they had checked whether their health plan would cover their costs prior to receiving care, and about one-third checked the price of a doctor's visit or other health service (Figure 31). People in HDHPs also appeared to be somewhat more willing than those in comprehensive plans to discuss the cost of their care with their doctors or ask them to recommend a less costly prescription drug.

Patients' Use of Information Alone Is Not Likely to Dramatically Improve Quality and Efficiency

Despite evidence that people in HSA-eligible HDHPs are more sensitive to costs when making medical decisions, it is simply not realistic to expect that even with better information the nation can achieve dramatic improvements in quality and efficiency through patient demand incentives. Most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending (Figure 32).[37] Most patients or their families are not able to shop around for the best and lowest-cost physician or hospital during a personal health care crisis. Moreover, to the extent that consumer-driven plans encourage people to skimp on preventive care or chronic disease management, over time they could fuel growth in health care costs.

Payers, federal and state governments, accrediting organizations, and professional societies are far more strongly positioned than patients to demand higher quality and

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[36] P. Fronstin and S. R. Collins, Dec. 2005.

[37] A. C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

efficiency from providers.[38] New York and Pennsylvania, for example, pioneered the publication of cardiac surgery mortality by surgeon and hospital name. Very few patients, however, used the information to choose providers.[39] Instead, the data helped improve the quality of cardiac surgery in those states because hospital CEOs investigated poor performance and acted on the findings to improve care in their institutions. Other research on managed care plans, hospitals, and medical groups has found similar evidence of provider-driven improvement in quality of care through the public reporting of information on quality.[40]

HSAs Will Not Solve Our Uninsured Problem

The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people without health insurance. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that more than one-quarter (28%) of U.S. adults ages 19 to 64, or 48 million people, were either uninsured at the time of the survey or had experienced a time without coverage in the previous 12 months (Figure 33).[41] Lack of insurance coverage continues to be highest among families with incomes under $20,000, with more than half (53%) uninsured for at least part of 2005. But uninsured rates are climbing rapidly among adults in moderate-income families—those with incomes between $20,000 and $40,000 (under 200 percent of poverty for a family of four)—rising from 28 percent in 2001 to 41 percent in 2005. Young adults ages 19 to 29, meanwhile, are the fastest-growing age group among the uninsured, a reflection of two factors: their loss of dependent coverage on their 19th birthday, or more importantly in terms of sheer numbers, their reclassification as adults at age 19 by Medicaid and the State Children's Health Insurance Program (SCHIP).[42] Nearly 70 percent of uninsured young adults are in families with incomes under 200 percent of poverty (Figure 34).

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[38] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," March 15, 2006.

[39] M. N. Marshall, P. G. Shekelle, S. Leatherman and R. H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (Apr. 2000): 1866 - 1874.

[40] National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005); J. H. Hibbard, J. Stockard and M. Tusler, "Hospital Performance Reports: Impact on Quality, Market Share, and Reputation: Evidence from a Controlled Experiment," *Health Affairs*, July/Aug. 2005 24(4):1150-60; J. H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs*, March/Apr. 2003 22(2):84-94; S.M. Shortell, J. Schmittdiel, M. C. Wang et al., "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study," *Medical Care Research and Review* 62, no. 4 (Aug. 2005): 407-434.

[41] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund) Apr. 2006.

[42] S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies can Help* (New York: The Commonwealth Fund) updated May 2006.

Because HSAs allow people to use pre-tax dollars to pay for out-of-pocket expenses not covered by health insurance, they are expected to draw previously uninsured people into the individual insurance market. People without insurance coverage have always had the option of purchasing a HDHP in order to lower their premium expense. Indeed, the majority of respondents to the EBRI/Commonwealth Fund Consumerism in Health Care Survey who had purchased an HSA-eligible HDHP, but had not opened an account, did so because of the lower premium.

The marginal effect of HSAs on the overall number of uninsured Americans depends on the degree to which uninsured individuals realize enough tax savings on out-of-pocket spending to make insurance affordable relative to their income. This will depend on expected out-of-pocket expenditures and marginal income tax rates, as well as savings from Medicare and Social Security taxes for employer-based plans. Research by Sherry Glied and Dahlia Remler found that 71 percent of uninsured Americans are in a 10-percent-or-lower income tax bracket. Indeed, more than half (55%) of people without coverage have no income tax liability at all (Figure 35).[43]

Using data from the Medical Expenditure Panel Survey, Glied and Remler calculated expected tax savings as a share of premiums, finding that savings associated with HSAs ranged from zero percent for those in the zero-percent tax bracket, to 6 percent for middle-income people in employer plans. Assuming a range of take-up rates in response to such savings, the authors estimated that the tax savings associated with HSAs would help cover fewer than 1 million previously uninsured people—even under their most generous assumptions of price sensitivity and not taking into account the effect of existing medical savings accounts, such as flexible spending accounts. In short, the major beneficiaries of the protective tax status of HSAs will be healthier, higher-income, *insured* taxpayers, who can afford to fund their accounts and afford the financial risk posed by higher-deductible health insurance plans.

Such plans could also reduce the availability of affordable health insurance for lower-wage or less-healthy employees, particularly those in small firms. In the employer group insurance market, the average deductible for a single person in a PPO plan, according to the Kaiser Family Foundation/HRET 2005 Survey of Employer-Sponsored Benefits, was $323, far lower than the average for HSA-eligible HDHPs of $1,901.[44] When an employer offers an HSA/HDHP as a choice among other plans, the HSA/HDHP

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[43] S. A. Glied and D. K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage* (New York: The Commonwealth Fund) Apr. 2005.

[44] G. Claxton et al., Sept. 14, 2005.

is most likely to be attractive to healthier, higher-income employees. This is because these employees have higher marginal tax rates and thus derive the greatest benefit from the tax benefit. They also have higher saving rates and less need for health care; consequently, they will be less likely to draw down their accounts to pay for health services and so will be able to accumulate balances over time.[45]

When an employer offers a product that is most attractive to healthier employees, a significant shift of those employees into the new product can leave an increasingly less healthy pool of employees in non-HSA/HDHP health plans.[46] This can have the effect of increasing premiums in those plans, making them less affordable for employees in worse health, and with lower incomes. As Sherry Glied and Dahlia Remler point out, the worst-case scenario is an escalating premium spiral that might ultimately lead to the disappearance of more-generous health plans.[47]

Many small employers only offer one health benefit plan—only one-quarter of privately insured workers in firms with fewer than 20 employees have a choice of health plan, compared with 70 percent of those in companies of 500 or more employees.[48] If small employers fully replace more generous health plans with HSA/HDHPs, this will disadvantage lower-income, less healthy employees, since these workers benefit less than higher-income employees from the tax benefits of HSAs and are less able to contribute to, or accumulate, balances in HSAs.[49] This increases the risk that lower-income employees, facing tradeoffs from other living expenses, might drop coverage if the plans' total costs, including out-of-pocket expenditures, are higher than those of more-comprehensive plans they were offered in the past.

The Individual Insurance Market Is Not a Solution to the Uninsured Problem

Incentives designed to encourage people to buy coverage on the individual market are also unlikely to reduce health care costs, or decrease the number of uninsured. The administrative costs of individual coverage comprise an estimated 25 to 40 percent of each premium dollar, compared with 10 percent for group coverage.[50] This means that premium dollars buy fewer benefits in the non-group market than they do in employer

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[45] S. A. Glied and D. K. Remler, Apr. 2005.
[46] Ibid.
[47] Ibid.
[48] S.R. Collins, J.L. Kriss, K. Davis, M.M. Doty, and A.L. Holmgren, Sept. 2006.
[49] S.A. Glied and D.K. Remler, Apr. 2005.
[50] J. Gabel et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund) May 2002.

group markets. Research has shown that few plans in the individual market, even with low deductibles and higher premiums, provide maternity benefits without a special rider.[51]

In addition, to remain competitive and to be responsible to their shareholders, insurers in the individual insurance market necessarily estimate risk and set premiums sufficiently high to cover risk. This means that in many states, people who are older, who are in poorer health, or have a chronic health problem like diabetes or heart disease will either be charged a higher premium than younger and healthier people, have their condition excluded from their coverage, or be turned down for coverage altogether.[52]

The Commonwealth Fund Biennial Health Insurance Survey of 2005 examined the experience of Americans in the individual insurance market over the past three years. An estimated 58 million privately insured adults ages 19 to 64 reported either that they had coverage purchased through the individual market or had considered buying, or tried to buy, a plan.[53] Of these, nearly 90 percent never bought a plan (Figure 36).

The survey asked adults who had been in the individual insurance market in the last three years about particular challenges they encountered in attempts to purchase a health plan on their own. These included ease of finding a plan with suitable or affordable coverage or being turned down for a preexisting condition. One-third (34%) of those in the individual market said they found it very difficult or impossible to find a plan with the coverage they needed (Figure 36). This problem was particularly pronounced among people with health problems: 48 percent of those with health problems (fair or poor health status, any one of four chronic conditions, or a disability) found it very difficult or impossible to find a plan with the coverage they needed.

Even greater proportions of people surveyed had difficulty finding an affordable plan. Nearly three of five (58%) adults who had ever shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford. This problem was especially evident among those with health problems and low incomes. More than 70 percent of people with health problems or incomes under 200 percent of the federal poverty level found it very difficult or impossible to find an affordable plan.

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[51] S. R. Collins, S.B. Berkson and D.A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund) Dec. 2002; J. Gabel et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund) May 2002.

[52] S. R. Collins, C. Schoen, M. M. Doty, A. L. Holmgren, and S. K.H. How, *Paying More for Less: Older Adults in the Individual Insurance Market* (New York: The Commonwealth Fund) June 2005.

[53] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Sept. 2006.

Even people who were able to find plans that met their needs were not always able to obtain coverage. About one-fifth (21%) of adults in the Commonwealth Fund survey who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage. People with health problems were the most likely to report such an experience: one-third had been turned down, charged a higher price, or had a health problem excluded from their coverage.

Some states like Massachusetts, New Jersey, and New York have strong individual market regulations that require community rating (everyone is charged the same premium regardless of age or health status) or impose age-rating bands which limit the degree to which premiums charged to older people can exceed those charged to younger people.[54] But in states that have less regulated individual markets, such as Iowa, Kansas, Kentucky, and Washington, there is no community rating, and carriers can reject applicants based on medical underwriting criteria. In these four states, researchers Nancy Turnbull and Nancy Kane have found that as many as 30 to 40 percent of applicants in the case of some insurance carriers are rejected for coverage.[55] In Kansas and Kentucky, carriers can impose permanent exclusions for preexisting conditions. Turnbull and Kane found that in Kentucky there is a 14-to-17-fold difference in premiums for the same insurance product based on health and age. While a 25-year-old Kentucky man could buy a $2,500 deductible plan for just $624 a year, a 63-year-old man would be charged $2,736 for the same product. If the 63-year-old had health problems and was eligible for coverage in the Kentucky's high-risk pool, the lowest annual premium for a $1,800 deductible plan was $10,800.

Still, while individual market regulations have improved access for older and less-healthy people, they also have made coverage more expensive for younger and healthier people. In addition, most states that have regulated their individual insurance markets have also experienced a reduction in the number of insurance carriers, leaving healthier consumers with fewer choices and distributing risk across fewer insurers.[56]

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[54] N. Turnbull and N. Kane, *Insuring the Health or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market, Findings from a Study of Seven States* (New York: The Commonwealth Fund) Feb. 2005.

[55] Ibid.

[56] N. Turnbull and N. Kane, Feb. 2005; A.M. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):133–73; M.A. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):71–99.

What Needs to Be Done?

With good information, patients can contribute in a small way to improving their own health, the quality of care and lowering the costs of care by exercising and eating well, by getting regular preventive care, by becoming educated about the risks and benefits of elective procedures, and by sharing their medical history with all their providers to reduce duplication of tests. But high-deductible health plans increase the risk that patients will fail to get care before a health condition becomes serious or to take medications that might control chronic conditions. It is important that modifications be made to the HSA legislation to reduce potentially harmful effects on these vulnerable populations. These might include:

- Permit employers to lower deductibles for lower-wage workers and qualify for HSAs;
- Exempt primary care as well as preventive services from the deductible; exempt prescription drugs essential for management of chronic conditions;
- Guarantee choice of a comprehensive health plan to workers covered under employer plans;
- Permit greater flexibility in benefit design (e.g. actuarially equivalent benefits);
- Set an income ceiling on eligibility for HSAs to reduce the tax subsidy for high income individuals.

Health care costs are high in part because we provide the wrong financial incentives to hospitals and doctors. Improving quality and efficiency in health care will require making fundamental changes in current provider payment methods. While Medicare and some state Medicaid programs have initiated demonstration programs and other measures aimed at improving efficiency and quality, both public and private payers need to do much more to change financial incentives in order to systematically reward providers for delivering high-quality and efficient care.[57] A recent study by The Institute of Medicine endorses pay-for-performance in the Medicare program, recommending that bonuses be awarded to physicians, hospitals and other providers on the basis of their

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[57] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.; M. B. Rosenthal, R. G. Frank, Z. Li et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *Journal of the American Medical Association,* Oct. 12, 2005, 294 (14): 1788–93; S. Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*, The Commonwealth Fund, Jan. 2003.

performance in clinical care, patient centered care, and efficiency.[58] Transparency in the quality and costs of care is essential to this effort, and Medicare needs to take a leadership role in making publicly available, by provider and by patient condition, information on total costs and quality.[59] Medicare should also forge public–private partnerships designed to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs. The Institute of Medicine has called for creation of a National Quality Coordination Board located within the U.S. Department of Health and Human Services to oversee the development of quality and efficiency measures and to ensure the collection of data on these measures at the individual provider level.

Finally, investment in health information technology is essential to facilitate the efficient transfer of information among patients, providers, and payers. Yet today, only about one of four physicians has electronic health records.[60]

A high performing health care system will always be beyond our grasp, however, if we continue to leave millions of Americans without adequate health insurance coverage. The Commonwealth Fund Biennial Health Insurance Survey (2005) finds alarming evidence that adults without health insurance who have chronic conditions are far more likely to skip medications or not fill prescriptions for controlling their conditions (Figure 37).[61] They are also far more likely than their insured counterparts to have gone to the emergency room or to have spent the night in the hospital. Uninsured adults are also more likely to report inefficiencies in their care, such as receiving duplicate tests (Figure 38). We need to cover the nation's nearly 47 million uninsured people, building on group forms of coverage that we know pool risk and provide affordable, meaningful protection to families.

Unless we can tolerate our sick and old neighbors, friends, and family members being charged far more than the healthy and the young or being left out of the market altogether, it is imperative that we pool risk. New forms of pooling are needed to allow people who lose, or have never had access to, employer-based coverage an affordable place to buy meaningful coverage. Particularly promising are strategies that expand

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[58] Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, Washington DC: National Academies Press, 2006; Audio Interview: Pay for Performance – Recommendations of the Institute of Medicine, with Dr. Elliott S. Fisher and Dr. Karen Davis, *New England Journal of Medicine* 2006;355(13):e14.

[59] S. R. Collins and K. Davis, Mar. 15, 2006.

[60] A-M. Audet, M. M. Doty, J. Peugh, J. Shamasdin, K. Zapert, and S. C. Schoenbaum, "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine,* Dec. 7, 2004.

[61] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Apr. 2006.

employer-based coverage, eliminate the two-year waiting period for coverage of the disabled under Medicare, let older adults "buy-in" to Medicare, and build on Medicaid and the State Children's Health Insurance Program to cover lower-income parents, young adults, and single adults.[62] In addition, new reforms in some states—such as Maine, Massachusetts, and Vermont—are providing models that may inform and shape national policy strategies.

Finally, we must ensure that health care coverage is affordable for people across the income spectrum and that patient incentives are designed to encourage, rather than discourage, the use of preventive services, primary care, and appropriate chronic disease management. Instead of asking families to pay a minimum deductible of $2,100, policy makers should focus on setting maximum limits on family cost-sharing, such as 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Years of research on patient health care use has produced a considerable body of evidence that patients respond to marginal increases in costs by not getting the health care they need. Guaranteeing affordable care for all Americans will help ensure that patients receive appropriate preventive care, have serious conditions diagnosed in their early stages, and have the financial means to control chronic conditions that will inevitably degrade their health, productivity, and standard of living—and ultimately lead to higher costs later in life.

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[62] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, Apr. 23, 2003.

APPENDIX. SURVEY METHODOLOGY

The Commonwealth Fund Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. There were 1,878 respondents ages 19 to 64 who were insured all year with private insurance. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 212 million adults age 19 and older, including 108 million adults ages 19 to 64 who were insured all year with private insurance. The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The 47 percent response rate was calculated consistent with standards of the American Association for Public Opinion Research.

The EBRI/Commonwealth Fund Consumerism in Health Care Survey was conducted by Harris Interactive between September 28, 2005 and October 19, 2005 through an 18 minute Internet survey of adults ages 21-64. The base sample was randomly drawn from Harris Poll Online, Harris Interactive's online sample of 4 million Internet users who have agreed to participate in research surveys. Harris stratified the sample by gender, age, and region before drawing the random sample. The base sample consisted of 1,204 adults and was then weighted by gender, age, education, and region to reflect the proportions in the population aged 21-64 with private health insurance coverage. Harris then drew an over-sample of adults who had HSA-eligible high deductible health plans ($1,000 for an individual and $2,000 for a family) without accounts that they could roll over at the end of the year. Harris also drew an over-sample of adults with HSA-eligible high deductible health plans who also had an account they could roll over at the end of the year. By definition, these accounts were either HSAs or health reimbursement arrangements (HRAs). The over-samples were not weighted. The final sample consisted of 1,061 adults with comprehensive health plans (deductibles under $1,000 for an individual and $2,000 for a family); 463 adults with HSA-eligible health plans and no accounts (HDHP); and 187 adults with HSA-eligible health plans with accounts (CDHP).

FIGURES

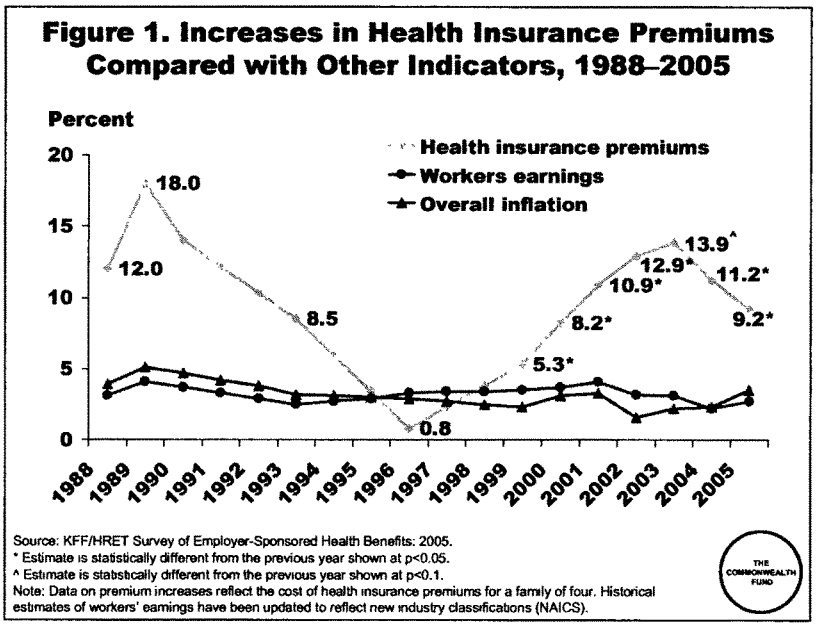
Figure 1. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2005
Percent
Health insurance premiums
Workers earnings
Overall inflation
20
15
10
5
0
18.0
12.0
8.5
0.8
5.3*
8.2*
10.9*
12.9*
13.9^
11.2*
9.2*
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2005.
* Estimate is statistically different from the previous year shown at p<0.05.
^ Estimate is statistically different from the previous year shown at p<0.1.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).
THE COMMONWEALTH FUND

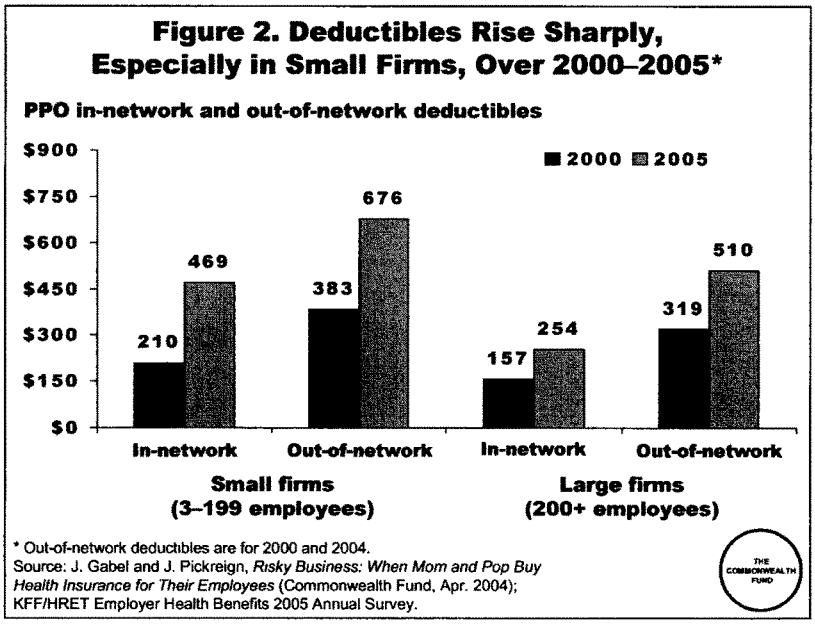
Figure 2. Deductibles Rise Sharply, Especially in Small Firms, Over 2000–2005*
PPO in-network and out-of-network deductibles
2000
2005
$900
$750
$600
$450
$300
$150
$0
210
469
383
676
157
254
319
510
In-network
Out-of-network
In-network
Out-of-network
Small firms (3–199 employees)
Large firms (200+ employees)
* Out-of-network deductibles are for 2000 and 2004.
Source: J. Gabel and J. Pickreign, Risky Business: When Mom and Pop Buy Health Insurance for Their Employees (Commonwealth Fund, Apr. 2004); KFF/HRET Employer Health Benefits 2005 Annual Survey.
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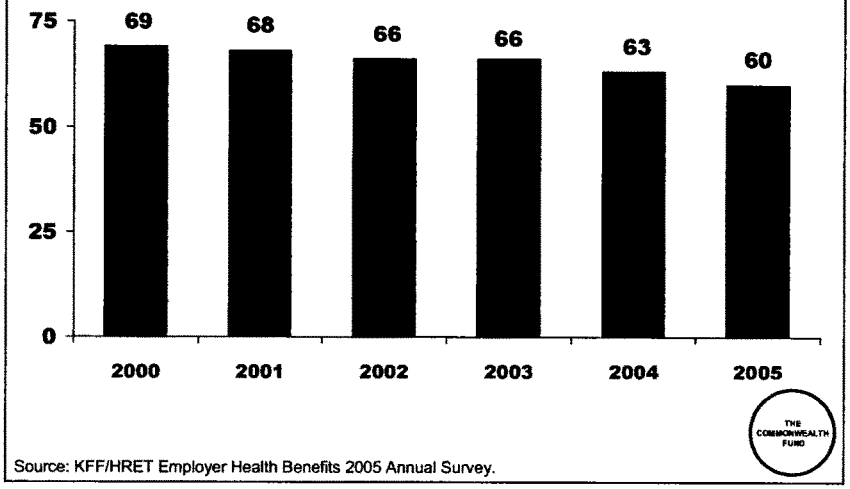
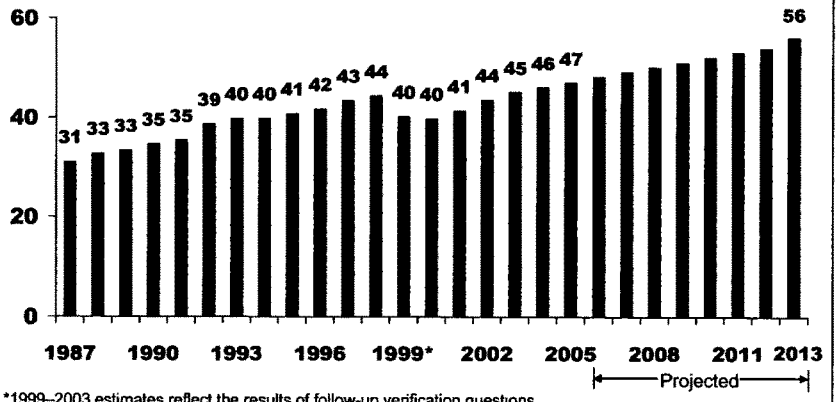
Figure 3. Percent of Firms Offering Health Benefits Declined Over 2000–2005



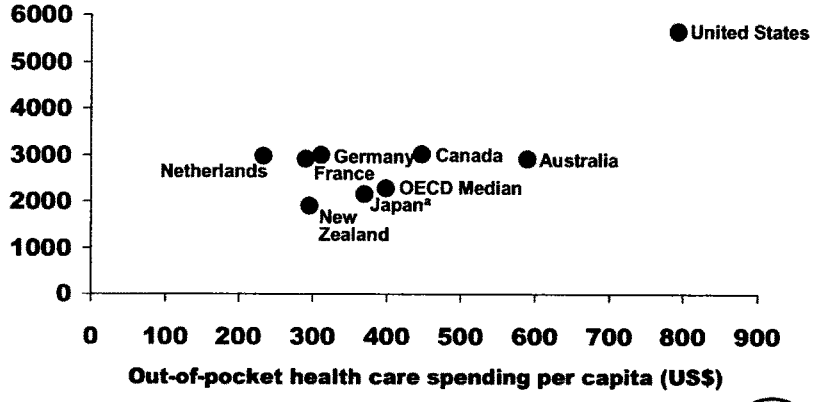
Source: KFF/HRET Employer Health Benefits 2005 Annual Survey.

Figure 4. 47 Million Uninsured in 2005; Increasing Steadily Since 2000



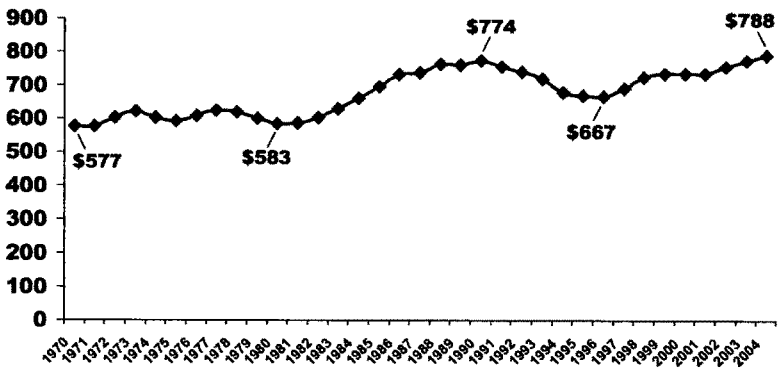
*1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.
Note. Projected estimates for 2006–2013 are for nonelderly uninsured based on T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive, Apr. 5, 2005.
Source U.S. Census Bureau, March CPS Surveys 1988 to 2005

Figure 5. Americans Spend More Out-of-Pocket on Health Care Expenses



* 2002
Note: Adjusted for differences in the cost of living, 2003.
Source: B.K. Frogner and G.F. Anderson, *Multinational Comparisons of Health Systems Data, 2005,* The Commonwealth Fund, April 2006.

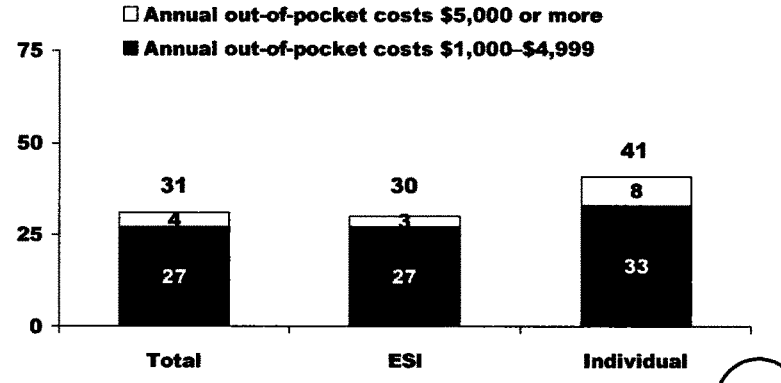
Figure 6. Americans Are Spending More Out-of-Pocket for Health Care



Source. C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (Jan./Feb. 2006); Centers for Medicare and Medicaid Services, National Health Expenditures Data; http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

Figure 7. Adults with Individual Coverage Are More Likely to Spend $5,000 or More Annually on Personal Out-of-Pocket Expenses

Percent of adults ages 19–64 insured all year with private insurance

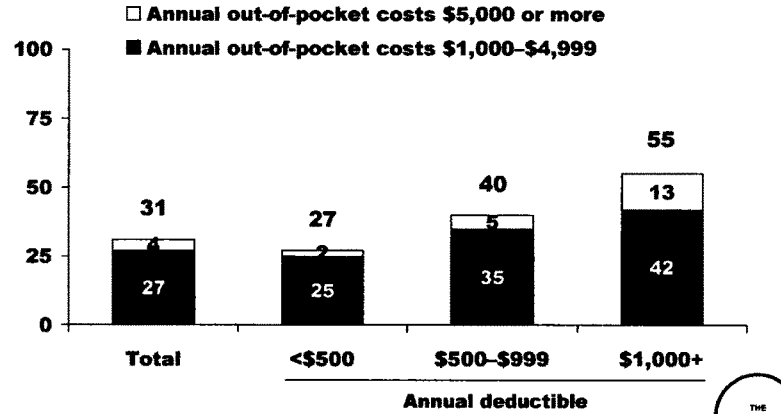


ESI = employer-sponsored insurance.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 8. Adults with Higher Deductibles Are More Likely to Spend $1,000 or More on Personal Out-of-Pocket Expenses

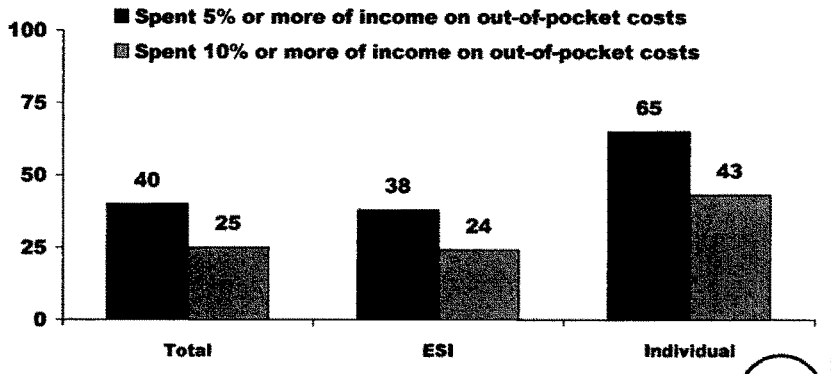
Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 9. One-Quarter of Adults Spent 10 Percent or More of Their Household Income Annually on Family Out-of-Pocket Expenses and Premiums

Percent of adults ages 19–64 insured all year with private insurance

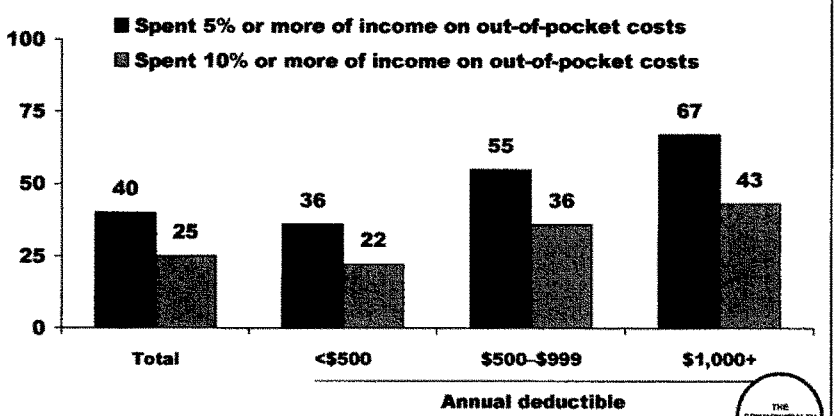


ESI = employer-sponsored insurance.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 10. Adults with Higher Deductibles Are More Likely to Spend a Greater Share of Household Income on Family Out-of-Pocket Expenses and Premiums

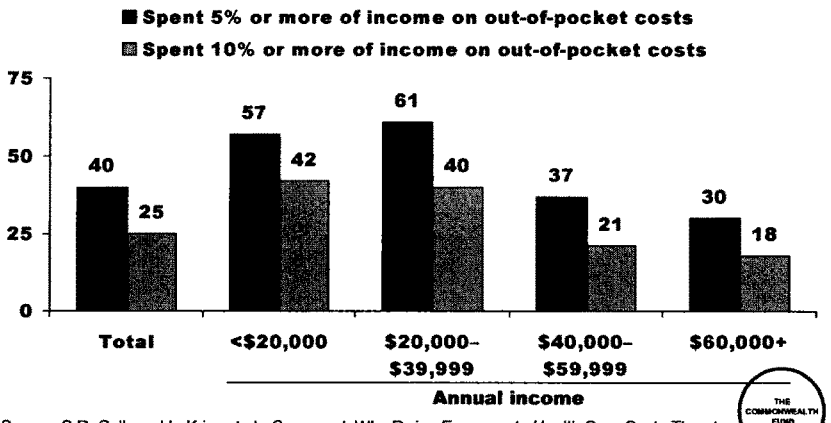
Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 11. Low-Income Households at Most Risk for Spending Greater Shares of Income on Family Out-of-Pocket Expenses and Premiums

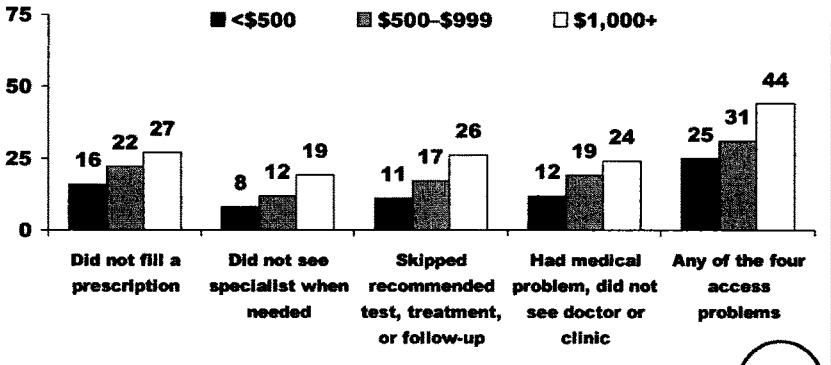
Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

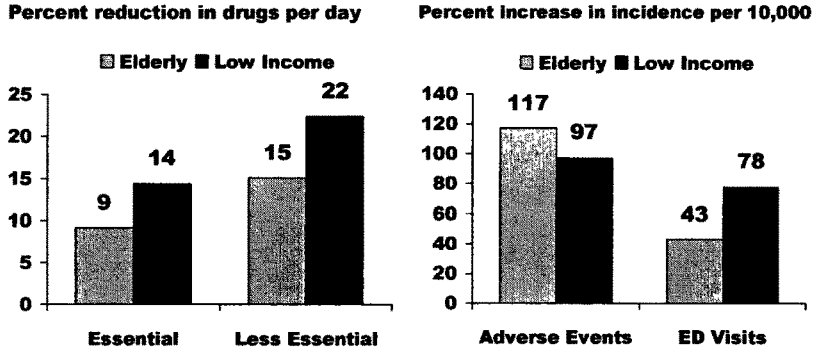
Figure 12. Adults with High Deductibles Are More Likely to Avoid Needed Health Care Because of Cost

Percent of adults ages 19–64 insured all year with private insurance



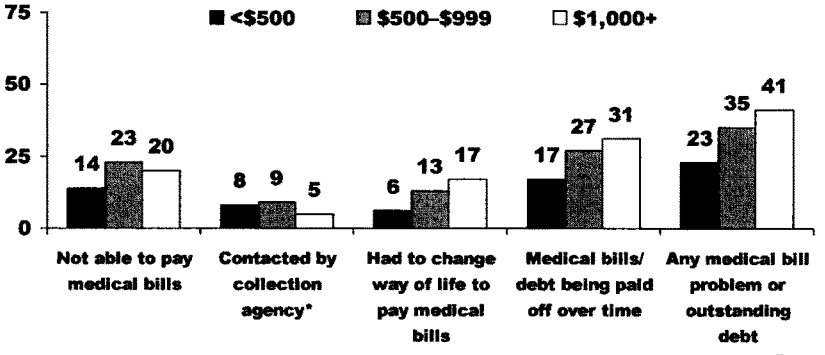
Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 13. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



Source. R. Tamblyn et al., "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *JAMA*, Jan. 24/31, 2001 285(4):421–29.

Figure 14. Adults with High Deductibles Have Problems Paying Medical Bills or Are Paying Off Medical Debt

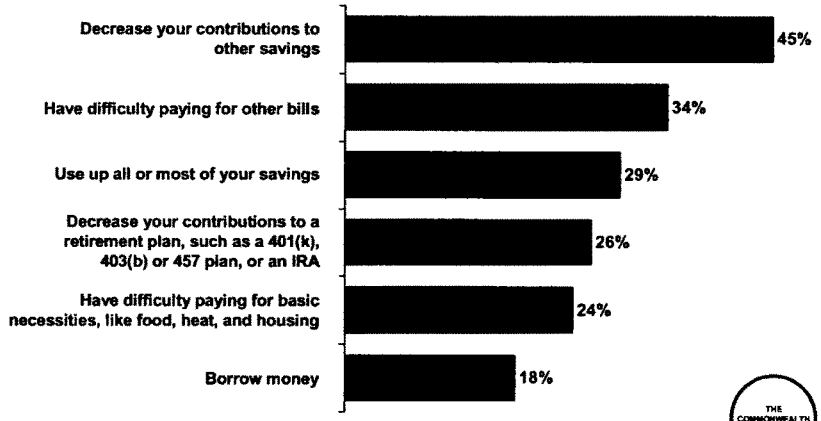


* Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund, Sept 2006.

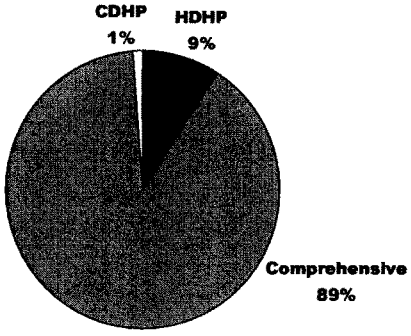
Figure 15. Increased Health Care Costs Have Reduced Savings

Has increased spending on health care expenses in the past year caused you to do any of the following? Among those with health insurance coverage who had increases in health care costs in the last year (n=731) (percentage saying yes)



Source: EBRI Health Confidence Survey, 2005.

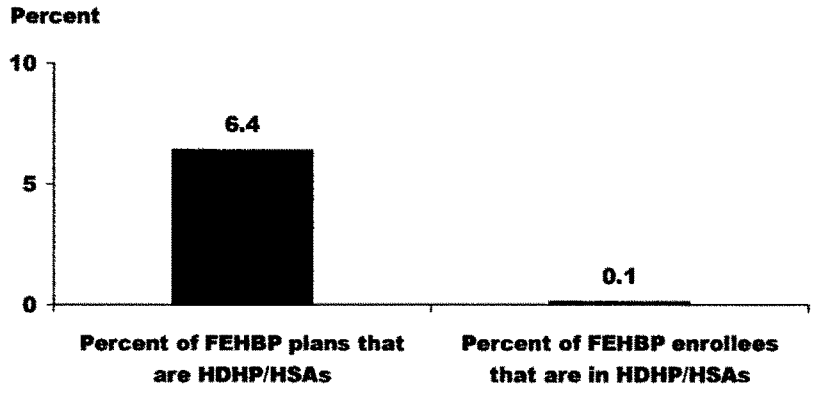
Figure 16. Few Insured People Are Currently Covered by High-Deductible Health Plans (HDHP) or Consumer-Directed Health Plans (CDHP) with a Savings Account



Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam);
HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account;
CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

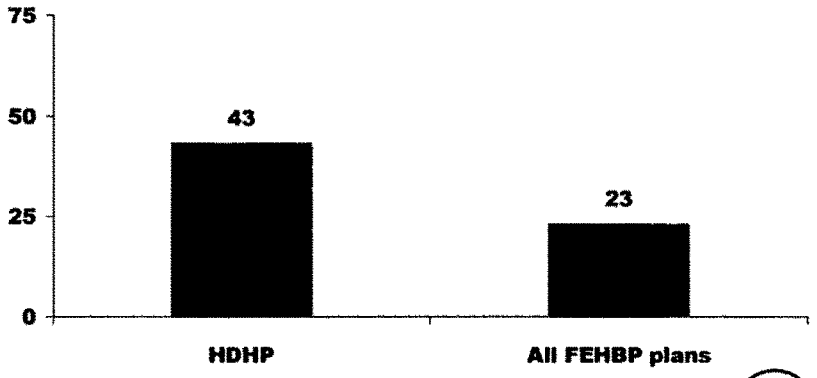
Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Dnven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

Figure 17. FEHBP HDHP/HSA Plans Enroll 7,500 Out of 9 Million Covered Lives



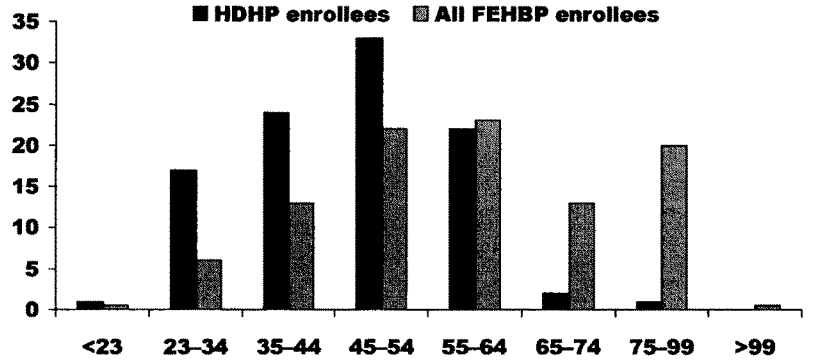
Note: As of March 2005.
Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006, OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf

Figure 18. Enrollees Who Chose HDHPs from the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes



Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006.

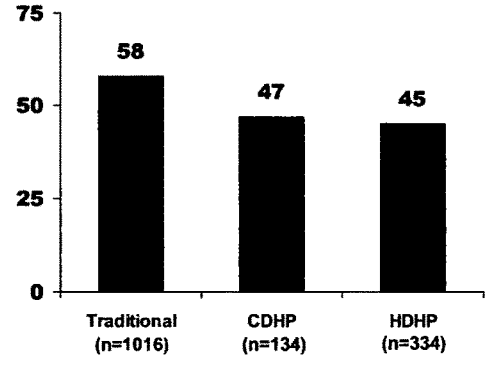
Figure 19. Age Distribution of HDHP and Other FEHBP Enrollees



Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan 2006.

Figure 20. Less than Half of Those Enrolled in Employer-Based High-Deductible Health Plans Had a Choice

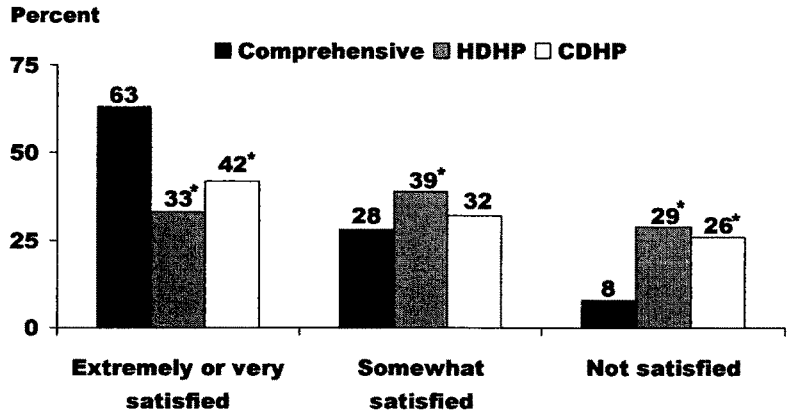
Percent of adults with employer-based coverage who were offered a choice of health plans



- **CDHP and HDHP owners are less likely to have a choice of plans from their employer**
- **When they have a choice, the savings account is the leading reason for choosing CDHP, while premium cost is the most frequent reason for choosing HDHP. Traditional plans are chosen for low out-of-pocket costs.**

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

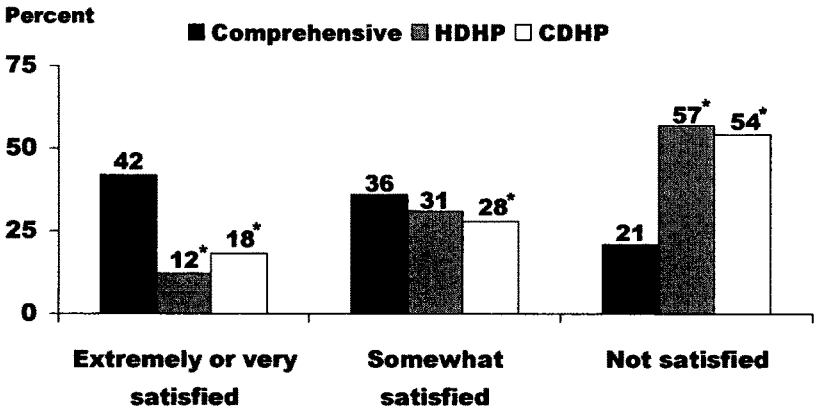
Figure 21. Enrollees of HDHP/CDHPs Are Less Satisfied with Their Coverage



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

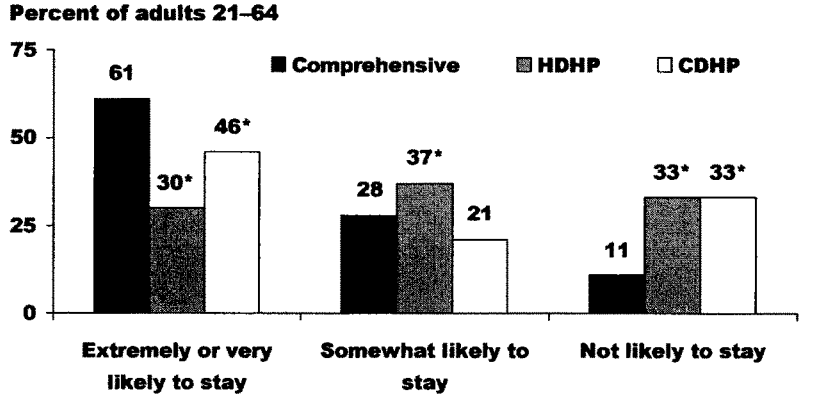
Figure 22. Enrollees of HDHP/CDHPs Are Less Satisfied with Out-of-Pocket Costs



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

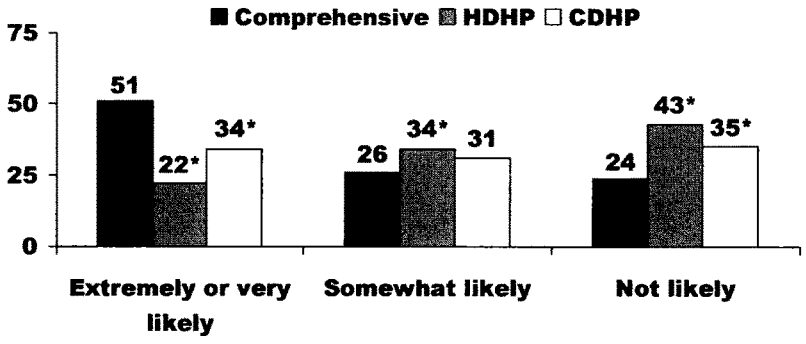
Figure 23. Enrollees of HDHP/CDHPs Are Less Likely to Stay with Their Current Health Plan If They Had the Opportunity to Change



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

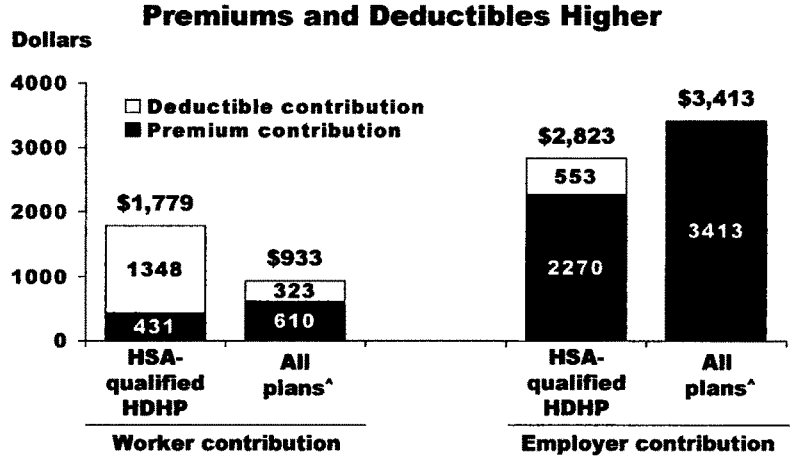
Figure 24. Enrollees of HDHP/CDHPs Are Less Likely to Recommend Their Plan to a Friend or Coworker



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source. P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

Figure 25. Employers' Contributions Lower for Workers in HSA-Qualified HDHPs; Employees' Premiums and Deductibles Higher



^ "All plans" refers to all conventional HMOs, PPOs, and POS plans in the survey, not just HDHP/HRA or HSA-qualified HDHPs.
Source: Calculated based on G. Claxton et al., "What High Deductible Health Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* Web Exclusive, Sept., 14, 2005; J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs*, Sept./Oct. 2004.

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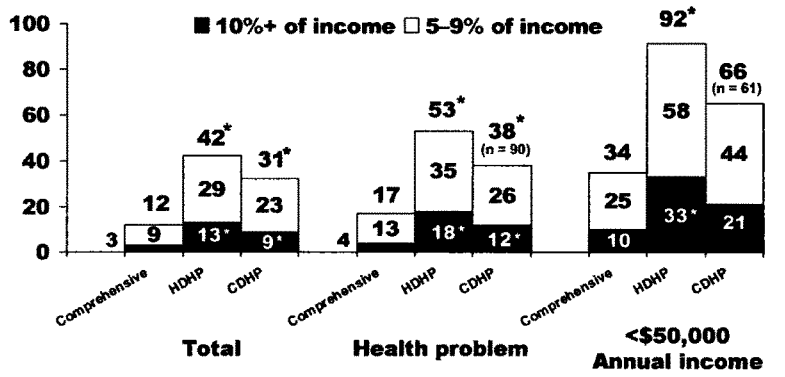
Figure 26. Enrollees of HDHP/CDHPs Spend Higher Percent of Income on Out-of-Pocket Medical Expenses and Premiums



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.
Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumensm in Health Care Survey*, EBRI Issue Brief, Dec. 2005

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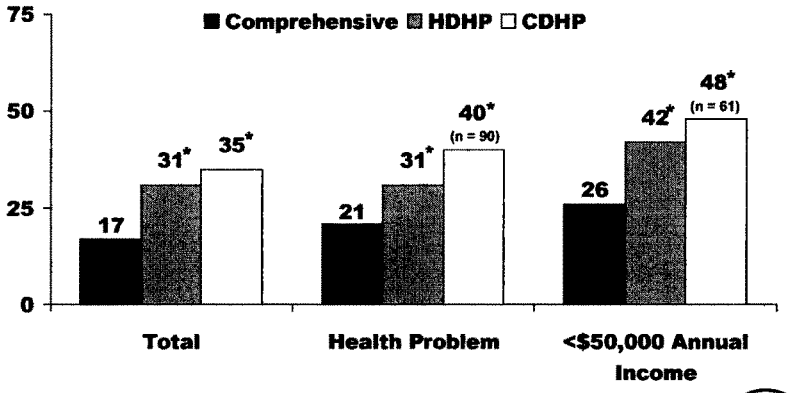
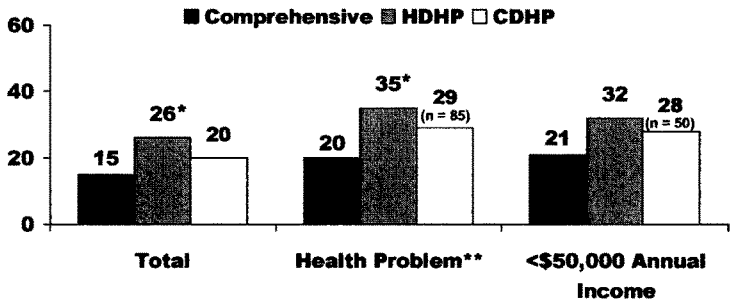
Figure 27. Enrollees of HDHP/CDHPs Are More Likely to Delay or Avoid Getting Health Care When Sick Due to Cost



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

Figure 28. Enrollees of HDHP/CDHPs Are More Likely To Skip Doses to Make Medications Last

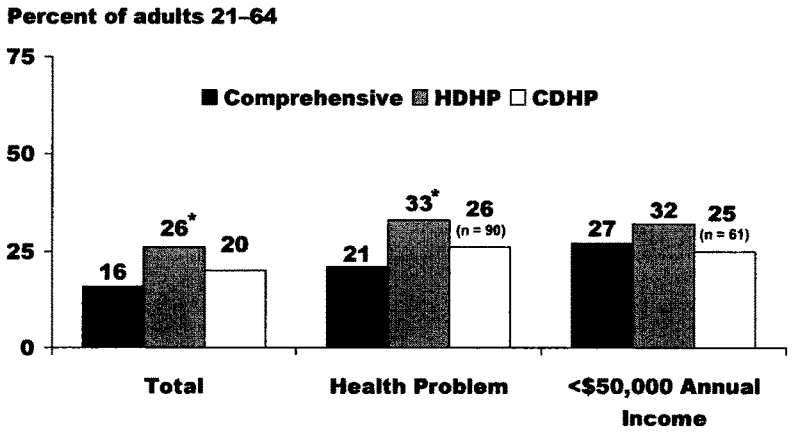


* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

** Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

Figure 29. Enrollees of HDHP/CDHPs Are More Likely to Not Fill a Prescription Due to Cost



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec. 2005.

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Figure 30. Most Insured Do Not Have Quality and Cost Information to Make Informed Choices

	Comprehensive	HDHP/CDHP
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36 (n = 76)
Hospitals	14	32 (n = 76)

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, Dec 2005.

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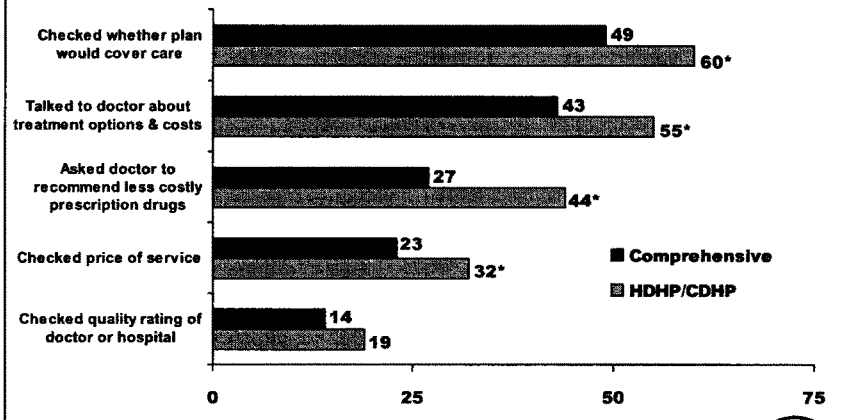
Figure 31. Cost Conscious Decision-Making, by Insurance Source

Percent of adults 21–64 who received health care in last 12 months

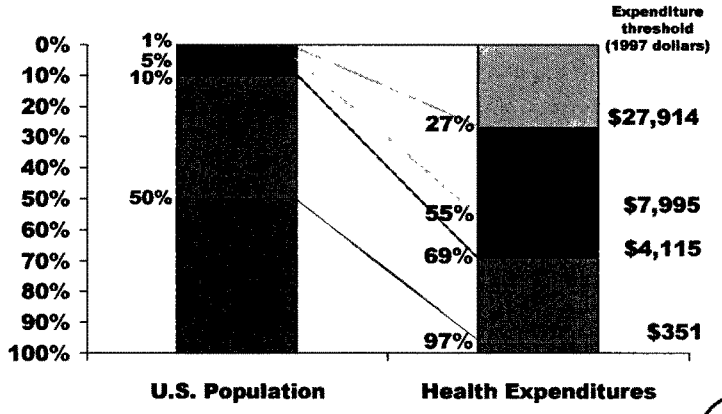


* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Bnef, Dec. 2005.

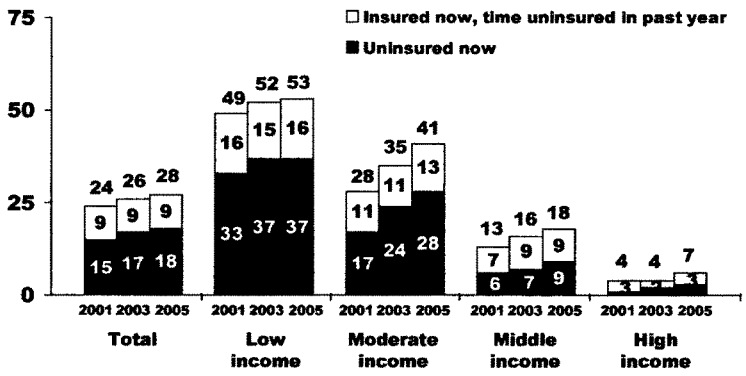
Figure 32. HSAs Won't Solve the Cost Problem: Most Costs Are Concentrated in the Very Sick

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 1997



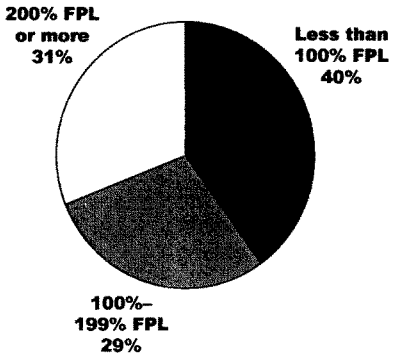
Source: A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003):III53–III64.

Figure 33. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005



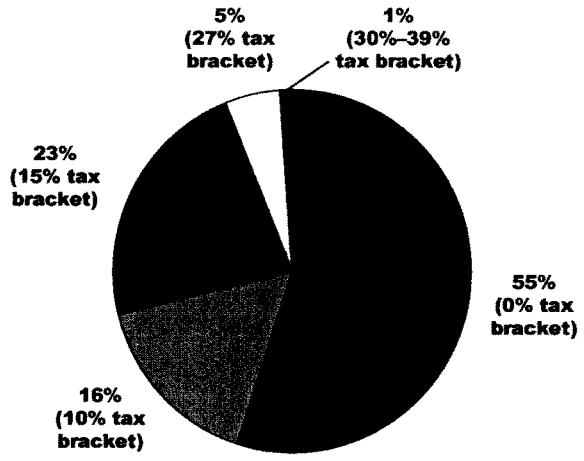
Note. Income refers to annual income. In 2001 and 2003, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source. S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, Apr. 2006.

Figure 34. Distribution of Uninsured Young Adults 19–29 by Poverty Status, 2004



Source: S.R. Collins, C. Schoen, J.L. Kriss et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, The Commonwealth Fund, updated May 2006.

Figure 35. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured



Source: S.A. Glied, *The Effect of Health Savings Accounts on Health Insurance Coverage*, The Commonwealth Fund, Apr. 2005.

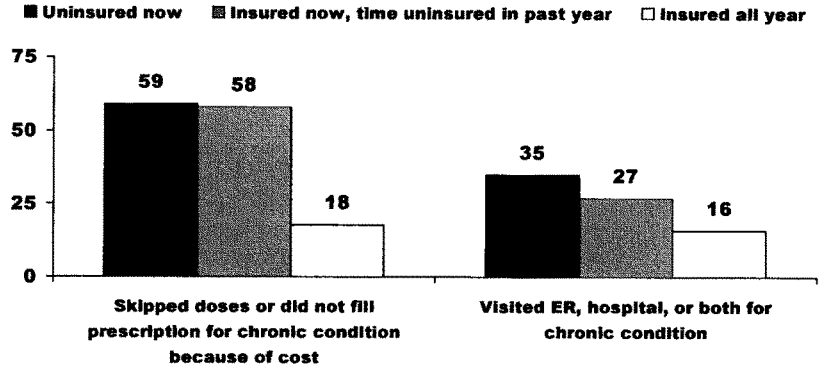
Figure 36. Individual Market Is Not an Affordable Option for Many People

Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of Amencan Families*, The Commonwealth Fund, Sept. 2006.

Figure 37. Lacking Health Insurance for Any Period Undermines Quality and Efficiency

Percent of adults ages 19–64 with at least one chronic condition*

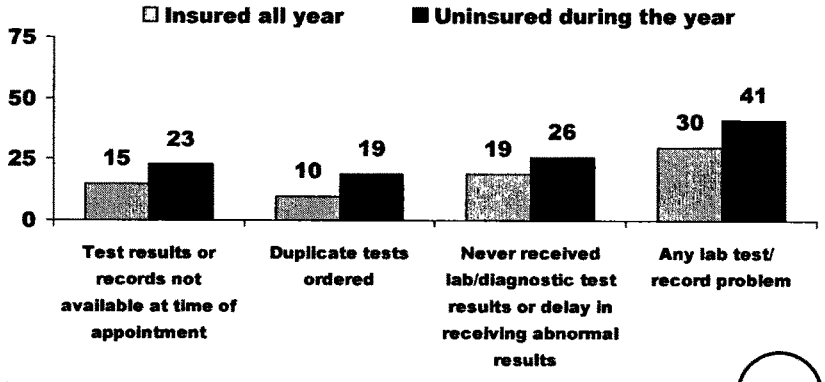


* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, Apr. 2006

Figure 38. Adults Without Insurance Have More Problems With Lab Tests and Records

Percent of adults ages 19–64 reporting the following problems in past two years:



Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem—Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, Apr 2006.

Subcommittee on Health
Committee on Finance
U.S. Senate
Hearing on "Health Savings Accounts: The Experience So Far"
September 26, 2006

Responses to Questions from Senator Hatch, Senator Baucus, and Senator Rockefeller

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund
October 17, 2006

From Senator Hatch:

1. Dr. Collins, there has been a good deal of focus on the cost of HSA expansion and the potential impact on existing insurance markets. Yet one of the critical features of these plans—their portability—has received less attention. In my experience, one of the aspects of health insurance that makes even insured Americans anxious is that they may loose their insurance if they switch jobs. The administration believes that HSAs have the potential to make insurance more portable. Do you see portability as a positive attribute of health coverage, and if so, how would you recommend making insurance more portable?

Portability of health insurance is an indeed an important goal for reducing gaps in insurance coverage that people often experience when they change jobs, or are unemployed for a period of time. However, while the health savings account (HSA) part of high deductible health plans is portable, the health insurance portion is not. Thus, while an employee might take their savings account with her when she changes jobs, she will still loose her health insurance, unless of course she buys into her former employer's coverage through COBRA.

It is clear that we need to create new options for people who lose health insurance coverage when they change or lose a job, or when their employer does not offer coverage, or drops coverage. Unless we can tolerate our sick and old neighbors, friends, and family members being charged far more than the healthy and the young or being left out of the individual insurance market altogether, it is imperative that we pool risk. New forms of pooling are needed to allow people who lose, or have never had access to, employer-based coverage an affordable place to buy meaningful coverage. Particularly promising are strategies that expand employer-based coverage – both private and public, eliminate the two-year waiting period for coverage of the disabled under Medicare, let older adults "buy-in" to Medicare, and build on Medicaid and the State Children's Health Insurance Program to cover more children and adults.

Finally, we should ensure that health care coverage is affordable for people across the income spectrum and that patient incentives are designed to encourage, rather than discourage, the use of preventive services, primary care, and appropriate chronic disease management. Instead of asking families to pay a minimum deductible of $2,100, policy makers should focus on setting maximum limits on family cost-sharing, such as 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Years of research on patient health care use has produced a considerable body of evidence that patients respond to marginal increases in costs by not getting the health care they need. Guaranteeing affordable care for all Americans will help ensure that patients receive appropriate preventive care, have serious conditions diagnosed in their early stages, and have the financial means to control chronic conditions that will inevitably degrade their health, productivity, and standard of living—and ultimately lead to higher costs later in life.

2. Dr. Collins, one of the sub-populations that these low-premium health insurance plans target are young, healthy, unmarried workers, who, more than any other group, go without health insurance. Their decision to do without insurance is often not the result of a lack of means but rather from a perspective that they are "invincible" or unlikely to have anything happen to them. Do you think that these plans will encourage this group to get more insurance and would this contribute to their financial security?

Uninsured adults who lack health insurance because they feel they do not need it is an important group to reach out to, but also a very small group. A recent survey conducted by ABC News, the Kaiser Family Foundation and USA Today, found that more than half (54%) of adults over age 18 without health coverage say the main reason they lack coverage is because they cannot afford it, while another 15% say they cannot get insurance because of poor health, illness or age.[1] Just 4% said the main reason they lack health insurance is because they think they don't need it. The young, healthy and unmarried uninsured group has always had access to high deductible health plans or catastrophic health plans with lower premiums through the individual insurance market. Indeed, the individual market has disproportionate numbers of younger adults. According to the Commonwealth Fund Biennial Health Insurance Survey, about 19 percent of adults ages 19-64 with individual coverage are ages 19 to 29, compared with 14 percent of those with employer-based coverage.[2] Whether the ability to open a health savings account in conjunction with a high deductible health plan will entice more of this group to buy health insurance is dependent on the degree to which uninsured individuals realize enough tax savings on out-of-pocket spending to make insurance affordable relative to their income. This will depend on expected out-of-pocket expenditures and marginal

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[1] ABC News, Kaiser Family Foundation, USA Today, *Health Care in America 2006 Survey*, October 2006, http://www.kff.org/kaiserpolls/upload/7572.pdf.

[2] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund) Sept. 2006.

income tax rates, as well as savings from Medicare and Social Security taxes for employer-based plans. Research by Sherry Glied and Dahlia Remler found that 71 percent of uninsured Americans are in a 10-percent-or-lower income tax bracket. Indeed, more than half (55%) of people without coverage have no income tax liability at all.[3]

Using data from the Medical Expenditure Panel Survey, Glied and Remler calculated expected tax savings as a share of premiums, finding that savings associated with HSAs ranged from zero percent for those in the zero-percent tax bracket, to 6 percent for middle-income people in employer plans. Assuming a range of take-up rates in response to such savings, the authors estimated that the tax savings associated with HSAs would help cover fewer than 1 million previously uninsured people—even under their most generous assumptions of price sensitivity and not taking into account the effect of existing medical savings accounts, such as flexible spending accounts.

3. Dr. Collins, what are your thoughts on allowing employers or employees to transfer existing HRA or FSA balances to HSAs?

From a tax perspective, allowing the transfer of HRA or FSA balances might lower taxable income which has federal budget implications, though it will depend on the rules governing the transfer. For example, if employees can rollover unspent FSA money each year it effectively wipes out the "use it or lose it" rule. This is good for the people who would lose money, but it also gives people an incentive to over-fund their FSAs. If the rollover were structured not to be subject to the annual HSA contribution, this would be a way to increase the annual HSA contribution. Overall, the policy would lower tax revenues and also benefit people in higher income tax brackets the most, just as HSAs do now.

But there are ways in which HSAs might be changed to be more favorable to lower income employees and people with health problems, the two groups which are most disadvantaged in HSA-eligible HDHPs. Strategies include:

- Permit employers to lower deductibles for lower-wage workers and still qualify for HSAs;
- Guarantee choice of a comprehensive health plan to workers covered under employer plans;
- Set an income ceiling on eligibility for HSAs to reduce the tax subsidy for high income individuals;
- Exempt primary care as well as preventive services from the deductible; exempt prescription drugs essential for management of chronic conditions.

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[3] S. A. Glied and D. K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage* (New York: The Commonwealth Fund) Apr. 2005.

From Senator Baucus:

Recent reports studying health literacy suggest Americans need help in navigating our health care system. A recent assessment from the National Center for Education Statistics found that only 12 percent of Americans could easily navigate the health care system. An Institute of Medicine report, *Health Literacy: A Prescription to End Confusion*, found that nearly half of all American adults have difficulty understanding and using health information, and that there is a higher rate of hospitalization and use of emergency services among patients with limited health literacy. What level of health literacy is needed for an individual to manage their own health expenses under an HSA/high-deductible health plan? Based on these findings and your research, do you believe most Americans are able to manage their health care effectively and efficiently under an HSA/high-deductible health plan? Please explain.

The purpose of health insurance is to provide people with meaningful access to the health care system and protect them from catastrophic financial loss because of illness or injury. While most high deductible health plans include catastrophic health coverage, the nature of a high deductible is itself a disincentive for people to get preventive care or manage their chronic health conditions adequately, since they could face at least $1,050 (individual) or $2,100 (family) in expenses before their coverage kicked in. And even in employer-based plans where employers can contribute to the HSA, many do not contribute, and on average employers do not contribute enough to HSAs to fully cover deductibles. The Kaiser Family Foundation/Health Research and Educational Trust (HRET) 2006 Survey of Employer Sponsored Health Benefits, a national survey of 3,000 employers, found that employers contributed an average of $689 to employees' HSAs, an amount representing just 34 percent of the average deductible in employer-based HSA-eligible plans of $2,011. This average contribution includes the 37 percent of workers whose employers did not contribute to the account.

By law employers can exclude preventive care from the deductible in HSA-eligible HDHPs. But a recent report by the General Accountability Office found that many participants in the plans had difficulty distinguishing between preventive services and other services provided during a physician office visit.[4] Some participants explained that in their experience some laboratory tests performed during a preventive care visit were not considered preventive services and were not excluded from the deductible.

The law governing HSAs is also explicit about not excluding other services from the deductible that enable people to get timely care for themselves and their family members, including those for management of an existing illness, injury or chronic health conditions.

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[4] General Accountability Office, *Consumer-Directed Health Plans: Early Experience with Health Savings Accounts and Eligible Health Plans*, Report to the Ranking Minority Member, Committee on Finance, U.S. Senate, Aug. 2006.

The evidence about how people respond to the incentives of HSA-eligible high deductible health plans should serve as a cautionary note about the reality of asking families to pay for the first few thousand dollars of their health care expenses each year with the hopes that they will become more prudent health care consumers. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay or avoid getting needed care, or to skip their medications. The EBRI/Commonwealth Fund Consumerism in Health Care Survey (2005), a national online survey of adults ages 21 to 64, found that one-third of those in HDHPs with and without accounts had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans.[5] People with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults in HSA/HDHPs with incomes of less than $50,000 reported delaying or avoiding care; this was nearly twice the rate of people in the same income group in more comprehensive plans. Two in five people with health problems said that they had delayed or avoided health care when they were sick because of cost, twice the rate of people with health problems in more comprehensive plans.[6] People enrolled in HSA-eligible HDHPs without accounts were more likely to skip doses of their medications in order to make them last longer, or to not fill their prescriptions at all. The rates of skipped medications were highest among people with health problems.

There is evidence that people in HSA-eligible HDHPs are more cost-conscious consumers of health care than those in more comprehensive plans. The EBRI/Commonwealth Fund Consumerism in Health Care Survey finds that three of five of those enrolled in HDHPs, both with and without accounts, said that they had checked whether their health plan would cover their costs prior to receiving care, and about one-third checked the price of a doctor's visit or other health service. People in HDHPs also appeared to be somewhat more willing than those in comprehensive plans to discuss the cost of their care with their doctors or ask them to recommend a less costly prescription drug.

Yet the EBRI/Commonwealth Fund survey also found that in general patients are not accustomed to seeking information about providers or trusting the information that is available. The survey found that the most trusted source of information is the patient's

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[5] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) Dec. 2005. The EBRI/Commonwealth Fund Consumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1,200 adults ages 21-64 and an oversample of those in HSA-eligible HDHPs with and without savings accounts that can be rolled over year to year (both HSAs and Health Reimbursement Arrangements or HRAs). There were 1,061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA.

[6] Health problem was defined as reporting fair or poor health or one of eight chronic health conditions: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; hypertension, high blood pressure or stroke.

own physician.[7] The least trusted sources of information are health plans and government agencies—with only about 1 in 20 trusting those sources of information. Yet health plans and government agencies are far more likely to be able to develop systematic measures of quality and cost, collect the information on these measures, and disseminate it to patients, payers and providers in a usable format.

In the end, payers, federal and state governments, accrediting organizations, and professional societies are far more strongly positioned than patients to utilize information on quality and costs in a way that promises to improve quality and efficiency in the delivery of health care.[8] New York and Pennsylvania, for example, pioneered the publication of cardiac surgery mortality by surgeon and hospital name. Very few patients, however, used the information to choose providers.[9] Instead, the data helped improve the quality of cardiac surgery in those states because hospital CEOs investigated poor performance and acted on the findings to improve care in their institutions. Other research on managed care plans, hospitals, and medical groups has found similar evidence of provider-driven improvement in quality of care through the public reporting of information on quality.[10]

From Senator Rockefeller:

1. Dr. Collins, in addition to being affluent, don't HSA purchasers tend to be younger workers in relatively good health?

In employer-based health plans, the evidence shows that workers who opt to enroll in HSA-eligible high deductible health plans (HSA/HDHPs) do tend to be more affluent, younger and healthier. The General Accountability Office (GAO) found in a study of federal employees who had enrolled in the HSA/HDHP product offered by the Federal Employee Health Benefits Program (FEHBP) that 43 percent had incomes of $75,000 or

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[7] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

[8] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," March 15, 2006.

[9] M. N. Marshall, P. G. Shekelle, S. Leatherman and R. H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (Apr. 2000): 1866 - 1874.

[10] National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005); J. H. Hibbard, J. Stockard and M. Tusler, "Hospital Performance Reports: Impact on Quality, Market Share, and Reputation: Evidence from a Controlled Experiment," *Health Affairs*, July/Aug. 2005 24(4):1150-60; J. H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs*, March/Apr. 2003 22(2):84-94; S.M. Shortell, J. Schmittdiel, M. C. Wang et al., "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study," *Medical Care Research and Review* 62, no. 4 (Aug. 2005): 407-434.

more, compared with 23 percent of those in all FEHBP plans.[11] In addition, rates of enrollment in the FEHBP HSA/HDHPs were higher among federal employees under age 54 than among those ages 55 to 64. In the EBRI/Commonwealth Fund Consumerism in Health Care Survey (2005), people with HSA/HDHPs in the individual insurance market and the employer market, were slightly more likely to be in excellent or very good health than those with more comprehensive insurance.[12]

2. Mr. Dicken and Dr. Collins, how appropriate are high-deductible health plans and HSAs for the average American, including those with low to moderate income or those with chronic conditions?

The purpose of health insurance is to provide people with meaningful access to the health care system and protect them from catastrophic financial loss because of illness or injury. While most high deductible health plans include catastrophic health coverage, the nature of a high deductible is a disincentive for people to get preventive care or manage their chronic health conditions adequately, since they could face at least $1,050 (individual) or $2,100 (family) in expenses before their coverage kicked in. Even in employer-based plans where employers can contribute to the HSA, many do not contribute, and on average employers do not contribute enough to HSAs to fully cover deductibles. The Kaiser Family Foundation/Health Research and Educational Trust (HRET) 2006 Survey of Employer Sponsored Health Benefits, a national survey of 3,000 employers, found that employers contributed an average of $689 to employees' HSAs, an amount representing just 34 percent of the average deductible in employer-based HSA-eligible plans of $2,011. This average contribution includes the 37 percent of workers whose employers did not contribute to the account.

By law employers can exclude preventive care from the deductible in HSA-eligible HDHPs. But a recent report by the General Accountability Office found that many participants in the plans had difficulty distinguishing between preventive services and other services provided during a physician office visit.[13] Some participants explained that in their experience some laboratory tests performed during a preventive care visit were not considered preventive services and were not excluded from the deductible.

The law is also explicit about not excluding other services from the deductible that enable people to get timely care for themselves and their family members, including services for the management of an existing illness, injury or chronic health conditions.

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[11] Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf.

[12] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) Dec. 2005.

[13] General Accountability Office, *Consumer-Directed Health Plans: Early Experience with Health Savings Accounts and Eligible Health Plans*, Report to the Ranking Minority Member, Committee on Finance, U.S. Senate, Aug. 2006.

Yet the costs of chronic conditions drive growth in U.S. health care costs each year so it seems we would want to give people strong incentives, rather than disincentives, to effectively manage their chronic conditions, like diabetes, to prevent serious and costly complications from occurring down the road.

The evidence about how people respond to the incentives of HSA-eligible high deductible health plans should serve as a cautionary note about the reality of asking families to pay for the first few thousand dollars of their health care expenses each year. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay or avoid getting needed care, or to skip their medications. The EBRI/Commonwealth Fund Consumerism in Health Care Survey (2005), a national online survey of adults ages 21 to 64, found that one-third of those in HDHPs with and without accounts had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans.[14] People with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults in HSA/HDHPs with incomes of less than $50,000 reported delaying or avoiding care; this was nearly twice the rate of people in the same income group in more comprehensive plans. Two in five people with health problems said that they had delayed or avoided health care when they were sick because of cost, twice the rate of people with health problems in more comprehensive plans.[15] People enrolled in HSA-eligible HDHPs without accounts were more likely to skip doses of their medications in order to make them last longer, or to not fill their prescriptions at all. The rates of skipped medications were highest among people with health problems.

Other studies confirm these findings. The Commonwealth Fund Biennial Health Insurance Survey found that adults with high deductibles are more likely to have problems getting necessary health care than those with lower deductibles.[16] Forty-four percent of adults with deductibles of $1,000 or more reported one of four cost-related access problems: because of cost did not fill a prescription, did not see a specialist when needed, skipped a recommended test, treatment, or follow-up, or had a medical problem but did not see a doctor. In contrast, 25 percent of adults with deductibles under $500 cited similar cost-related access problems.

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[14] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) Dec. 2005. The EBRI/Commonwealth Fund Consumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1,200 adults ages 21-64 and an oversample of those in HSA-eligible HDHPs with and without savings accounts that can be rolled over year to year (both HSAs and Health Reimbursement Arrangements or HRAs). There were 1,061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA. See appendix to this testimony for survey methodology.

[15] Health problem was defined as reporting fair or poor health or one of eight chronic health conditions: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; hypertension, high blood pressure or stroke.

[16] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund) Sept. 2006.

The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care.[17] A recent study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels. Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.[18]

Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room.[19] A review by Thomas Rice and K.Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.[20]

3. On September 25th, the *Wall Street Journal* had an article entitled "New Premium: When Employees Pay for Health Care, The Boss Pays Too – Questions Besiege Mr. Bond As Workers Try to Scrimp In High-Deductible Plan," which discussed the experience of an employer who provides HSAs to his employees. The article pointed out that since instituting HSAs his employees have shared a lot more information about their medical conditions with him. In particular, many of his employees do not have internet access, or do not know how to investigate cheaper treatment options, and they have been coming to him with questions. This employer has spent a great deal of time researching treatment options for his employees, from suitable generic drugs to cheaper hospitals for some procedures.

He expressed unease about having so much detailed medical information about his employees, because if he ever let an employee go, they may claim that he had done so as a result of some information he had about their health.

Do you have any concerns about employers having so much medical information, recognizing that there may be some employers who would use it in inappropriate ways?

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[17] J. P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, Nov./Dec. 2004.

[18] J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

[19] R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.

[20] T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (Dec. 2004): 415–452.

This story reveals the dearth of information available to workers and their employers on the cost and quality of health care providers in any health insurance plan and the consequences to workers and employers. In this case, the consequences to workers are the significant amount of time devoted to finding a high quality, low cost provider and the revealing of highly personal health care information to one's employer at a time of personal crisis. The consequences to the employer are the time costs associated with helping workers find high quality and efficient providers, and perhaps, as this employer suggests, the possession of detailed health information that may be perceived as biasing employment decisions later.

Ideally, if all insurance plans or the federal government, provided the necessary quality and cost information to help people and their employers make informed choices about providers, people would not have to enlist their employers to help them choose high quality and efficient health care providers during a personal health crisis. Employers that select networks of providers should know at the time of network selection that the participating physicians and providers are both high quality and efficient and payment systems should be established that reward such behavior. A recent study by The Institute of Medicine endorses pay-for-performance in the Medicare program, recommending that bonuses be awarded to physicians, hospitals and other providers on the basis of their performance in clinical care, patient centered care, and efficiency.[21]

But at the present time, the information about the cost and quality of providers doesn't begin to meet the needs of patients, payers, or providers. Patients report that they rarely have cost and quality information available to them. The Employee Benefit Research Institute (EBRI) and Commonwealth Fund Consumerism in Health Care Survey (2005) found that 14 to 16 percent of insured individuals—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their health plan on quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.[22] About half of those with the information had tried using it.

4. I would like to explore the argument that health care savings accounts would drive down the costs of health care by having consumers be more price sensitive.

It has been argued that patients will be more careful about what health care they receive if they personally must pay the bills, as part of a high deductible plan. But I am very skeptical of this argument for several reasons.

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[21] Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, Washington DC: National Academies Press, 2006; Audio Interview: Pay for Performance – Recommendations of the Institute of Medicine, with Dr. Elliott S. Fisher and Dr. Karen Davis, *New England Journal of Medicine* 2006;355(13):e14.

[22] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

I understand that 70% of all health care costs are insured by the sickest 10% of Americans. People who have chronic conditions or a catastrophic medical event will quickly exceed their deductible, even in plans with high deductibles.

Will the HSA model actually impose any pricing pressure on those patients who have already exceeded their deductible?

Despite evidence that people in HSA-eligible HDHPs are more sensitive to costs when making medical decisions, it is simply not realistic to expect that even with better information we can achieve dramatic improvements in quality and efficiency through patient demand incentives. As Senator Rockefeller points out, most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending.[23] HSA/HDHPs do not address spending at this level at all and in fact, through the perverse incentive of a high deductible, actually discourage people with chronic health conditions from effectively managing their conditions to prevent the difficult and costly complications that ultimately drive growth in health care costs.

We should ensure that patient incentives are designed to encourage, rather than discourage, the use of preventive services, primary care, and appropriate chronic disease management. A study by John Hsu and colleagues at Kaiser Permanente reveals the unintended cost consequences of increasing what people have to pay out of pocket for chronic disease medication.[24] The researchers found that Medicare beneficiaries whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels. Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.

Instead of asking families to pay a minimum deductible of $2,100, policy makers should focus on setting maximum limits on family cost-sharing, such as 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Years of research on patient health care use has produced a considerable body of evidence that patients respond to marginal increases in costs by not getting the health care they need. Guaranteeing affordable care for all Americans will help ensure that patients receive appropriate preventive care, have serious conditions diagnosed in their

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[23] A. C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

[24] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005; J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386; R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429; J. P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, Nov./Dec. 2004; T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (Dec. 2004): 415–452.

early stages, and have the financial means to control chronic conditions that will inevitably degrade their health, productivity, and standard of living—and ultimately lead to higher costs later in life.

5. If the data are correct that 70% of costs are incurred by a small share of the total patient population, then is it realistic to expect that price pressure – if it actually happened – would affect more than one third of health care expenditures?

The demand incentives of high deductible health plans are based on the theory that patients will become more prudent consumers of health care. The evidence shows that people in these plans do tend to focus more on the costs of their care in making decisions. The EBRI/Commonwealth Fund Consumerism in Health Care Survey for example finds that three of five of those enrolled in HSA-eligible HDHPs, both with and without accounts, said that they had checked whether their health plan would cover their costs prior to receiving care, and about one-third checked the price of a doctor's visit or other health service. People in HDHPs also appeared to be somewhat more willing than those in comprehensive plans to discuss the cost of their care with their doctors or ask them to recommend a less costly prescription drug.

With good information, patients can contribute in a small way to improving their own health, the quality of care and lowering the costs of care by exercising and eating well, by getting regular preventive care, by becoming educated about the risks and benefits of elective procedures, and by sharing their medical history with all their providers to reduce duplication of tests. But these small changes in behavior will not, as Senator Rockefeller points out, contribute in a significant way to reducing growth in the substantial share of health care costs stemming from serious illness, injury, and chronic disease.

Moreover, the EBRI/Commonwealth Fund Survey and a considerable body of research on the effects of cost sharing on health care use also find that people facing high deductibles and other increases in cost-sharing skimp on both essential and less essential care.[25] Some of this research has also found that whatever cost savings resulted from reduced care because of the extra costs on prescription drugs, for example, were offset by the costs of excess hospitalizations and emergency room visits because of the reduction in use of preventive or management services. Thus, the concern with these plans, if they were implemented on a broad basis, especially among people most sensitive to excess out-of-pocket costs such as those with lower incomes or health problems, is that they might inadvertently fuel growth in health care costs over time if people failed to get timely preventive or chronic disease care.

If we are serious about making major strides in controlling health care costs we need to look beyond increasing patient cost-sharing. Patients are in the weakest position to demand greater quality and efficiency from providers, particularly when they are very ill. Payers, federal and state governments, accrediting organizations, and professional

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[25] J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

societies are far more strongly positioned than patients to demand higher quality and efficiency from providers. To control health care costs and improve quality, we need to make fundamental changes in the way we pay providers. While Medicare and some state Medicaid programs have initiated demonstration programs and other measures aimed at improving efficiency and quality, both public and private payers need to do much more to change financial incentives in order to systematically reward providers for delivering high-quality and efficient care.[26] A recent study by The Institute of Medicine endorses pay-for-performance in the Medicare program, recommending that bonuses be awarded to physicians, hospitals and other providers on the basis of their performance in clinical care, patient centered care, and efficiency.[27]

Transparency in the quality and costs of care is essential to this effort, and Medicare needs to take a leadership role in making publicly available, by provider and by patient condition, information on total costs and quality.[28] Medicare should also forge public–private partnerships designed to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs. The Institute of Medicine has called for creation of a National Quality Coordination Board located within the U.S. Department of Health and Human Services to oversee the development of quality and efficiency measures and to ensure the collection of data on these measures at the individual provider level.

Investment in health information technology is essential to facilitate the efficient transfer of information among patients, providers, and payers. Yet today, only about one of four physicians has electronic health records.[29]

A high performing health care system will always be beyond our grasp, however, if we continue to leave millions of Americans without adequate health insurance coverage. The Commonwealth Fund Biennial Health Insurance Survey (2005) finds

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[26] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.; M. B. Rosenthal, R. G. Frank, Z. Li et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *Journal of the American Medical Association,* Oct. 12, 2005, 294 (14): 1788–93; S. Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*, The Commonwealth Fund, Jan. 2003.

[27] Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, Washington DC: National Academies Press, 2006; Audio Interview: Pay for Performance – Recommendations of the Institute of Medicine, with Dr. Elliott S. Fisher and Dr. Karen Davis, *New England Journal of Medicine* 2006;355(13):e14.

[28] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.

[29] A-M. Audet, M. M. Doty, J. Peugh, J. Shamasdin, K. Zapert, and S. C. Schoenbaum, "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine,* Dec. 7, 2004.

alarming evidence that adults without health insurance who have chronic conditions are far more likely to skip medications or not fill prescriptions for controlling their conditions.[30] They are also far more likely than their insured counterparts to have gone to the emergency room or to have spent the night in the hospital. Uninsured adults are also more likely to report inefficiencies in their care, such as receiving duplicate tests. We need to cover the nation's nearly 47 million uninsured people, building on group forms of coverage that we know pool risk and provide affordable, meaningful protection to families.

6. I wonder whether patients typically have all the information they need to be savvy consumers of health care. Most people are comfortable deferring to their doctors' judgment about what procedures or tests are medically necessary. And pricing information from doctors or hospitals is extremely difficult to compile. Furthermore, even when pricing data is available, I'm not convinced that it is in a usable form.

What tools do individuals have to be informed health care consumers? Is data available in a usable form?

Patients report that they rarely have cost and quality information available to them. The Employee Benefit Research Institute (EBRI) and Commonwealth Fund Consumerism in Health Care Survey found that 14 to 16 percent of insured individuals—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their health plan on quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.[31] About half of those with the information had tried using it.

Patients are not accustomed to seeking information on the cost or quality of providers or trusting the information that is available. The EBRI/Commonwealth Fund Consumerism in Health Care Survey found that the most trusted source of quality information about other providers is the patient's own physician.[32] The least trusted sources of information are health plans and government agencies—with only about 1 in 20 trusting those sources of information. Yet health plans and government agencies are the institutions most likely to be able to develop systematic measures of quality and cost, collect the information on these measures, and disseminate it to patients, payers and providers in a usable format.

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[30] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund) Apr. 2006.

[31] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

[32] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

Knowing prices of health care services is of little value without information on the total cost of caring for a given condition and the quality or outcomes of that care.[33] Health care is not a homogeneous commodity. Rather than simply seeking out the surgeon with the lowest fee, for example, it important that patients know the quality of care provided and a surgeon's track record with complications or mortality. Even if a hospital room charge is lower, it is not a bargain if the patient is more likely to stay longer or be readmitted for an infection or complication.

Additionally, the price of an individual service is just one element in the total cost that a patient or insurer faces. There is often no standard set of services that are provided to patients with a given condition. The total bill can depend on the tests ordered, the length of the hospital stay, and the number of specialist consultants involved in the care. A surgeon's fee is an important component of the total bill, but so is the anesthesiologist's and radiologist's fee.

Private insurers have started classifying providers by quality and costs, but their methods for doing so are not transparent and are often proprietary. Furthermore, most private insurers have too few patients with a given condition obtaining care from a given physician to create reliable quality and efficiency metrics.

The science of measuring quality and patient experiences with care has advanced considerably in the last decade, although the data are not routinely collected and made publicly available at the individual provider level. The science of measuring efficiency at the individual provider level with appropriate adjustment for patient complexity and other factors is less advanced.

But perhaps the greatest barrier to creating databases of critical information on the cost and quality of care is the resistance of providers to making quality information available. A Commonwealth Fund survey of physicians and quality of care in 2003 found that one-fourth of physicians would definitely or probably not be willing to make their own quality information available to the medical leadership of their organization or to other physicians; two in five would not make this information available to their own patients; and two-thirds definitely or probably would not make it available to the general public.[34] Similarly, in a Commonwealth Fund international survey in 2003, one-third of

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[33] S. R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," Mar. 15, 2006.

[34] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

hospital CEOs in the U.S. indicated that information on mortality rates, medical errors, and nosocomial infection rates should not be released to the public.[35]

Even the most optimistic estimate is that it will be 5 to 10 years before systematic information on quality and cost is available to all parties—and then only if the federal government, especially Medicare, demonstrates far greater leadership in creating the kinds of information databases necessary.

7. By encouraging so-called price transparency, don't we also run the risk of encouraging patients to forgo important medical tests or treatment that would ultimately lower their long-term health care costs?

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Health Insurance Survey found that adults with high deductibles are more likely to have problems getting necessary health care than those with lower deductibles.[36] Forty-four percent of adults with deductibles of $1,000 or more reported one of four cost-related access problems: because of cost did not fill a prescription, did not see a specialist when needed, skipped a recommended test, treatment, or follow-up, or had a medical problem but did not see a doctor. In contrast, 25 percent of adults with deductibles under $500 cited similar cost-related access problems.

Several studies also provide evidence that people facing increases in cost sharing decrease the use of essential as well as less essential care. Some studies have also shown subsequent adverse health events and consequently, higher spending that offset savings achieved through reduction in health service use as result of the higher cost-sharing. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care.[37] A recent study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels. Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.[38]

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[35] R.J. Blendon, C. Schoen, C.M. DesRoches, R. Osborn, K. Zapert and E. Raleigh, "Confronting Competing Demands To Improve Quality: A Five Country Survey," *Health Affairs* 2004 23(3):119-135.

[36] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund) Sept. 2006.

[37] J. P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, Nov./Dec. 2004.

[38] J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room.[39] A review by Thomas Rice and K.Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.[40]

8. We have heard some testimony referring to the fact that 42% of HSA participants make less than $50,000 per year. I would like to explore what that figure reveals. More than three-quarters of West Virginians make less than $50,000 per year. Can you tell me the percentage of the total population nationwide that makes less than $50,000 per year? Assuming it is a figure considerably higher than 42%, then doesn't this tell us that HSAs are appealing to higher-income individuals more than low income individuals?

The median income for the U.S. population in 2005 was $46,326. This means that one-half of U.S. households earned less than $46,326. Several studies have found that HSA-eligible high deductible health plans disproportionately attract people with higher incomes. The GAO study of enrollment in FEHBP's HSA/HDHP product found that 43 percent of those enrolled in the HSA/HDHP plans had incomes of $75,000 or more, compared with 23 percent of those in all FEHBP plans.[41] Another recent GAO analysis of consumer-directed health plans found that 51 percent of tax filers who reported contributing to an HSA had adjusted gross incomes of $75,000 or more, compared with 18 percent of all tax filers under 65.[42] The EBRI/Commonwealth Fund Consumerism in Health Care Survey found that people with HDHPs with savings accounts were more likely than adults with comprehensive health insurance or HDHPs without accounts to earn $150,000 or more annually.[43]

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[39] R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.

[40] T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (Dec. 2004): 415–452.

[41] Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf.

[42] General Accountability Office, *Consumer-Directed Health Plans: Early Experience with Health Savings Accounts and Eligible Health Plans*, Report to the Ranking Minority Member, Committee on Finance, U.S. Senate, Aug. 2006.

[43] P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

It should not be surprising that these plans, when employees have a choice of plan, are most attractive to higher income employees. The tax benefits of the plans are greater the higher are people's incomes. Moreover employees with higher incomes are both better positioned than lower income employees to save and to pay for health care expenses out-of-pocket so as to accumulate savings in their HSAs over time.

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HEALTH SAVINGS ACCOUNTS

Early Enrollee Experiences with Accounts and Eligible Health Plans

Statement of John E. Dicken
Director, Health Care

GAO-06-1133T

GAO
Accountability-Integrity-Reliability
Highlights

Highlights of GAO-06-1133T, a testimony before the Subcommittee on Health Care, Committee on Finance, U.S. Senate

September 26, 2006

HEALTH SAVINGS ACCOUNTS

Early Enrollee Experiences with Accounts and Eligible Health Plans

Why GAO Did This Study

Health savings accounts (HSA) and the high-deductible health insurance plans that are eligible to be coupled with them are a new type of consumer-directed health plan attracting interest among employers and consumers. HSA-eligible plans constitute a small but growing share of the private insurance market, and the novel structure of the plans has raised questions about how they could affect enrollees' health care purchasing decisions and costs.

This statement is based on GAO's August 2006 report entitled *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans* (GAO-06-798). In this report, GAO reviewed (1) the financial features of HSA-eligible plans in comparison with those of traditional plans, such as preferred provider organizations (PPO); (2) the characteristics of HSA-eligible plan enrollees in comparison with those of traditional plan enrollees or others; (3) HSA funding and use; and (4) enrollees' experiences with HSA-eligible plans.

What GAO Found

HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than did traditional plans in 2005, but both plan types covered similar services, including preventive services. For the three employers' health plans GAO reviewed to illustrate enrollees' potential health care costs, GAO estimated that HSA-eligible plan enrollees would incur higher annual costs than PPO enrollees for extensive use of health care, but would incur lower annual costs than PPO enrollees for low to moderate use of health care.

HSA-eligible plan enrollees generally had higher incomes than comparison groups, but data on age differences were inconclusive. In 2004, 51 percent of tax filers reporting an HSA contribution had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under 65 years old. Two of the three employers GAO reviewed, the Federal Employees Health Benefits Program, and a national broker of health insurance also reported that HSA-eligible plan enrollees had higher incomes than traditional plan enrollees in 2005.

Just over half of all HSA-eligible plan enrollees and most employers contributed to HSAs, and account holders used their HSA funds to pay for medical care and accumulate savings. About 55 percent of HSA-eligible plan enrollees reported HSA contributions to the Internal Revenue Service in 2004, and about two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs. About 45 percent of tax filers reporting 2004 HSA contributions also reported that they withdrew funds in that year, and 90 percent of these funds were withdrawn for qualified medical expenses. The other 55 percent of those reporting HSA contributions did not withdraw any funds from their HSA in 2004.

HSA-eligible plan enrollees who participated in GAO's focus groups generally reported positive experiences, but most would not recommend the plans to all consumers. Few participants reported researching cost before obtaining health care services, although many researched the cost of prescription drugs. Most participants were satisfied with their HSA-eligible plans and would recommend them to healthy consumers, but not to those who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

www.gao.gov/cgi-bin/getrpt?GAO-06-1133T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or dickenj@gao.gov.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the findings from our August 2006 report entitled *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans.*[1] In this report, we examined enrollees' experiences with health savings accounts (HSA) and the high-deductible health insurance plans that are eligible to be coupled with them. Since tax-advantaged HSAs were made available in 2004,[2] this new type of consumer-directed health plan has been attracting interest among employers and enrollees. HSA-eligible plans now constitute a small but growing share of the private health insurance market. The number of enrollees and dependents covered by an HSA-eligible plan increased from about 438,000 in September 2004 to about 3 million in January 2006.[3] Both employers and plan enrollees may contribute to tax-advantaged HSAs, and enrollees can use the accounts to pay for their health care expenses. The high-deductible health plans typically have lower premiums than other types of health plans because high-deductible health plan enrollees bear a greater share of the initial costs of care.[4]

The novel structure of HSA-eligible plans has raised questions regarding how the plans and HSAs will affect enrollees' health care purchasing decisions and costs. Proponents of HSA-eligible plans believe that the high deductibles will encourage enrollees to become more astute health care consumers and thus restrain health care spending increases. However, some critics contend that the plans may attract a disproportionate share of wealthier enrollees who seek to use the HSA as a tax-advantaged savings vehicle, or healthier or younger individuals who use fewer health care

[1]GAO-06-798 (Washington, D.C.: Aug. 9, 2006).

[2]Tax advantages for HSAs were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 for individuals covered by high-deductible health insurance plans that meet certain criteria. Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469.

[3]In 2004 and 2005, more than half of these enrollees and dependents were covered by an HSA-eligible plan purchased from an insurance carrier in the individual insurance market, rather than obtained from an employer. However, preliminary data for 2006 suggest that the number of HSA-eligible plan enrollees in the group market, which includes health plans offered by employers to employees, is growing faster than in the individual market.

[4]Most employers subsidize a share of employees' health coverage purchased in the group market, whereas individuals purchasing coverage in the individual market typically pay the full cost.

services. If this occurred, premiums for traditional health insurance plans, such as preferred provider organizations (PPO),[5] could rise faster than they otherwise would because of the disproportionate share of enrollees with higher health care expenses remaining in those plans.

My remarks today will focus on (1) the financial features of HSA-eligible plans in comparison with those of traditional plans, (2) the characteristics of HSA-eligible plan enrollees in comparison with those of traditional plan enrollees or others, (3) HSA funding and use, and (4) enrollees' experiences with HSA-eligible plans. These remarks are based on information contained in our August 2006 report.

In conducting our work, we analyzed data regarding HSA-eligible and traditional plans and enrollees from two national employer health benefits surveys; three selected large employers; and eHealthInsurance, a large, national broker of individual and small business health insurance.[6] To illustrate the potential health care costs faced by HSA-eligible and traditional plan enrollees, we estimated the total annual costs incurred by enrollees of the three employers' 2005 HSA-eligible and PPO plans, considering different levels of health care utilization. We compared Internal Revenue Service (IRS) data for tax filers reporting HSA contributions with corresponding data for all tax filers under 65 years old. We also conducted focus groups with employees of the three employers. A detailed explanation of our scope and methodology is included in the report's appendix I. This report is the most recent of several related reports GAO has issued within the last year.[7] The work done for these reports was performed from November 2004 through July 2006 in accordance with generally accepted government auditing standards.

[5]PPO plans generally allow enrollees to select their own health care providers and reimburse either the provider or the enrollee for the cost of covered services. Enrollees' costs are generally lower if they obtain care from the plan's network of preferred providers. For the purposes of this report, unless noted otherwise, traditional plans refers to PPO plans.

[6]Data we report on traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

[7]See GAO, *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, GAO-06-143 (Washington, D.C.: Nov. 21, 2005); *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, GAO-06-271 (Washington, D.C.: Jan. 31, 2006); and *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, GAO-06-514 (Washington, D.C.: Apr. 28, 2006).

In summary, we found that HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than did traditional plans in 2005, but both plan types covered similar services, including preventive services. Our illustration of enrollees' potential health care costs for the three employers' 2005 health plans we reviewed showed that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive amounts of health care, but would incur lower annual costs than PPO enrollees for low to moderate use of health care. HSA-eligible plan enrollees generally had higher incomes than comparison groups, but data on age differences were inconclusive. Just over half of all HSA-eligible plan enrollees and most employers contributed to HSAs. About 45 percent of tax filers reporting 2004 HSA contributions also reported that they withdrew funds in 2004, and 90 percent of withdrawn funds were used for qualified medical expenses. HSA-eligible plan enrollees who participated in our focus groups generally reported positive experiences, but most would not recommend the plans to all consumers. Most participants said they would recommend the plans to healthy consumers, but not to those who use maintenance medications, have a chronic condition, have children, or may not have the funds to meet the high deductible.

Background

Consumer-directed health plans generally include three components: a health plan with a high deductible, a savings account—such as an HSA—to pay for health care expenses, and enrollee decision-support tools.

- **An insurance plan with a high-deductible**. HSA-eligible plans are required to meet certain statutory criteria. The plans must have a minimum deductible amount—$1,050 for single coverage and $2,100 for family coverage in 2006—and a maximum limit on enrollee out-of-pocket spending[8]—$5,250 for single coverage and $10,500 for family coverage in 2006.[9] Preventive care services may be exempted from the deductible requirement, but coverage of most other services, including prescription

[8]An out-of-pocket spending limit represents the maximum amount an enrollee is required to pay toward the cost of covered services. The out-of-pocket spending limit includes deductibles and other payments, but does not include premiums.

[9]These amounts are annually adjusted for cost-of-living increases. In 2005, the minimum deductible amount was $1,000 for single coverage and $2,000 for family coverage, and the maximum limit on enrollee out-of-pocket spending was $5,100 for single coverage and $10,200 for family coverage.

drugs, is subject to the deductible.[10] After meeting the deductible, the HSA-eligible plan pays for most of the cost of covered services until the enrollee meets the out-of-pocket spending limit, at which point the plan pays 100 percent of the cost of covered services.

- **A savings account to pay for health care expenses.** There are several types of savings accounts that may be associated with consumer-directed health plans, with HSAs being among the most prominent. An HSA is a tax-advantaged savings account established for paying qualified medical expenses.[11] Individuals are eligible to open an HSA if they are enrolled in an HSA-eligible plan and have no other health coverage, with limited exceptions.[12] HSAs are owned by the account holder, and the accounts are portable—individuals may keep their accounts if they switch jobs or enroll in a non-HSA-eligible health plan. Both employers and individuals may contribute to HSAs, and individuals may claim a deduction on their federal income taxes for their HSA contributions. HSA balances can earn interest; roll over from year to year; and be invested in a variety of financial instruments, such as mutual funds. HSA-eligible plan enrollees who choose to pay for medical expenses from their HSA may access their account funds by check, by debit card, or by authorizing insurance carriers to allow providers to directly debit their account funds. HSAs are subject to annual contribution limits. In 2006, contributions were limited to 100 percent of the deductible, but not more than $2,700 for single coverage or $5,450 for family coverage.[13] Contributions, earned interest, and withdrawals for qualified medical expenses are not subject to federal income taxation.[14] A financial institution, such as a bank or insurance company, typically administers the account.

[10]The IRS definition of preventive care includes periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services. Through 2006, IRS allows certain plans to be treated as HSA eligible, where, in order to comply with state requirements, the plans cover certain services (such as prescription drugs) before enrollees meet the deductible. After 2006, no such transitional relief will be available.

[11]Qualified medical expenses are identified under the Internal Revenue Code.

[12]HSA-eligible plan enrollees are not required to open or contribute to an HSA and can use non-HSA funds to pay for medical expenses.

[13]The annual contribution limit is adjusted annually for cost-of-living increases. In 2005, contributions were allowed up to 100 percent of the deductible, but not more than $2,650 for single or $5,250 for family coverage.

[14]Withdrawals for nonqualified expenses are subject to income tax and, if made before age 65, a tax penalty.

- **Decision-support tools**. HSA-eligible plans typically provide enrollee decision-support tools that include, to some extent, information on the cost of health care services and the quality of health care providers. Experts suggest that reliable information about the cost of particular health care services and the quality of specific health care providers would help enrollees become more actively engaged in making health care purchasing decisions. These tools may be provided by health insurance carriers to all health insurance plan enrollees, but are likely to be more important to enrollees of HSA-eligible plans who have a greater financial incentive to make informed decisions about the quality and costs of health care providers and services.

Financial Features of HSA-Eligible Plans Differed From Those of Traditional Plans, but Covered Services Were Similar

HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans in 2005. Specifically, data from national employer health benefits surveys regarding plans offered in the group market indicate:

- Premiums for HSA-eligible plans averaged 35 percent less than employers' traditional plan premiums for single coverage and 29 percent less for family coverage in 2005.[15]
- Annual deductibles for HSA-eligible plans averaged $1,901 for single coverage and $4,070 for family coverage in 2005—nearly six times greater than those of employers' traditional plans.[16]
- The median annual out-of-pocket spending limit for HSA-eligible plans offered by large employers was $3,500 for single coverage in 2005, which was higher than the median out-of-pocket spending limit of $1,960 reported for traditional plans.[17]

The HSA-eligible and traditional plans we reviewed covered the same broad categories of services, including preventive services, and also used similar provider networks in 2005.

[15]See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: 2005).

[16]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey*.

[17]See Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report* (New York, N.Y.: 2006).

Our illustration of enrollees' potential health care costs—including premiums, deductibles, and other out-of-pocket costs for covered services—for the three employers' 2005 health plans we reviewed showed that HSA-eligible plan enrollees would incur higher annual costs than PPO enrollees for extensive use of health care, but would incur lower annual costs than PPO enrollees for low to moderate use of health care.[18] Specifically, we estimated that in the event of an illness or injury resulting in a hospitalization costing $20,000, the total costs incurred by the three employers' HSA-eligible plan enrollees would be 47 to 83 percent higher than those faced by the employers' PPO enrollees. In contrast, we estimated that the total costs paid by HSA-eligible plan enrollees who used low to moderate amounts of health care, visiting the doctor for illnesses or injuries six times in one year, would be 48 to 58 percent lower than the costs paid by the PPO enrollees.[19] If HSA-eligible plan enrollees used tax-advantaged funds that they, or someone other than their employer, contributed to their HSA, their costs could have been lower than our estimates.

HSA-Eligible Plan Enrollees Had Higher Incomes than Comparison Groups, but Data on Age Differences Were Inconclusive

HSA-eligible plan enrollees generally had higher incomes than comparison groups. The average adjusted gross income of the estimated 108,000 tax filers reporting HSA contributions in 2004 was about $133,000,[20] compared with $51,000 for all tax filers under age 65, according to IRS data. Moreover, 51 percent of tax filers reporting HSA contributions had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under age 65.[21] (See fig. 1.)

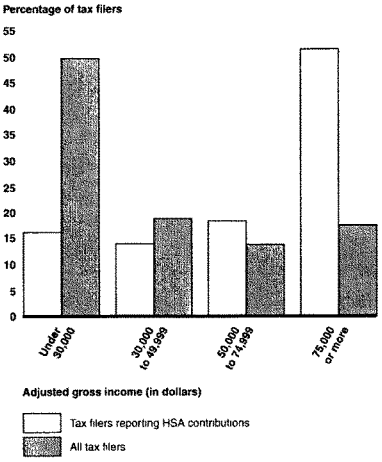
[18]We assumed that enrollees had single coverage and used in-network services. We also assumed that enrollees used the funds their employers contributed to their HSA in 2005 and paid for the rest out of pocket. We assumed that enrollees did not have HSA funds carried over from a prior year, which, if used, could have lowered enrollees' out-of-pocket costs. We considered only the costs associated with medical care provided by a physician and did not consider any other costs that could be incurred by an enrollee, such as prescription drug costs.

[19]We assumed that the negotiated rate for each doctor's visit was $80. We developed this assumption based on our analysis of one insurance carrier's negotiated rates for office visits for low to moderate problems in the regions the three employers' plans were offered.

[20]To receive a deduction, tax filers must report HSA contributions to IRS. Those reporting HSA contributions in 2004 represented about 0.1 percent of the 115 million tax filers less than 65 years of age.

[21]All tax filers includes both insured and uninsured individuals. The uninsured tend to have lower incomes than those with health insurance coverage.

Figure 1: Adjusted Gross Income of Tax Filers Reporting HSA Contributions and All Tax Filers, 2004



Source: GAO analysis of IRS data.

Notes: Data are based on a sample of 2004 tax returns processed by IRS. For the all tax filers category, we excluded those 65 years and older because they are generally enrolled in Medicare and are ineligible to contribute to an HSA.

We also found similar income differences between HSA-eligible plan and traditional plan enrollees when we examined other data sources from the group and individual markets. Among Federal Employees Health Benefits Program (FEHBP) enrollees actively employed by the federal government, 43 percent of HSA-eligible plan enrollees earned federal incomes of $75,000 or more, compared with 23 percent for all enrollees in 2005. Additionally, two of the three employers we reviewed and eHealthInsurance reported that HSA-eligible plan enrollees had higher incomes than did traditional plan enrollees in 2005.

The data sources we examined did not conclusively indicate whether HSA-eligible plan enrollees were older or younger than comparison groups. IRS data suggest that the average age of tax filers who reported HSA

contributions was about 9 years higher than the average age of all tax filers under age 65 in 2004.[22] Similarly, eHealthInsurance reported that in the individual market the average age of its HSA-eligible plan enrollees was 5 years higher than that of its traditional plan enrollees in 2005. In contrast, data from FEHBP and the three employers we reviewed indicate that the average age of HSA-eligible plan enrollees, excluding retirees, was 2 to 6 years lower than that of comparison groups of enrollees.

Just Over Half of Enrollees and Most Employers Contributed to HSAs, and These Funds Were Used to Pay for Medical Care and to Accumulate Savings

Just over half of HSA-eligible plan enrollees and most employers contributed to HSAs. About 55 percent of HSA-eligible plan enrollees reported HSA contributions in 2004, according to our analysis of data obtained from IRS and a publicly available survey. HSA-eligible plan enrollees from the employers we reviewed were more likely to contribute to an HSA when their employer also offered account contributions. Among tax filers who claimed a deduction for an HSA in 2004, the average deduction was about $2,100 and the average amount deducted increased with income. About two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs in 2005, according to two national employer health benefits surveys.[23] In 2004, the average employer HSA contribution reported to IRS was about $1,064.

Account holders used HSA funds to pay for medical care and to accumulate savings. About 45 percent of tax filers reporting an HSA contribution in 2004—made by themselves, their employers, or others on their behalf—also reported withdrawing funds in 2004. The average annual amount withdrawn by these tax filers was about $1,910. About 90 percent of these withdrawn funds were used to pay for expenses identified under the Internal Revenue Code as eligible medical expenses. IRS data show that about 40 percent of all funds contributed to HSAs in 2004 were withdrawn from the accounts by the end of the year. In addition to using HSAs for medical and other expenses, account holders appeared to use their HSA as a savings vehicle. About 55 percent of tax filers reporting HSA contributions in 2004 withdrew no money from their account in 2004. We could not determine whether HSA-eligible plan enrollees accumulated

[22]All tax filers include both insured and uninsured individuals. The uninsured tend to be younger than those with health insurance coverage.

[23]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey*; and Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report*.

balances because they did not need to use their accounts (that is, they paid for care from out-of-pocket sources or did not need health care during the year) or because they reduced their health care spending as a result of financial incentives associated with the HSA-eligible plan and HSA. However, many focus group participants reported using their HSA as a tax-advantaged savings vehicle, accumulating HSA funds for future use.

Focus Group Participants Were Generally Satisfied with HSA-Eligible Plans, but Would Not Recommend Them to All Consumers

HSA-eligible plan enrollees who participated in our focus groups at the three employers we reviewed generally reported positive experiences with their plans. These focus group participants, who had voluntarily elected to enroll in HSA-eligible plans as one of several choices offered by their employers, cited the ability to accumulate savings, the tax advantages of having an HSA, and the ability to use an HSA debit card as positive aspects of HSAs. Participants reported few problems obtaining care, and when given a choice, many reported that they had reenrolled in the HSA-eligible plan.

While focus group participants enrolled in HSA-eligible plans generally understood the key attributes of their plan, such as low premiums, high deductibles, and the mechanics of using the HSA, they were confused about certain other features. For example, many participants understood that certain preventive services were covered free of charge, but they also had trouble distinguishing between the preventive services and other services provided during a preventive office visit. Moreover, many participants were unsure what medical expenses qualified for payment using their HSA.

Few participants researched the cost of hospital or physician services before obtaining care, although many participants researched the cost of prescription drugs. A few participants reported asking physicians about the cost of services, but others expressed discomfort with asking physicians about cost. For example, one participant said, "Americans don't negotiate. It's not polite to question the value of [a provider's] work." Participants of one focus group also reported not initially understanding the extent to which they needed to manage and take responsibility for their health care, including by asking questions about the cost of services and medications. Participants also reported that only limited information was available regarding key quality measures for hospitals and physicians, such as the volume of procedures performed and the outcomes of those procedures. The decision-support tools provided with consumer-directed health plans we previously reviewed were limited and did not provide

sufficient information to allow enrollees to fully assess cost and quality trade-offs of health care purchasing decisions.[24]

Most participants reported that they would not recommend HSA-eligible plans to all consumers. Some participants said they enrolled in the HSA-eligible plan specifically because they did not anticipate getting sick, and many said they considered themselves and their families as being fairly healthy. Most participants would recommend the plans to healthy consumers, but not to those who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

Concluding Observations

In closing, as more individuals face the choice of enrolling in HSA-eligible plans or other consumer-directed health plans, they will likely weigh the savings potential and financial risks associated with these plans in relation to their own health care needs and financial circumstances. Because healthier individuals who use little health care could incur lower costs under HSA-eligible plans than under traditional plans, when given a choice they may be more likely to select an HSA-eligible plan than will less healthy individuals who use greater amounts of health care. It will be important to monitor enrollment trends and assess their implications for the cost of health care coverage for all HSA-eligible and traditional plan enrollees.

Few of the HSA-eligible plan enrollees who participated in our focus groups researched cost before obtaining health care services. This may be due in part to a reluctance of consumers to question health care providers about the cost of their services and the dearth of information provided by insurance carriers to their enrollees about the cost of health care services under their plans—a limitation that insurance carriers are beginning to address. According to proponents, an increase in such health care consumerism can help restrain health care spending increases under the plans. Such an increase will likely require time, education, and improved decision-support tools that provide enrollees with more information about the cost and quality of health care providers and services.

[24]Representatives from insurance carriers told us that they were planning to offer additional cost and quality data in the coming years. GAO-06-514.

Finally, while HSA-eligible plan enrollees we spoke with were generally satisfied with their plans, it is notable that these enrollees each had a choice of health plans and voluntarily selected the HSA-eligible plan. Their caution that HSA-eligible plans may not be appropriate for everyone suggests that satisfaction may be lower when employees are not given a choice or when employer contributions to premiums or accounts do not sufficiently offset the potentially greater costs faced by HSA-eligible plan enrollees.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For future contacts regarding this testimony, please contact John E. Dicken at (202) 512-7119 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Randy DiRosa, Assistant Director; Pamela N. Roberto; and Patricia Roy made key contributions to this statement.

United States Government Accountability Office

GAO

Report to the Ranking Minority Member, Committee on Finance, U.S. Senate

August 2006

CONSUMER-DIRECTED HEALTH PLANS

Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans

GAO-06-798

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Highlights

Highlights of GAO-06-798, a report to the Ranking Minority Member, Committee on Finance, U.S. Senate

August 2006

CONSUMER-DIRECTED HEALTH PLANS

Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans

Why GAO Did This Study

Health savings accounts (HSA) and the high-deductible health insurance plans that are eligible to be coupled with them are a new type of consumer-directed health plan attracting interest among employers and consumers. Employers and plan enrollees may contribute to tax-advantaged HSAs, and enrollees can use the accounts to pay for health care expenses. Because HSAs and HSA-eligible plans are new, there is interest in the experiences of plan enrollees, as well as in comparing the plan features and enrollee characteristics with those of traditional plans, such as preferred provider organization (PPO) plans.

GAO reviewed (1) the financial features of HSA-eligible plans in comparison with those of traditional plans, (2) the characteristics of HSA-eligible plan enrollees in comparison with those of traditional plan enrollees, (3) HSA funding and use, and (4) enrollees' experiences with HSA-eligible plans. GAO analyzed data regarding HSA-eligible and traditional plans and enrollees from national employer health benefits surveys, three selected employers, and a national broker of health insurance. GAO compared Internal Revenue Service (IRS) data for tax filers reporting HSA contributions with corresponding data for all tax filers under 65 years old. GAO also conducted focus groups with employees of the three employers.

www.gao.gov/cgi-bin/getrpt?GAO-06-798.

To view the full product, including the scope and methodology, click on the link above. For more information, contact John E. Dicken at (202) 512-7119 or dickenj@gao.gov.

What GAO Found

In 2005, HSA-eligible plans had different financial features than traditional plans—such as lower premiums and higher deductibles—but both plan types covered similar health care services, including preventive services, and used similar provider networks. For the three employers' health plans GAO reviewed to illustrate enrollees' potential health care costs, GAO estimated that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive use of health care, but would incur lower annual costs than PPO plan enrollees for low to moderate use of health care.

HSA-eligible plan enrollees generally had higher incomes than comparison groups, but data on age differences were inconclusive. In 2004, 51 percent of tax filers reporting an HSA contribution had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under 65 years old. Two of the three employers GAO reviewed and a national broker of health insurance also reported that HSA-eligible plan enrollees had higher incomes than traditional plan enrollees in 2005. GAO's data sources did not conclusively indicate whether HSA-eligible plan enrollees were older or younger than individuals and enrollees in comparison groups.

Just over half of all HSA-eligible plan enrollees and most employers contributed to HSAs, and account holders used their HSA funds to pay for current medical care and to accumulate savings. About 55 percent of HSA-eligible plan enrollees reported HSA contributions to IRS in 2004. Tax filers claimed an average deduction of about $2,100 for their HSA contributions in 2004, and the average amount increased with income. About two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs, and the average employer HSA contribution was about $1,064 in 2004. About 45 percent of tax filers reporting 2004 HSA contributions also reported that they withdrew funds in 2004, and 90 percent of these funds were withdrawn for qualified medical expenses. The other 55 percent of those reporting HSA contributions in 2004 did not withdraw any funds from their HSA in 2004.

HSA-eligible plan enrollees who participated in GAO's focus groups generally reported positive experiences, but most would not recommend the plans to all consumers. Participants enrolled in the plans generally understood the key attributes of their plan. Few participants reported researching cost before obtaining health care services, although many researched the cost of prescription drugs. Most participants were satisfied with their HSA-eligible plan and would recommend these plans to healthy consumers, but not to those who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

GAO received technical comments from IRS and a national broker of health insurance and incorporated the comments as appropriate.

Contents

Figures

Abbreviations

CDHP	consumer-directed health plan
FEHBP	Federal Employees Health Benefits Program
FSA	flexible spending arrangement
HSA	health savings account
IRS	Internal Revenue Service
PPO	preferred provider organization
SOI	Statistics of Income

GAO
Accountability * Integrity * Reliability
United States Government Accountability Office
Washington, DC 20548

August 9, 2006

The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Baucus:

Health savings accounts (HSA) and the high-deductible health insurance plans that are eligible to be coupled with them are a new type of consumer-directed health plan (CDHP) attracting interest among employers and consumers.[1] Both employers and plan enrollees may contribute to tax-advantaged HSAs, and enrollees can use the accounts to pay for their health care expenses.[2] The high-deductible health plans typically have lower premiums than other types of health plans because high-deductible health plan enrollees bear a greater share of the initial costs of care.

The novel structure of HSA-eligible plans has raised questions regarding how the plans and HSAs will affect enrollees' health care purchasing decisions and costs. Proponents of HSA-eligible plans believe that the plans will encourage enrollees to become more astute health care consumers and thus restrain health care spending increases. Proponents argue that the high deductibles give enrollees an incentive to seek lower-cost health care services and that the ability to carry over unspent HSA funds from year to year gives enrollees an incentive to obtain services only when necessary. However, some critics contend that the high deductibles associated with HSA-eligible plans may discourage enrollees from obtaining necessary health care services. Some critics are also concerned

[1]In addition to HSAs, other types of accounts associated with CDHPs include health reimbursement arrangements, which differ from HSAs in that they are owned by the employer, not the enrollee, and medical savings accounts, which are enrollee owned and have lower allowable contributions than HSAs. Since December 31, 2005, medical savings accounts can no longer be opened.

[2]Tax advantages for HSAs were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 for individuals covered by high-deductible health insurance plans that meet certain criteria. Pub. L. No. 108-173, § 1201, 117 Stat. 2066, 2469.

that the plans may attract a disproportionate share of wealthier enrollees who seek to use the HSA primarily as a tax-advantaged savings vehicle or healthier or younger individuals who use fewer health care services. If these plans do attract a larger share of individuals who are likely to use fewer health care services, premiums for traditional health insurance plans, such as preferred provider organization (PPO) plans,[3] could rise faster than they otherwise would because of the disproportionate share of enrollees with higher health care expenses remaining in those plans.

Because HSAs and HSA-eligible plans are a relatively new concept in health insurance coverage, there is interest in the plan features and the characteristics and experiences of early plan enrollees.[4] For example, there is interest in who is enrolling in HSA-eligible plans, and whether they differ from enrollees in traditional health plans, such as PPO plans. In response to your request, we examined the following questions:

1. How do financial features, covered services, and enrollees' annual costs compare between HSA-eligible and traditional plans?
2. How do the characteristics of enrollees compare between HSA-eligible and traditional plans?
3. How are HSAs funded, and how are HSA account holders using their funds?
4. What are enrollees' experiences with HSA-eligible plans?

To compare the financial features of HSA-eligible plans with those of traditional plans, we summarized 2005 data from national employer health benefits surveys. We also reviewed the financial features of plans offered

[3]PPO plans generally allow enrollees to select their own health care providers and reimburse either the provider or the enrollee for the cost of covered services. Enrollees' costs are generally lower if they obtain care from the plan's network of preferred providers. For the purposes of this report, unless noted otherwise, traditional plans refers to PPO plans.

[4]We have recently reported on the features of CDHPs and HSAs offered to federal employees and others. See GAO, *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, GAO-06-143 (Washington, D.C.: Nov. 21, 2005); *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, GAO-06-271 (Washington, D.C.: Jan. 31, 2006); and *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, GAO-06-514 (Washington, D.C.: Apr. 28, 2006).

in 2005 by three large employers in the public, utility, and insurance sectors, as well as those of plans sold for 2005 by eHealthInsurance, a large, national broker of individual and small business health insurance.[5] To compare the covered health care services and provider networks of HSA-eligible plans with those of traditional plans, we reviewed plan brochures provided by the three large employers and spoke with employer and insurance carrier officials and industry experts. To illustrate the potential health care costs faced by HSA-eligible and traditional plan enrollees, we examined the total annual costs to enrollees of the three employers' HSA-eligible and PPO plans in 2005. We compared the total costs for enrollees who used extensive and low to moderate amounts of health care.

To compare the characteristics of HSA-eligible and traditional plan enrollees, we analyzed demographic data provided by the Internal Revenue Service (IRS) on adjusted gross income and age reported by tax filers who reported an HSA contribution on their returns for 2004[6] and compared them with the corresponding data for all tax filers under 65 years old.[7,8] We also compared 2005 income and age data for HSA-eligible and traditional plan enrollees who purchased coverage from the three employers we reviewed and from eHealthInsurance.[9]

To examine how HSAs are funded and used, we analyzed data on individual and employer contributions and account withdrawals. To determine the share of enrollees that opened HSAs, we analyzed survey data on HSA-eligible plan enrollment and IRS data on HSA contributions. We also conducted interviews with industry experts regarding the share of enrollees that opened HSAs. To examine individuals' HSA contributions,

[5]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

[6]The first year that individuals could contribute to HSAs was 2004.

[7]The IRS data set we used is a random sample of 200,295 individual income tax returns in 2004 from IRS's Statistics of Income (SOI) individual tax return file. The findings from the IRS data that we report were estimates derived from the SOI sample, which was weighted to represent an estimated population of about 132 million tax returns. IRS uses the SOI file to develop annual statistics on the population of individual taxpayers.

[8]Individuals 65 and older are generally enrolled in Medicare and are ineligible to contribute to an HSA.

[9]Data from the three employers excluded retirees, and data from eHealthInsurance excluded enrollees 65 or older.

we analyzed IRS data on the average tax deduction for 2004 HSA contributions and reviewed data provided by the three employers on the 2005 contributions of employees enrolled in HSA-eligible plans. To examine employer HSA contributions, we analyzed IRS data on the average employer contribution in 2004 and summarized 2005 data reported by two national employer health benefits surveys and the three large employers we reviewed. To determine how account holders use HSA funds, we analyzed IRS data on reported HSA withdrawals in 2004 and conducted a series of focus groups with employees of the three large employers we reviewed regarding HSA-eligible plan enrollees' use of accounts in 2005.

To determine enrollees' experiences with HSA-eligible plans, we gathered information from focus groups of employees of the three large employers regarding enrollee education, plan comprehension, experience with obtaining care, use of decision-support tools, and plan satisfaction in 2005. Unless otherwise noted, the participant experiences we report reflect multiple focus groups.

Much of the data we present cannot be generalized to all HSA-eligible plans and enrollees or HSA account holders. For example, the IRS data for tax filers reporting an HSA contribution cannot be generalized to all HSA-eligible plan enrollees because the sample is not designed to capture individuals enrolled in a high-deductible health plan who did not have an associated HSA. The results of the focus groups and the data obtained from the three employers cannot be generalized to all HSA-eligible plan enrollees or employers because they represent only the experiences of the focus group participants and the benefit offerings of the three employers. We reviewed all data for reasonableness and consistency and determined that the data were sufficiently reliable for our purposes. We performed our work from November 2004 through July 2006 in accordance with generally accepted government auditing standards. Appendix I provides more detailed information on our methodology and the characteristics and limitations of the data we report.

Results in Brief

The financial features of HSA-eligible plans differed from those of traditional plans, but both plan types covered similar health care services. HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans in 2005. For example, a 2005 national employer health benefits survey reported HSA-eligible plan premiums that were, on average, 35 percent less than traditional plan premiums for single coverage and 29 percent less for family coverage. The

same survey found that employers' HSA-eligible plan deductibles were, on average, nearly six times greater than those for employers' traditional plans. The HSA-eligible plans offered by the three employers we reviewed covered the same broad categories of health care services as did traditional plans in 2005, including preventive, diagnostic, maternity, surgical, and emergency services, and also used similar provider networks. For the three employers' health plans we reviewed to illustrate enrollees' potential health care costs—including premiums, deductibles, and other out-of-pocket costs for covered services—we estimated that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive use of health care, but would incur lower annual costs than PPO enrollees for low to moderate use of health care.

HSA-eligible plan enrollees generally had higher incomes than comparison groups, but data on age differences were inconclusive. In 2004, 51 percent of tax filers reporting an HSA contribution to IRS had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under age 65. Two of the three employers we reviewed and eHealthInsurance also reported that HSA-eligible plan enrollees had higher incomes than did traditional plan enrollees in 2005. IRS data also suggest that the average age of tax filers who reported HSA contributions was about 9 years higher than the average age of all tax filers under age 65 in 2004. Similarly, eHealthInsurance reported that in the individual market the average age of its HSA-eligible plan enrollees was 5 years higher than that of its traditional plan enrollees in 2005. In contrast, data from several employer groups indicate that the average age of HSA-eligible plan enrollees, excluding retirees, was 2 to 6 years lower than that of other groups of enrollees.

Just over half of HSA-eligible plan enrollees and about two-thirds of employers contributed to HSAs, and account holders used HSA funds to pay for medical care and to accumulate savings. About 55 percent of HSA-eligible plan enrollees reported HSA contributions in 2004, according to our analysis of data obtained from IRS and a publicly available survey. Among tax filers who claimed a deduction for an HSA in 2004, the average deduction was about $2,100, and the average amount increased with income. About two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs in 2005, according to national surveys. In 2004, the average employer HSA contribution was about $1,064. About 45 percent of tax filers reporting an HSA contribution in 2004—made by themselves, others on their behalf, or their employers—also reported withdrawing funds in 2004, and the average annual amount withdrawn by these tax filers was about $1,910. About 90 percent of these

withdrawn funds were used to pay for expenses identified under the Internal Revenue Code as eligible medical expenses. Fifty-five percent of tax filers reporting HSA contributions withdrew no money from their account in 2004.

HSA-eligible plan enrollees who participated in focus groups at the three employers we reviewed generally reported positive experiences with their plan, but most would not recommend these plans to all consumers. While focus group participants enrolled in HSA-eligible plans understood the key attributes of their plan, such as low premiums, high deductibles, and the mechanics of using the HSA, they were confused about certain other features. For example, many participants were unsure what medical expenses qualified for payment using their HSA. Few participants researched the cost of hospital or physician services before obtaining care, although many participants researched the cost of prescription drugs. Most participants reported satisfaction with their HSA-eligible plan, but said they would not recommend these plans to everyone. Participants said they would recommend HSA-eligible plans to healthy consumers, but not to people who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

We provided pertinent portions of a draft of this report to IRS and eHealthInsurance and incorporated their technical comments as appropriate.

Background

The majority of Americans receive their health coverage through the private health insurance market. In 2004, as many as 177 million enrollees and dependents—up to 84 percent—of the nearly 210 million individuals under age 65 with health insurance coverage received coverage through the private health insurance market.[10] Since 2004, insurance carriers selling coverage in this market have added HSA-eligible plans to their portfolio of insurance products.

Private Health Insurance Markets

Private health plans are offered in two primary markets—the group and the individual markets. The group market includes health plans offered by

[10]Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey," Issue Brief No. 287 (Washington, D.C.: November 2005).

employers to employees, either by purchasing the coverage from an insurance carrier or by funding their own health plans, and health plans offered by other groups, such as professional associations. About 159 million individuals and their dependents under age 65 received health coverage through the group market in 2004.[11] The individual market includes health plans sold by insurance carriers to individuals who do not receive coverage through an employer or other group. In this market, health insurance brokers may link individuals with an insurance carrier, and the enrollee pays a premium for coverage. About 17 million individuals and their dependents under age 65 received health coverage through the individual market in 2004.[12] Most employers subsidize a share of employees' health coverage purchased in the group market, whereas individuals purchasing coverage in the individual market typically pay the full cost.

HSA-Eligible Plans and HSAs

HSA-eligible plans constitute a small but growing share of the private health insurance market. As we noted in our April 2006 report, the number of enrollees and dependents covered by an HSA-eligible plan increased from about 438,000 in September 2004 to about 1 million in March 2005 and to about 3 million in January 2006.[13] In 2004 and 2005, more than half of these enrollees and dependents were covered by an HSA-eligible plan purchased in the individual insurance market, rather than obtained from an employer.[14]

HSA-eligible plans are required to meet certain statutory criteria. The plans must have a minimum deductible amount of $1,050 for single coverage and $2,100 for family coverage in 2006 and a maximum limit on enrollee out-of-pocket spending[15] of $5,250 for single coverage and $10,500

[11]Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey."

[12]Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey."

[13]GAO-06-514.

[14]Preliminary data for 2006 suggest that the number of HSA-eligible plan enrollees in the group market is growing faster than in the individual market.

[15]An out-of-pocket spending limit represents the maximum amount an enrollee is required to pay toward the cost of covered services. The out-of-pocket spending limit includes deductibles and other payments, but does not include premiums.

for family coverage in 2006.[16] Most HSA-eligible plan enrollees are covered by plans that operate similarly to traditional plans. HSA-eligible plan enrollees pay premiums to access covered services. As with traditional plans, rates negotiated by insurance carriers provide incentives for HSA-eligible plan enrollees to access in-network care. However, HSA-eligible plan enrollees are subject to higher-than-average deductibles. Preventive care services may be exempted from the deductible requirement, but coverage of most other services, including prescription drugs, is subject to the deductible.[17] After meeting the deductible, the HSA-eligible plan pays for most of the cost of covered services until the enrollee meets the out-of-pocket spending limit, at which point the plan pays 100 percent of the cost of covered services. Insurance carriers offer HSA-eligible plans to both employers in the group market and individuals in the individual market.

An HSA is a tax-advantaged savings account established for paying qualified medical expenses.[18] Individuals are eligible to open an HSA if they are enrolled in an HSA-eligible plan and have no other health coverage, with limited exceptions.[19] However, HSA-eligible plan enrollees are not required to open or contribute to an HSA and can use non-HSA funds to pay for medical expenses. HSA-eligible plan enrollees who choose to pay for medical expenses from their HSA may access their account funds by check, by debit card, or by authorizing the insurance carriers to allow the providers to directly debit their account funds. HSAs are owned by the account holder, and the accounts are portable—individuals may keep their accounts if they switch jobs or enroll in a non-HSA-eligible health plan. Both employers and individuals may contribute to HSAs, and individuals may claim a deduction on their federal income taxes for their

[16]These amounts are annually adjusted for cost-of-living increases. In 2005, the minimum deductible amount was $1,000 for single coverage and $2,000 for family coverage, and the maximum limit on enrollee out-of-pocket spending was $5,100 for single coverage and $10,200 for family coverage.

[17]The IRS definition of preventive care includes periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various screening services. Through 2006, IRS allows certain plans to be treated as HSA eligible, where, in order to comply with state requirements, the plans cover certain services (such as prescription drugs) before enrollees meet the deductible. After 2006, no such transitional relief will be available.

[18]Qualified medical expenses are identified under the Internal Revenue Code.

[19]Limited coverage (including specific injury or accident, disability, dental care, or vision care) in addition to the HSA-eligible plan is permissible.

HSA contributions regardless of whether they itemize deductions or claim the standard deduction. HSA balances can earn interest; roll over from year to year; and be invested in a variety of financial instruments, such as mutual funds. HSA balances may also accumulate subject only to annual limits on contributions. In 2006, contributions were limited to 100 percent of the deductible, but not more than $2,700 for single coverage or $5,450 for family coverage.[20] Contributions, earned interest, and withdrawals for qualified medical expenses are not federally taxed. Withdrawals for nonqualified expenses are subject to income tax and, if made before age 65, a tax penalty. A financial institution, such as a bank or insurance company, typically administers the account. Table 1 describes the key features of HSA-eligible plans and HSAs.

[20]The annual contribution limit is adjusted annually for cost-of-living increases. In 2005, contributions were allowed up to 100 percent of the deductible, but not more than $2,650 for single or $5,250 for family coverage.

Table 1: Key Features of HSA-Eligible Plans and HSAs for 2006

Feature	Description
HSA-eligible plan features	
Deductible requirements[a]	Minimum of $1,050 for single and $2,100 for family coverage; to be adjusted for cost-of-living increases in future years.[b]
Maximum out-of-pocket limits[a]	Maximum of $5,250 for single and $10,500 for family coverage; to be adjusted for inflation in future years.
HSA features	
Ownership	Accounts are owned by the individual.
Portability	Accounts are fully portable—individuals can retain their HSA balances if they change jobs or obtain other health coverage.
Who may contribute	Individuals, family members, employers, and other entities may contribute on behalf of the individual.
Annual contribution limits	Contributions are allowed up to 100 percent of deductible, but not more than $2,700 for single or $5,450 for family coverage; however, account holders aged 55 or over and not enrolled in Medicare can contribute an additional $700.
Unspent funds	Unspent funds may roll over from year to year without limit.
Definition of qualified medical expenses	Included are expenses intended to alleviate or prevent a physical or mental condition or illness, including vision and dental services, and premiums for long-term care insurance, certain continuation coverage, coverage while receiving unemployment benefits, and coverage after age 65 (except Medigap[c]).
Tax treatment	Withdrawals for qualified medical expenses and earned interest are exempt from federal income taxes; employer contributions are excluded from gross income, and employee contributions are deductible from federal income taxes.
Nonmedical withdrawals	Nonmedical withdrawals are subject to income tax, and an additional 10 percent penalty is assessed if these withdrawals are made before age 65.
History	Tax advantages for HSAs were authorized in December 2003 and made available beginning January 1, 2004.

Source: GAO analysis of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and IRS guidance on HSAs.

[a]Services not covered by the insurance plan do not count toward the deductible or out-of-pocket maximum.

[b]Through 2006, IRS allows certain plans to be treated as HSA eligible, where, in order to comply with state requirements, they cover certain services (such as prescription drugs) prior to meeting the deductible. After 2006, no such transitional relief will be available.

[c]Medigap is a private supplemental insurance available to Medicare enrollees. It helps to pay for some of Medicare's deductibles, copayments, and coinsurance amounts, as well as some benefits Medicare does not cover.

HSA-eligible plans typically provide, to some extent, information on the cost of health care services and the quality of health care providers. This information may help enrollees to become more actively engaged in making health care purchasing decisions. Experts suggest that in order to assess the price competitiveness of different providers or the cost of different treatment options, enrollees need reliable, specific information

about the cost of services. Experts also suggest that in order to make informed provider choices, enrollees need data on key quality measures to assess the quality of different providers. These quality measures may include the volume of procedures performed, the outcomes of those procedures, and certain process indicators demonstrating whether providers followed certain recommended treatment guidelines. Insurance carriers offering HSA-eligible plans may also provide online access to health accounts for enrollees to manage their health care spending.

These tools may be provided by health insurance carriers to all health insurance plan enrollees, but are likely to be more important to enrollees of HSA-eligible plans and other CDHPs, who have a greater financial incentive to make informed decisions about the quality and costs of health care providers and services. However, insurance carriers have faced challenges in obtaining or presenting quality and cost data. As we noted in our April 2006 report, the decision-support tools provided with CDHPs were limited and did not provide sufficient information to allow enrollees to fully assess cost and quality trade-offs of health care purchasing decisions.[21]

Financial Features of HSA-Eligible Plans Differed from Those of Traditional Plans, but Covered Services Were Similar

The financial features—premiums, deductibles, and out-of-pocket spending limits—of HSA-eligible plans differed from those of traditional plans in 2005, but both plan types covered similar health care services. HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans in 2005. The HSA-eligible plans we reviewed covered the same broad categories of services as traditional plans and used similar provider networks in 2005. Our illustration of enrollees' potential health care costs for the three employers' health plans we reviewed showed that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive use of health care, but would incur lower annual costs than PPO plan enrollees for low to moderate use of health care.

[21]GAO-06-514.

HSA-Eligible Plans Had Lower Premiums, Higher Deductibles, and Higher Out-of-Pocket Spending Limits Than Traditional Plans

In the group market, HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans in 2005. Similarly, in the individual market, HSA-eligible plans had lower premiums and higher deductibles than traditional plans in 2005.

Group Market

In the group market, HSA-eligible plans had lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans in 2005. Premiums for HSA-eligible plans were lower than those for traditional plans in 2005. According to a national employer health benefits survey, monthly premiums for HSA-eligible plans averaged $225 for single coverage and $659 for family coverage in 2005.[22] These HSA-eligible plan premiums were, on average, 35 percent less than surveyed employers' traditional plan premiums for single coverage and 29 percent less than surveyed employers' traditional plan premiums for family coverage. On average, surveyed employers paid about the same share of the premiums for their HSA-eligible plans as for their traditional plans. Monthly premiums for the HSA-eligible plans offered by the three employers we reviewed ranged from $231 to $319 for single coverage and from $612 to $995 for family coverage in 2005.[23] These HSA-eligible plan premiums were 13 to 27 percent less than the employers' traditional plan premiums for single coverage and 18 to 23 percent less for family coverage. In contrast to data from the national employer health benefits survey, data from the three employers we reviewed showed that the employers paid a greater share of the premium for their HSA-eligible plan enrollees than for their traditional plan enrollees.

HSA-eligible plan deductibles were higher than traditional plan deductibles in 2005.[24] For example, one national employer health benefits survey reported that annual deductibles for HSA-eligible plans averaged

[22]See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: 2005). In this survey, family coverage refers to coverage of four individuals.

[23]For these employers, family coverage refers to coverage of three or more individuals.

[24]Deductibles may vary depending on whether the enrollee seeks care from a provider that is part of the insurance carrier's provider network. For the purposes of this report, if the plans or data we reviewed reported separate deductibles for services received from in-network and out-of-network providers, we discuss only the deductibles for services received from in-network providers.

$1,901 for single coverage and $4,070 for family coverage in 2005—nearly six times greater than those of surveyed employers' traditional plans.[25] Another national employer health benefits survey reported that the median annual deductible for HSA-eligible plans offered by large employers was $1,200 for single coverage in 2005, four times greater than those of surveyed employers' traditional plans.[26] Annual deductibles for the HSA-eligible plans offered by the three employers we reviewed ranged from $1,250 to $3,000 for single coverage and from $2,500 to $6,000 for family coverage in 2005. In contrast, deductibles for two of the three employers' traditional plans were zero and for the other employer were $350 for single coverage and $700 for family coverage.

Out-of-pocket spending limits for HSA-eligible plans were higher than those of traditional plans in 2005.[27] According to a national employer health benefits survey, the median annual out-of-pocket spending limit for HSA-eligible plans offered by large employers was $3,500 for single coverage in 2005, which was higher than the median out-of-pocket spending limit of $1,960 reported for traditional plans.[28] Out-of-pocket spending limits for HSA-eligible plans offered by the three employers we reviewed ranged from $3,750 to $5,000 for single coverage and from $7,500 to $10,000 for family coverage in 2005, in contrast to the limits among the employers' traditional plans of $1,000 to $2,350 for single coverage and $2,000 to $4,700 for family coverage.[29] Table 2 summarizes the financial features of HSA-eligible and traditional plans offered by employers in 2005.

[25]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey.*

[26]Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report* (New York, N.Y.: 2006).

[27]Out-of-pocket spending limits may vary depending on whether the enrollee seeks care from a provider that is part of the insurance carrier's provider network. For the purposes of this report, if the plans or data we reviewed reported separate out-of-pocket spending limits for services received from in-network and out-of-network providers, we discuss only the limits for services received from in-network providers.

[28]Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report.*

[29]The employers' plans we reviewed may not be comparable because some plans excluded certain covered services from the calculation of their out-of-pocket spending limit.

Table 2: Financial Features of HSA-Eligible and Traditional Plans Offered by Employers, 2005

Feature	Coverage type	Kaiser Family Foundation Survey[a]		Mercer Survey[b]		Employer 1		Employer 2		Employer 3	
		HSA-eligible	Traditional	HSA-eligible	Traditional	HSA-eligible	Traditional	HSA-eligible	Traditional	HSA-eligible	Traditional
Monthly premium	Single	$225	$346	N.A.	$339[c]	$231	$315	$319	$365	$251	$318
Enrollee share of premium		16%	15%	N.A.	23%[c]	4%	30%	18%	28%	2%[d]	25%[e]
Employer share of premium		84%	85%	N.A.	77%[c]	96%	70%	82%	72%	98%[d]	75%[e]
	Family[f]	$659	$924	N.A.	$879[c]	$612	$798	$995	$1,208	$758	$969
Enrollee share of premium[f]		21%	25%	N.A.	33%[c]	18%	37%	13%	28%	2%[d]	24%[e]
Employer share of premium[f]		79%	75%	N.A.	67%[c]	82%	63%	87%	72%	98%[d]	76%[e]
Annual deductible[g]	Single	$1,901	$323	$1,200[h]	$300[h]	$3,000	$350	$1,800	$0	$1,250	$0
	Family	$4,070	$679	N.A.	$750[h]	$6,000	$700	$3,600	$0	$2,500	$0
Annual out-of-pocket spending limit[i]	Single	$2,551[j]	N.A.	$3,500[h]	$1,960[h]	$5,000	$2,350	$4,800	$1,000	$3,750	$1,000
	Family	$4,661[j]	N.A.	N.A.	N.A.	$10,000	$4,700	$9,600	$2,000	$7,500	$3,000
Annual employer contribution to HSA	Single	$553	N.A.	$100[k]	N.A.	$0	N.A.	$1,400[l]	N.A.	$100	N.A.
	Family	$1,185	N.A.	N.A.	N.A.	$0	N.A.	$2,300[l]	N.A.	$200	N.A.

Source: GAO analysis of data reported by Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey*; Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report*; and the three employers we reviewed.

Notes: N.A. indicates that the data were not available. Family coverage refers to coverage of four individuals for the survey data and coverage of three or more individuals for the three employers.

[a]Data represent average values of surveyed employers.

[b]Data represent average or median values, as noted, for large employers.

[c]Data represent average values among surveyed employers that required enrollee premium contributions.

[d]If HSA-eligible plan enrollees participated in an employer-sponsored wellness program, the employee share of the premium was 0 percent, and the employer share was 100 percent.

[e]If traditional plan enrollees participated in an employer-sponsored wellness program, the employee share of the premium was 22 percent, and the employer share was 78 percent.

[i]Premium data are reported for families where a covered spouse does not have access to medical benefits through his or her employer.

[g]If the plans or data we reviewed reported separate deductibles for services received from in-network and out-of-network providers, we reported only the deductibles for services received from in-network providers.

[h]Data represent median values among surveyed employers.

[j]An out-of-pocket spending limit represents the maximum amount an enrollee is required to pay toward the cost of covered services. The out-of-pocket spending limit includes deductibles and other payments, but does not include premiums. If the plans or data we reviewed reported separate out-of-pocket spending limits for services received from in-network and out-of-network providers, we reported only the limits for services received from in-network providers.

[k]Kaiser was unable to determine for all survey respondents whether the annual out-of-pocket spending limits were inclusive or exclusive of the deductible.

[l]Data represent the median values among surveyed employers offering HSA contributions.

[m]If HSA-eligible plan enrollees participated in employer-sponsored wellness programs, the employer contributed up to $250 in excess of the base contribution amount listed.

Individual Market

Premiums and deductibles for HSA-eligible plans sold in the individual market by eHealthInsurance followed a pattern similar to that of plans sold in the group market, with lower premiums and higher deductibles than traditional plans.[30] According to eHealthInsurance, the average monthly premiums for HSA-eligible plans were $111 for single coverage and $277 for family coverage in 2005.[31] Premiums for traditional health plans were, on average, 24 percent more for single coverage and 31 percent more for family coverage.[32] The average annual deductible for an HSA-eligible plan was $3,190 for single coverage and $5,213 for family coverage in 2005, compared with deductibles for traditional plans of $1,597 for single coverage and $2,025 for family coverage. (See table 3.)

[30]Data on annual out-of-pocket spending limits were not available.

[31]Family coverage refers to coverage of three or more individuals.

[32]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

Table 3: Financial Features of HSA-Eligible and Traditional Plans Offered in the Individual Market through eHealthInsurance, 2005

Feature	Coverage type	HSA-eligible	Traditional
Monthly premium	Single	$111	$138
	Family	277	363
Annual deductible*	Single	3,190	1,597
	Family	5,213	2,025

Source: eHealthInsurance

Notes: Data represent average values for HSA-eligible and traditional plans. Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans. Family coverage refers to coverage for three or more individuals.

*Reported for in-network services only.

HSA-Eligible Plans Covered Similar Health Care Services and Used Similar Provider Networks as Traditional Plans

HSA-eligible plans offered in 2005 by the three employers we reviewed covered health care services similar to those covered by the traditional plans offered by the same employers. The HSA-eligible and traditional plans offered by the same employer covered the same broad categories of services, such as preventive, diagnostic, maternity, surgical, outpatient, and emergency care, and typically covered the same services within these categories.[33] While each HSA-eligible plan defined preventive services differently, each plan covered, and paid 100 percent of the cost of, certain core services, including annual physical exams, routine immunizations for children, routine mammograms, routine Pap tests, and well-child care.[34] These services were generally also covered by the traditional plans offered by the employers.[35]

The provider networks used by HSA-eligible plans and traditional plans were similar. Two of the three employers we reviewed used the same insurance carrier and the same provider network for the HSA-eligible plan and the traditional plan it offered to its employees in 2005. One employer used different insurance carriers for its HSA-eligible and traditional plan in

[33]The HSA-eligible and traditional plans we reviewed generally covered the same categories of services for all plan enrollees and dependents. Both plan types covered maternity services for only the primary enrollee and spouse, and generally not for female dependents.

[34]One employer's HSA-eligible plan required a copayment (a fixed payment generally made at the time of service) before paying 100 percent of the cost of covered preventive services.

[35]One employer did not cover annual physical exams under its traditional plan.

2005, and in this case, the HSA-eligible plan network was broader than the traditional plan network. Other evidence suggests that the provider networks used by CDHPs and traditional plans are similar. For instance, industry experts told us that insurance carriers that offer both CDHPs and traditional plans typically use the same provider networks for both products. Insurance carriers we spoke with told us that they used the same provider network for their CDHP and traditional plan products. Additionally, as we noted in our November 2005 report, the provider networks used throughout the country by a national CDHP in the Federal Employees Health Benefits Program (FEHBP) were the same or comparable to those used by the program's traditional plans.[36]

Enrollee Costs Would Be Higher for HSA-Eligible Plans Than for PPO Plans When Extensive Care Is Used, but Lower When Low to Moderate Care Is Used

Our illustration of enrollees' potential health care costs—including premiums, deductibles, and other out-of-pocket costs for covered services—for the three employers' 2005 health plans we reviewed showed that HSA-eligible plan enrollees would incur higher annual costs than PPO plan enrollees for extensive use of health care, but would incur lower annual costs than PPO plan enrollees for low to moderate use of health care.[37] For example, we estimated that in the event of an illness or injury resulting in a hospitalization costing $20,000, the total costs incurred by the three employers' HSA-eligible plan enrollees would be 47 to 83 percent higher than those faced by the employers' PPO plan enrollees. Specifically, the total costs of health coverage paid by HSA-eligible plan enrollees would range from $3,710 to $5,111, while the costs paid by PPO plan enrollees would range from $2,136 to $3,472. In contrast, we estimated that the total costs paid by HSA-eligible plan enrollees who used low to moderate amounts of health care, visiting the doctor for illnesses or injuries six times in one year, would be 48 to 58 percent lower than the

[36]GAO-06-143.

[37]We assumed that enrollees had single coverage and used in-network services. We also assumed that enrollees used the funds their employers contributed to their HSA in 2005 and paid for the rest out of pocket. We assumed that enrollees did not have HSA funds carried over from a prior year, which, if used, could have lowered enrollees' out-of-pocket costs. We considered only the costs associated with medical care provided by a physician and did not consider any other costs that could be incurred by an enrollee, such as prescription drug costs. We also did not consider the tax implications associated with enrollee spending for health care services; if HSA-eligible plan enrollees used tax-advantaged funds they, or someone other than their employer, contributed to their HSA, their costs could have been lower.

costs paid by the PPO plan enrollees.[38] Specifically, the total annual costs of health coverage for HSA-eligible plan enrollees would range from $440 to $679, compared with $1,056 to $1,317 for PPO plan enrollees.

HSA-Eligible Plan Enrollees Had Higher Incomes Than Comparison Groups, but Data on Age Differences Were Inconclusive

HSA-eligible plan enrollees generally had higher incomes than comparison groups, but age differences varied depending on the data reviewed. Fifty-one percent of tax filers reporting HSA contributions had an adjusted gross income of $75,000 or more, compared with 18 percent for all tax filers under age 65 in 2004. Two of the three employers we reviewed and eHealthInsurance reported that HSA-eligible plan enrollees had higher incomes than did traditional plan enrollees in 2005. Regarding age differences, data from IRS for tax filers and from eHealthInsurance for individual market enrollees indicate that the average age of HSA-eligible plan enrollees was higher than that of individuals from comparison groups. In contrast, data from several employer groups indicate that the average age of HSA-eligible plan enrollees was lower than that of comparison groups of enrollees.

HSA-Eligible Plan Enrollees Had Higher Incomes Than Comparison Groups

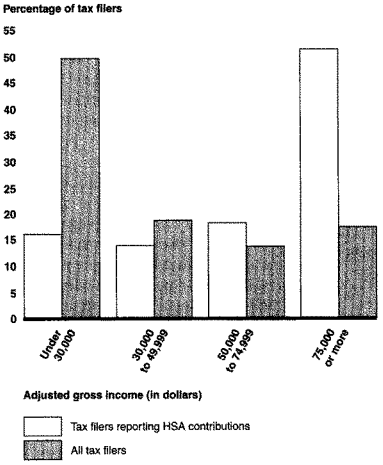
HSA-eligible plan enrollees had higher incomes than comparison groups. The average, or mean, adjusted gross income of the estimated 108,000 tax filers reporting HSA contributions in 2004 was about $133,000,[39] compared with $51,000 for all tax filers under age 65, according to IRS data. Similarly, the median adjusted gross income for these tax filers was about $76,000, compared with $30,000 for all tax filers under age 65. Moreover, 51 percent of tax filers reporting HSA contributions had an adjusted gross income of $75,000 or more, compared with 18 percent of all tax filers under age 65.[40] (See fig. 1.)

[38]We assumed that the negotiated rate for each doctor's visit was $80. We developed this assumption based on our analysis of one insurer's negotiated rates for office visits for low to moderate problems in the regions in which the three employers' plans were offered.

[39]To receive a deduction, tax filers must report HSA contributions to IRS. Those reporting HSA contributions in 2004 represented about 0.1 percent of the 115 million tax filers less than 65 years of age.

[40]All tax filers includes both insured and uninsured individuals. The uninsured tend to have lower incomes than those with health insurance coverage.

Figure 1: Adjusted Gross Income of Tax Filers Reporting HSA Contributions and All Tax Filers, 2004



Source: GAO analysis of IRS data

Notes: Data are based on a sample of 2004 tax returns processed by IRS. For the all tax filers category, we excluded those 65 years and older because they are generally enrolled in Medicare and are ineligible to contribute to an HSA.

We also found similar income differences between HSA-eligible plan and traditional plan enrollees when we examined other data sources from the group and individual markets. As we previously reported, among FEHBP enrollees actively employed by the federal government, 43 percent of HSA-eligible plan enrollees earned federal incomes of $75,000 or more, compared with 23 percent for all enrollees in 2005.[41] Actively employed HSA-eligible plan enrollees also had higher incomes than traditional plan enrollees in 2005 for two of the three employers we reviewed. One employer reported that the average salary of its HSA-eligible plan

[41]GAO-06-271.

enrollees was $75,000, compared with $61,000 for its traditional plan enrollees, and the second employer reported that the average salary of its HSA-eligible plan enrollees was $91,000, compared with $81,000 for its traditional plan enrollees. The third employer reported that about the same share (4 percent) of its actively employed HSA-eligible plan and traditional plan enrollees had incomes of $75,000 or more in 2005. In the individual market, eHealthInsurance reported that 35 percent of its HSA-eligible plan enrollees had incomes of $75,000 or more, compared with 21 percent of its traditional plan enrollees in 2005.[42]

Data Sources Did Not Show Consistent Age Differences between HSA-Eligible Plan Enrollees and Comparison Groups

The data sources we examined did not conclusively indicate whether HSA-eligible plan enrollees were older or younger than comparison groups. IRS data indicate that the average age of tax filers reporting HSA contributions was about 9 years higher than that of all tax filers under age 65 in 2004.[43] Similarly, eHealthInsurance reported that the average age of its individual market HSA-eligible plan enrollees was 5 years higher than that of its individual market traditional plan enrollees in 2005.[44] In contrast, several data sources from the group market in 2005 suggest that the average age of HSA-eligible plan enrollees was lower than that of the traditional plan enrollees or the average of all enrollees. As we previously reported, the average age of FEHBP's HSA-eligible plan enrollees, excluding retirees, was about 3 years lower than that of all FEHBP enrollees.[45] The three employers we reviewed reported that the average age of HSA-eligible plan enrollees, excluding retirees, was 2 to 6 years lower than that of their traditional plan enrollees. (See table 4.)

[42]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

[43]All tax filers include both insured and uninsured individuals. The uninsured tend to be younger than those with health insurance coverage.

[44]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

[45]GAO-06-271.

Table 4: Average Age of HSA-Eligible Plan Enrollees and Comparison Groups

Source	Average age of HSA-eligible plan enrollees	Average age of comparison group	Comparison group
All Markets			
IRS [a,b]	47[c]	39	All tax filers under 65 years of age
eHealthInsurance[d]	38	33	Traditional plan enrollees[e]
Group market			
FEHBP[f]	44	47[g]	All FEHBP enrollees
Employer 1[f]	40	46	Traditional plan enrollees
Employer 2[f]	44	50	Traditional plan enrollees
Employer 3[f]	42	44	Traditional plan enrollees

Source: GAO analysis of data from IRS, eHealthInsurance, the Office of Personnel Management, and three employers we reviewed.

Note: All data are for 2005 unless otherwise noted.

[a]Data are based on a sample of 2004 tax returns processed by IRS, and the average age is for the primary taxpayer filing the income tax return in 2004. Most HSA-eligible plans were sold in the individual market in 2004.

[b]The average age of tax filers reporting HSA contributions was about 9 years higher than that of all tax filers under age 65. The average ages listed in the table are rounded.

[c]Average age of tax filers reporting an HSA contribution.

[d]Enrollees under 65 years of age.

[e]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

[f]Excludes retirees.

[g]Average age of all FEHBP enrollees, excluding retirees, in 2004.

Just over Half of Enrollees and Most Employers Contributed to HSAs, and Account Holders Used HSA Funds to Pay for Medical Care and to Accumulate Savings

Just over half of HSA-eligible plan enrollees, and most employers, contributed to HSAs, and account holders used their HSA funds to pay for current medical care and to accumulate savings. About 55 percent of HSA-eligible plan enrollees reported HSA contributions in 2004. On average, tax filers claimed a deduction of about $2,100 for their HSA contributions in 2004, and the average amount increased with income. Most employers offering HSA-eligible plans contributed to their employees' HSAs, and the average employer HSA contribution was about $1,064 in 2004. HSA account holders used their funds to pay for medical care and to accumulate savings. About 45 percent of those reporting 2004 HSA contributions also reported withdrawing funds in 2004, and 90 percent of these funds were withdrawn for qualified medical expenses. The remaining 55 percent of those reporting HSA contributions in 2004 reported that they did not withdraw any funds from their HSA in 2004.

Just over Half of Enrollees Opened and Contributed to HSAs

Not all HSA-eligible plan enrollees opened and contributed to an HSA. According to our analysis of publicly available survey data and data obtained from IRS, about 55 percent of HSA-eligible plan enrollees reported HSA contributions in 2004. Industry experts we spoke with also estimated that the share of all HSA-eligible plan enrollees that had opened and contributed to an HSA was about 50 percent to 60 percent. Similarly, one insurance carrier representative reported that about 60 percent of its HSA-eligible plan enrollees who obtained coverage through an employer opened and contributed to an HSA.

HSA-eligible plan enrollees from the employers we reviewed were more likely to contribute to an HSA when their employer also offered account contributions. Specifically, two employers we reviewed contributed to employees' HSAs and reported that 64 percent and 90 percent of employees enrolled in HSA-eligible plans contributed to an HSA in 2005. In contrast, the third employer did not contribute to its employees' HSAs and reported that 38 percent of its employees who were enrolled in HSA-eligible plans contributed to an HSA in 2005.[46]

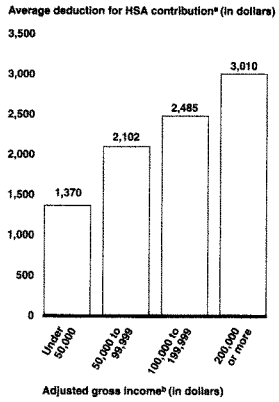
[46]For the three employers we reviewed, these data represent only those individuals who contributed to their HSA through payroll deduction.

Tax filers claimed an average deduction of about $2,100 for HSA contributions in 2004, and the average amount increased with income.[47] (See fig. 2.) The three employers we reviewed reported that employees enrolled in HSA-eligible plans contributed, on average, $826, $1,284, and $1,544 to their HSAs in 2005.[48]

[47]Tax filers may claim an income tax deduction for contributions they, or someone other than their employer, make to their HSA. The average deduction amount does not include HSA contributions individuals may have made through pretax payroll deductions and therefore may understate the amount individuals contributed to their HSAs.

[48]These data represent the contributions made by employees who contributed to their HSA through payroll deduction.

Figure 2: Average Deduction Claimed for HSA Contribution, 2004



Source: GAO analysis of IRS data

Note: Data are based on a sample of 2004 tax returns processed by IRS.

[a]HSA deductions represent the amount individuals claimed they, or someone other than their employer, contributed to their HSA. Deductions do not include employer contributions, although employers may contribute to employees' HSAs. Average deduction amounts do not include HSA contributions individuals may have made through pretax payroll deductions and therefore may understate the amount individuals contributed to their HSAs. In 2004, most HSA-eligible plan enrollees purchased coverage in the individual market rather than obtaining coverage through an employer. These data are reported on a per-return basis and thus could include contributions to more than one HSA in some instances. Moreover, the data do not distinguish between deductions claimed for HSA contributions made by enrollees with single and family coverage or between HSA-eligible coverage obtained in the group and individual market. The maximum allowable HSA contribution in 2004 was $2,600 for single coverage and $5,150 for family coverage; account holders aged 55 or over and not enrolled in Medicare could contribute an additional $500.

[b]Adjusted gross income may include income earned by family members who are not covered under HSA-eligible plans.

Most Employers Offering HSA-Eligible Plans Contributed to HSAs

About two-thirds of employers offering HSA-eligible plans contributed to their employees' HSAs. According to a national employer health benefits survey, about two-thirds of employers offering HSA-eligible plans—covering approximately 65 percent of workers in these plans—contributed

to HSAs for either single or family coverage in 2005.[49] Similarly, another national employer health benefits survey reported that 62 percent of large employers offering HSA-eligible plans contributed to their employees' HSAs in 2005.[50]

The amounts contributed by employers to employees' HSAs varied. In 2004, the average employer HSA contribution reported to IRS was about $1,064. Two national employer health benefits surveys reported that employers contributed different amounts to their employees' HSAs. Specifically, one national employer health benefits survey reported that the average annual employer contribution to HSAs in 2005 was $553 for single coverage and $1,185 for family coverage.[51] Another survey reported that among large employers that contribute to employees' HSAs, the median employer contribution was $100 for single coverage.[52] Two of the three employers we reviewed contributed to their employees' HSAs in 2005. The employers' contribution amounts varied from $100 to $1,400 for single coverage and from $200 to $2,300 for family coverage in 2005.[53] One employer offered fixed HSA contribution amounts to employees, and the other employer offered varying contribution amounts, which were linked to employees' participation in wellness programs. (See annual employer contribution to HSA in table 2.)

[49]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey.*

[50]Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report.*

[51]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey.* This average includes HSAs to which the employer did not make a contribution.

[52]Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report.* This median includes only HSAs to which the employer made a contribution.

[53]One employer contributed an additional $50 if an employee completed a health risk assessment and an additional $200 if an employee completed a health coaching program. These amounts are in addition to its base contribution amounts of $1,400 for single coverage and $2,300 for family coverage.

HSA Account Holders Used HSA Funds to Pay for Medical Care and to Accumulate Savings

Our review of available data showed that HSA account holders used HSA funds to pay for current medical care and to accumulate savings. Data from IRS indicate that about 45 percent of those reporting 2004 HSA contributions—made by themselves, others on their behalf, or their employers—also reported withdrawing funds from their HSA, and the average annual amount withdrawn by these tax filers was about $1,910. Our analysis of data from IRS also indicates that about 90 percent of these withdrawn funds were used to pay for qualified medical expenses. Additionally, IRS data show that about 40 percent of all funds contributed to HSAs in 2004 were withdrawn from the accounts by the end of the year.

In addition to using HSAs to pay for medical and other expenses, account holders appeared to use their HSA as a savings vehicle. About 55 percent of those reporting HSA contributions to IRS in 2004 did not withdraw any funds from their account in 2004. We could not determine whether HSA-eligible plan enrollees accumulated balances because they did not need to use their account (that is, they paid for care from out-of-pocket sources or did not need health care during the year) or because they reduced their health care spending as a result of financial incentives associated with the HSA-eligible plan and HSA. However, many focus group participants reported using their HSA as a tax-advantaged savings vehicle, accumulating HSA funds for future use. For example, one focus group participant reported paying out of pocket for a costly surgery in order to save HSA funds for future use.

Focus Group Participants Generally Understood and Were Satisfied with HSA-Eligible Plans, but Would Not Recommend These Plans to All Consumers

Participants in our focus groups who were enrolled in HSA-eligible plans generally reported positive experiences, but most would not recommend these plans to all consumers. Participants generally understood the key attributes of their plan, such as low premiums, high deductibles, and the mechanics of using the HSA, but were confused about certain other features. Few participants researched the cost of hospital or physician services before obtaining care, although many participants researched the cost of prescription drugs. Most participants reported satisfaction with their HSA-eligible plan and account, but said they would not recommend these plans to everyone. Participants said they would recommend HSA-eligible plans to healthy consumers, but not to people who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

Focus Group Participants Generally Understood Key Attributes of HSA-Eligible Plans and Accounts, but Expressed Confusion about Certain Features

Many participants in our focus groups were able to describe key attributes of HSA-eligible plans, including low premiums, high deductibles, and how to pay for services using the HSA.[54] Participants understood that employers and employees can contribute to an HSA and were aware of the maximum contribution limits. Participants also understood the ability to accumulate savings over time and that their HSA was portable if they left their company.

Participants expressed confusion about certain other features of HSA-eligible plans and accounts. Regarding their HSA-eligible plan, many participants understood that certain preventive visits were covered free of charge,[55] but cited problems distinguishing between preventive services and other services provided during a preventive visit to a physician. In particular, participants noted that certain laboratory tests associated with a preventive visit were not considered a preventive service and thus were not paid for by the plan. Participants of one focus group also reported that they did not always know whether services were provided by an in- or out-of-network provider, particularly in emergency situations. For example, one participant had to pay $1,800 for transporting his wife 10 miles in an ambulance because the ambulance that was dispatched was not an in-network provider. Regarding their HSAs, many participants were unsure what medical expenses qualified for payment using their HSA.[56] Some participants said that they were initially unaware of, or confused about, how having an HSA limited their use of flexible spending arrangement (FSA) funds to certain medical expenses.[57,58] Participants from one

[54]Unless otherwise noted, the participant experiences we report reflect multiple focus groups.

[55]One employer's HSA-eligible plan required a copayment before paying 100 percent of the cost of covered preventive services.

[56]According to Mercer Human Resource Consulting's briefing, "Mercer's National Survey of Employer-Sponsored Health Plans" (Feb. 24, 2006), about 70 percent of large employers offering CDHPs reported that their employees had at least some difficulty understanding what services may be paid from their account.

[57]Health FSAs are employer-established benefit plans that allow employees to be reimbursed for medical expenses. According to IRS, employees with HSAs can have only a limited-purpose FSA, which is restricted to certain benefits, such as vision, dental, or preventive care, or a postdeductible FSA, which can be used only after a minimum annual deductible is met.

[58]About 60 percent of large employers offering CDHPs reported that their employees had at least some difficulty understanding how their account coordinated with an FSA, according to "Mercer's National Survey of Employer-Sponsored Health Plans" briefing.

employer said that they were initially unaware of a monthly $3 administrative bank fee for maintaining the HSA and felt that it diminished any potential savings from interest earned on their HSA balance.

Few Focus Group Participants Researched Cost before Obtaining Health Care Services

Few focus group participants enrolled in HSA-eligible plans researched the cost of services before obtaining care, although many researched the cost of prescription drugs. A few participants reported asking physicians about the cost of services, but others expressed discomfort with asking physicians about cost.[59] For example, one participant said, "Americans don't negotiate. It's not polite to question the value of [a provider's] work." Participants noted that physicians did not always know the cost of the services and that this information was generally handled through a billing office. Participants of one focus group also reported not initially understanding the extent to which they needed to manage and take responsibility for their health care as consumers, including by asking questions about the cost of services and medications.

Participants reported that only limited information was available regarding key quality measures for hospitals and physicians, such as the volume of procedures performed and the outcomes of those procedures.[60] Many participants relied on referrals from family, friends, or health care providers for recommendations on providers. Some participants continued going to physicians with whom they already had an established relationship. Most participants did research general information on health care issues, such as on health conditions or treatment options.

Focus Group Participants Were Generally Satisfied with HSA-Eligible Plans but Would Not Recommend These Plans to All Consumers

Most participants, who had voluntarily elected to enroll in the HSA-eligible plan as one of several choices offered by their employer, reported that they were generally satisfied with their health plan. Many participants cited the ability to accumulate savings, the tax advantages of having an HSA, and the ability to use an HSA debit card or online accounts as positive aspects of HSAs. Participants reported few problems obtaining care, and many used their health plan to obtain preventive services, visit

[59]"Mercer's National Survey of Employer-Sponsored Health Plans" briefing noted that 40 percent of all employers reported that they provided access to Web sites on provider quality and cost information.

[60]In an earlier study, we reported on the challenges faced by carriers in providing cost and quality data. See GAO-06-514.

an emergency room or urgent care clinic, or fill prescriptions. When given a choice of health plan options, many focus group participants reported that they reenrolled in an HSA-eligible plan for the following year.

Despite their general satisfaction with HSAs and HSA-eligible plans, some participants did not like certain aspects of their plan or account. Some participants said that they would prefer the ability to contribute more to the HSA to accumulate savings, while others noted that deductibles for HSA-eligible plans were too high and they would be willing to pay higher premiums for plans with lower deductibles. Participants also reported that the cost of prescription drugs was high under HSA-eligible plans. Under two employers' HSA-eligible plans, participants had to pay 100 percent of the plan's negotiated price for prescription drugs until meeting the deductible.[61] In using the HSA, some participants said they encountered problems paying for services, such as billing errors for physician visits, and that the physician offices did not understand how to accept payment for services with an HSA debit card.

Most participants said they would recommend HSA-eligible plans to healthy consumers. Some participants said they enrolled in the HSA-eligible plan specifically because they did not anticipate getting sick, and many said they considered themselves and their families as being fairly healthy. However, participants would not recommend these plans to people who use maintenance medication, have a chronic condition, have children, or may not have the funds to meet the high deductible.

Focus Group Participants Enrolled in Traditional Plans Cited Several Reasons for Not Enrolling in HSA-Eligible Plans

Participants enrolled in traditional plans from all three employers reported that they received and reviewed information about their health care options, including HSA-eligible plans. Most participants easily understood the features of their traditional plan, including copayments, deductibles, and the differences between in- and out-of-network providers, and one group of participants characterized the information on HSA-eligible plans as confusing and complicated. Participants reported that they did not elect to enroll in an HSA-eligible plan because their costs under a traditional plan would be lower and they were concerned about meeting the high deductible for potentially high medical expenses. Most participants said

[61]Under these two employers' traditional plans, enrollees pay a portion of prescription drug costs through a copayment or coinsurance. A copayment is a fixed payment generally made at the time of service, while coinsurance is a payment representing a percentage of expenses.

they were satisfied with their traditional plan, citing steady monthly premiums, no unexpected costs or coverage limitations, no need to manage one's own health care, or an overall sense of comfort with traditional plans. If given a choice, most of the participants enrolled in traditional plans would reenroll in these plans. One group of participants, whose employer was planning to offer only CDHP options in the future, suggested they would consider seeking employment elsewhere if forced into a CDHP. Some participants said they might have considered enrolling in an HSA-eligible plan if they had been younger and healthier.

Concluding Observations

As more individuals face the choice of enrolling in HSA-eligible plans or other CDHPs, they will likely weigh the savings potential and financial risks associated with these plans in relation to their own health care needs and financial circumstances. We found that enrollees who use little health care could incur lower costs under HSA-eligible plans than under traditional plans, while those who use more extensive health care services could incur higher costs under HSA-eligible plans. Thus, when individuals are given a choice between HSA-eligible and traditional plans—as in the individual market and with employers offering multiple health plans—HSA-eligible plans may attract healthier individuals who use less health care or, as we found, higher-income individuals with the means to pay higher deductibles and the desire to accrue tax-free savings. While patterns evident during the first few years of HSA-eligible plan enrollment may not predict future trends and enrollment will depend on the particular choices available, it will be important to monitor enrollment trends and assess their implications for the cost of health care coverage for all HSA-eligible and traditional plan enrollees.

Contrary to the hopes of CDHP proponents, few of the HSA-eligible plan enrollees who participated in our focus groups researched cost before obtaining health care services. According to proponents, an increase in such health care consumerism is central to cost reductions that may occur under the plans. Any increase in consumerism that may be exhibited by CDHP enrollees will likely require time, education, and improved decision-support tools that provide enrollees with more information about the cost and quality of health care providers and services.

Finally, while HSA-eligible plan enrollees we spoke with were generally satisfied with their plan, it is notable that these enrollees each had a choice of health plans and voluntarily selected the HSA-eligible plan. Their caution that HSA-eligible plans may not be appropriate for everyone and the views of traditional plan enrollees who opted not to elect an HSA-

eligible plan suggest that satisfaction may be lower when employees are not given a choice or when employer contributions to premiums or accounts do not sufficiently offset the potentially greater costs faced by CDHP enrollees.

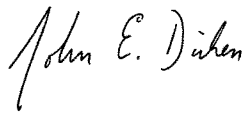
Agency Comments

We provided to IRS and eHealthInsurance portions of a draft of this report pertaining to the data each had provided us. We received technical comments from IRS and eHealthInsurance by email and incorporated these comments as appropriate.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies to others who are interested and make copies available to others who request them. The report will also be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7119 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,



John E. Dicken
Director, Health Care

Appendix I: Scope and Methodology

To respond to our study objectives regarding health savings accounts (HSAs) and HSA-eligible plans, we examined (1) the financial features, covered services, and enrollees' annual costs of HSA-eligible plans in comparison with those of traditional plans; (2) the characteristics of HSA-eligible plan enrollees in comparison with those of other individuals and traditional plan enrollees; (3) the funding and use of HSAs; and (4) the experiences of enrollees with HSA-eligible plans. We reviewed all data for reasonableness and consistency and determined that the data were sufficiently reliable for our purposes. We performed our work from November 2004 through July 2006 in accordance with generally accepted government auditing standards.

Financial Features and Covered Services

We relied on several sources to compare the financial features—that is, the premiums, deductibles, and out-of-pocket spending limits—of HSA-eligible plans with those of traditional plans.[1] For the group market, we summarized data on financial features of HSA-eligible and traditional plans from two 2005 national employer health benefits surveys.[2] In addition, we hired a contractor, Hewitt Associates LLC, to contact employers, conduct focus groups with their employees, and obtain information about the employers' 2005 health plans. We judgmentally selected employers for review that (1) offered an HSA-eligible plan and a traditional plan in 2005, (2) had at least 500 enrollees in their HSA-eligible plan in 2005, and (3) allowed us to conduct focus groups with their employees. We selected three large employers in the public, utility, and insurance sectors that met these criteria, and we agreed not to identify these employers by name in this report. The three employers we reviewed offered HSA-eligible plans that were administered by different insurance carriers. We requested that each employer provide us with plan brochures and other documentation, including responses to a questionnaire describing its 2005 HSA-eligible and traditional plans.[3]

[1]Unless otherwise noted, traditional plans refers to preferred provider organization (PPO) plans.

[2]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: 2005); and Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report* (New York, N.Y.: 2006).

[3]For the three employers, we reviewed the features of their PPO plan with the largest enrollment.

To examine the financial features of HSA-eligible and traditional plans in the individual market, we reviewed data for plans sold for 2005 by eHealthInsurance, a large, national broker of individual and small business health insurance that offers more than 5,600 plans for more than 140 health insurance carriers.[4] Data reported from eHealthInsurance represent only the policies of individuals who purchased insurance in the individual market through the brokerage for 2005 and cannot be generalized to all enrollees. These data were based on a random sample of policies sold by eHealthInsurance as of December 31, 2005.

To examine the covered services and provider networks of HSA-eligible and traditional plans, we reviewed the three employers' plan brochures and spoke with employer and insurance carrier officials and industry experts.

To illustrate the potential health care costs faced by HSA-eligible and traditional plan enrollees, we estimated the total annual costs to enrollees of the three employers' HSA-eligible and preferred provider organization (PPO) plans in 2005. We considered the following annual costs associated with coverage under the plans:

- **Premiums**. HSA-eligible plans typically have lower premiums than PPO plans. We considered only enrollees' share of the premiums.
- **Deductibles**. HSA-eligible plans typically have higher deductibles than PPO plans. We considered all costs for covered services that enrollees incurred before meeting their deductible.
- **Out-of-pocket spending limits**. HSA-eligible plans typically have higher out-of-pocket spending limits than PPO plans. The out-of-pocket spending limit includes deductibles and other payments, but does not include premiums. We considered all copayments and coinsurance enrollees incurred before meeting their out-of-pocket spending limit.

We also considered the contributions employers made to employees' HSAs. Most employers contribute to their employees' HSAs. We assumed that when paying for their health care expenses, enrollees only used funds their employer contributed to their HSA in 2005 and paid for the rest out of pocket.

[4]Traditional plans offered through eHealthInsurance include both PPO plans and other major medical plans that do not meet the federal criteria for HSA-eligible plans.

When performing these calculations, we assumed that enrollees had single coverage and used in-network services. For the analysis of enrollees' total health care costs related to extensive use of health care, we examined the potential costs incurred by enrollees for an illness or injury resulting in a hospitalization costing $20,000. For the analysis of costs related to low to moderate use of health care, we examined the potential costs incurred by enrollees for six doctor's office visits, classified as for low to moderate problems, and assumed the negotiated rate for each visit was $80. We developed this assumption based on our analysis of one insurer's negotiated rates for office visits for low to moderate problems in the regions the three employers' plans were offered. We considered only the costs associated with medical care provided by a physician and did not consider any other costs that could be incurred by an enrollee, such as prescription drugs. We assumed that enrollees did not have HSA funds carried over from a prior year. If enrollees had used funds carried over from a prior year, their out-of-pocket costs could have been lower. We also did not consider the tax implications associated with enrollee spending for health care services; if HSA-eligible plan enrollees used tax-advantaged funds they or someone other than their employer contributed to their HSA, their costs could have been lower.

Characteristics of HSA-Eligible Enrollees

To compare the characteristics of HSA-eligible and traditional plan enrollees, we compared demographic data provided by the Internal Revenue Service (IRS) on adjusted gross income and age for tax filers who reported HSA contributions on their 2004 tax returns with the corresponding data for all tax filers less than 65 years of age. IRS data were based on a random probability sample of 200,295 individual income tax returns for 2004 from the IRS Statistics of Income (SOI) individual tax return file, of which a small proportion reported an HSA contribution. The SOI file is a stratified probability sample of income tax returns filed with IRS, weighted to represent an estimated population of about 132 million tax returns. Of the 115 million tax filers less than 65 years of age in 2004, approximately 0.1 percent—an estimated 108,000 tax filers—reported an HSA contribution. To assess the relative precision of IRS's data estimates, we reviewed the coefficients of variation for all estimates we used in our calculations.[5] The coefficient of variation measures the magnitude of

[5]GAO, *Using Statistical Sampling*, GAO/PEMD-10.1.6 (Washington, D.C.: Revised May 1992).

dispersion around the mean. In each instance, the coefficient of variation was less than 33 percent, indicating small to moderate variation.[6]

IRS data for tax filers reporting an HSA contribution are not generalizable to all HSA-eligible plan enrollees because the sample is not designed to capture individuals enrolled in a high-deductible health plan who did not have an associated HSA. IRS data depend on tax filing status (e.g., single, married filing jointly, married filing separately) and are not linked to plan size; a tax return reporting an HSA contribution therefore may include contributions to multiple HSAs that may represent single and family policies obtained in the group or individual market. With regard to specific data elements, adjusted gross income data may represent the income earned by other family members who may or may not be covered under the HSA-eligible plan, whereas age data represent the age of the primary taxpayer, who may or may not be enrolled in the HSA-eligible plan. For comparison purposes, we analyzed data for a sample of all tax filers under age 65, because individuals 65 years and older are generally enrolled in Medicare and are ineligible to contribute to an HSA.

To supplement IRS data, we analyzed 2005 income and age data reported for HSA-eligible and traditional plan enrollees who purchased coverage in the group market, excluding retirees, through the three employers we reviewed as well as in the individual market through eHealthInsurance for enrollees under 65 years of age.

HSA Funding and Use

To determine how HSAs are funded and how HSA account holders are using their funds, we gathered and analyzed SOI data from IRS, data from two national employer health benefits surveys, and data from the three employers we reviewed. To determine the share of enrollees that opened HSAs, we analyzed survey data on the number of HSA-eligible plan enrollees[7] and IRS data on the number of tax returns reporting HSA contributions,[8] and examined data provided by the three employers we reviewed regarding the share of HSA-eligible plan enrollees who

[6]GAO/PEMD-10.1.6.

[7]America's Health Insurance Plans, *Number of HSA Plans Exceeded One Million in March 2005* (Washington, D.C.: 2005).

[8]Department of the Treasury, "Fact Sheet: Dramatic Growth of Health Savings Accounts (HSAs)." http://www.treasury.gov/offices/public-affairs/hsa/pdf/fact-sheet-dramatic-growth.pdf (downloaded Mar. 28, 2006).

contributed to HSAs through pretax payroll deductions. We also conducted interviews with industry experts regarding the share of enrollees that opened HSAs. To examine individuals' HSA contributions, we analyzed IRS data on the average 2004 HSA tax deduction claimed by tax filers and reviewed 2005 data provided by the three employers regarding the contributions of employees enrolled in HSA-eligible plans. To examine employer HSA contributions, we analyzed IRS data on the average employer contribution among those who reported any HSA contribution on their 2004 tax return and summarized 2005 data reported by two national employer health benefits surveys[9] and the three employers. To determine how HSAs are used, we analyzed IRS data on account withdrawals among those who reported HSA contributions made by themselves, others on their behalf, or their employers in 2004. We also obtained information regarding enrollee HSA funding and use through the focus groups with employees of the three employers we reviewed.[10]

Enrollee Experiences

To determine enrollees' experiences with HSA-eligible plans, we used focus groups of HSA-eligible plan enrollees to obtain qualitative information on enrollee education, plan comprehension, experience with obtaining care, use of decision-support tools, and plan satisfaction in 2005. We contracted with Hewitt Associates LLC, a human resources consulting firm, to screen and select participants and to moderate these focus groups. For each of the three employers selected, focus groups were conducted with employees enrolled in an HSA-eligible plan or, for comparison purposes, in a traditional plan in 2005. Across the three employers, eight focus groups were conducted, comprising 47 employees enrolled in HSA-eligible plans and 28 employees enrolled in traditional plans.[11] Each group consisted of 7 to 12 participants. In screening and selecting focus group participants, we requested that Hewitt Associates LLC attempt to balance the focus groups by demographic characteristics, including age, sex, and

[9]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey*, and Mercer Human Resource Consulting, *National Survey of Employer-Sponsored Health Plans: 2005 Survey Report.*

[10]In addition to the focus groups, we also gathered information regarding enrollee HSA funding and use on a questionnaire administered to focus group participants.

[11]For two employers, two focus groups were conducted with employees enrolled in HSA-eligible plans, and a third focus group was conducted with employees enrolled in a traditional plan. For the third employer, one focus group was conducted with employees enrolled in an HSA-eligible plan, and a second focus group was conducted with employees enrolled in a traditional plan.

type of coverage (i.e., single or family), and with regard to employee job title or position. In order to ensure that the focus groups could describe the experiences of both users and nonusers of health care services, we requested that Hewitt Associates LLC include a mix of participants who used their health care plan to obtain medical care or prescription drugs and participants who did not. Finally, we requested that employees and their supervisors not be included in the same focus group to encourage participants to speak freely. Unless otherwise noted, the participant experiences we report reflect multiple focus groups. The results of the focus groups and the data obtained from the three employers may not be generalized to all HSA-eligible plan enrollees or employers because they represent only the experiences of the focus group participants and the benefit offerings of the three employers.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7119 or dickenj@gao.gov

Acknowledgments

In addition to the contact named above, Randy DiRosa, Assistant Director; N. Rotimi Adebonojo; Rashmi Agarwal; Martha R. W. Kelly; Roseanne Price; Pamela N. Roberto; and Patricia Roy made key contributions to this report.

Related GAO Products

Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage. GAO-06-514. Washington, D.C.: April 28, 2006.

Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts. GAO-06-271. Washington, D.C.: January 31, 2006.

Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan. GAO-06-143. Washington, D.C.: November 21, 2005.

Response to Questions
For GAO Witness John E. Dicken
Regarding the September 26, 2006 Hearing on Health Savings Accounts

Responses for Senator Hatch

"...the GAO report concludes that enrollee out-of-pocket costs are higher for HSA-eligible plans than for PPO plans when extensive care is used. Yet, one of the principal benefits of an HSA is that the employee owns his health savings account and can carry over unused deposits. Did the report take into account that people may be saving for their health care costs? If not, how might this consideration have impacted your analysis?"

Our finding that enrollees' potential health care costs would be higher for HSA-eligible plan enrollees relative to PPO enrollees when extensive health care is used is limited to the 2005 health plans offered by the three employers we studied. Our analysis was based on the actual designs of these plans and assumptions that we necessarily made in estimating enrollees' health care costs under different health care usage scenarios. Other assessments of different plans using different assumptions could arrive at different conclusions. While no single employer's plans can represent the multitude of plan options offered by employers, for each of the three large employers we reviewed—with differing characteristics and plan features—we found that enrollees' health care costs would be higher in the HSA-eligible plans than the PPO plans for extensive use. Specifically, each of the employers we reviewed had at least 500 enrollees in their HSA-eligible plan in 2005 and were in different industries, and their HSA-eligible plans were administered by different insurance carriers and had varied designs for financial features such as enrollee premium shares, deductible amounts, out-of-pocket spending limits, and employer contributions to the HSA.

Our illustration of enrollees' potential health care costs did not take into account the extent to which enrollees saved money in their HSAs. We considered only what enrollees would have spent for their health care in 2005, including premiums, deductibles, and

coinsurance.[1] We assumed that when paying for their health care expenses, enrollees used funds their employer contributed to their HSA in 2005. We also assumed that HSA-eligible plan enrollees did not have funds carried over from 2004. If enrollees had used tax-advantaged funds carried over from a prior year, their costs could have been lower, particularly if these funds were contributed by their employer. However, as HSA-eligible plans were first introduced in 2004 and the three employers we reviewed began offering these HSA-eligible plans in 2005, it is unlikely that their employees carried over HSA funds from 2004.

More generally, our study found that many enrollees appeared to use their HSA as a savings vehicle. We reported that about 55 percent of those reporting HSA contributions to IRS in 2004 made no withdrawals in 2004. However, we could not determine whether HSA-eligible plan enrollees accumulated balances because they did not need to use their account (that is, they paid for care from out-of-pocket sources or did not need health care during the year) or because they reduced their health care spending as a result of financial incentives associated with the HSA-eligible plan and HSA. Additionally, many focus group participants reported using their HSA as a tax-advantaged savings vehicle, accumulating HSA funds for future use.

"...you testified about the growth of health savings accounts and said they have increased in number from about 438,000 in September 2004 to about 3 million in January 2006. How would you characterize this growth rate? Has it exceeded expectations? Do you have any rough projections for what the number might be by January 2007, or in three or five years?"

We found small but growing enrollment for HSA-eligible high deductible plans. Based on industry estimates, the number of enrollees increased nearly 600 percent from September 2004 through January 2006, with the fastest rate of enrollment occurring in the group market. While this growth rate was rapid, the growth occurred from a relatively small base. We reported that in January 2006, there were about 3 million HSA-eligible plan enrollees and dependents, which represented a small share of the

[1]We considered only the costs associated with medical care provided by a physician and did not consider any other costs that could be incurred by an enrollee, such as prescription drug costs.

approximately 177 million individuals covered under a private health insurance plan. Since the issuance of our report, a new survey released in September of 2006 suggests a more moderate enrollment growth in group market HSA-eligible health plans of about 75 percent from 2005 to 2006.[2] We have not conducted estimates of future enrollment growth in HSA-eligible high deductible health plans or HSAs, and doing so would be highly speculative.

"...you mentioned that this [low to moderate amounts of health care] meant visiting the doctor for illnesses or injuries six times in one year. For some people, six doctor visits in a year is not very significant, but for a large number of American families... six visits in one year may qualify as a considerable use of health care. How did you determine that six doctor visits in a year for injury or illness constituted low to moderate usage? In addition, did that number include routine, preventive care?"

In estimating potential health care costs under different health care usage scenarios, we selected an illustrative range from low/moderate on one end to extensive on the other. To determine either low/moderate or high use of health care for a person with single coverage, we selected amounts of health care that would not reflect extremes. For example, an individual who sought no health care within a year would have been the extreme on the low end, whereas an individual who had several intensive physician visits for an ongoing condition and underwent two or more inpatient procedures may have represented an extreme on the high end. Therefore, for our illustrations we examined the potential costs incurred by enrollees for six physician's office visits, classified as for low to moderate problems at a negotiated rate of $80 per visit,[3] and we examined the potential costs incurred by enrollees for a single hospitalization costing $20,000 for relatively high use. Though we did not consider what services enrollees would have received during the physician visits, we included the costs for low to moderate problem visits and not for routine, preventive care. Each employer's HSA-eligible plan that we

[2] See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: 2006).
[3]We developed this assumption based on one insurance carrier's negotiated rates for office visits for low to moderate problems in the regions in which the three employers' plans were offered.

reviewed covered, and paid 100 percent of the cost of, certain core preventive services, including annual physical exams and routine immunizations for children.[4]

"...some have suggested that the GAO study indicates that further expanding HSAs will not ensure quality health care. Did the GAO's report measure the quality of services provided?"

Consistent with our reporting objectives, we did not measure the quality of services enrollees received through their HSA-eligible health plans. Such a study would have required a different methodological approach than the one we undertook. We did, however, find and report that the focus group participants enrolled in HSA-eligible high deductible health plans offered by the three employers we studied were generally satisfied with their plans and had few problems accessing care.

"...proponents of HSAs believe that they are ideal for people who are extensive users in some years but not in others, because they could accrue tax-deductible, income-producing contributions for later planned or unplanned events.... In that the study covered only one year, did this group include only those with chronic conditions, or did it also include otherwise healthy people who may have had unusual health care expenses for that particular year?"

For our study, we reviewed several sources of data relating to HSA-eligible and traditional plan enrollees, none of which were selected on the basis of the enrollees' health status. For example, IRS data on HSA contributions and withdrawals were based on a sample of all tax filers who reported an HSA contribution in 2004. Data on the characteristics of HSA-eligible and traditional plan enrollees from the national broker of health insurance represent individuals who purchased insurance in the individual market for 2005 through that broker. And similarly, focus group participants of the three employers we studied were selected, among other criteria, on the basis of their enrollment in an HSA-eligible or PPO plan. Although we tried to ensure that the focus groups included a mix of participants who used their health care plan to obtain medical

[4]Each HSA-eligible plan we reviewed defined preventive services differently. One employer's HSA-eligible plan required a copayment, a fixed payment generally made at the time of service, before paying 100 percent of the cost of covered preventive services.

care or prescription drugs and those who did not, we did not select focus group participants on the basis of their health status.

Responses for Senator Bunning

"My state of Kentucky has adopted HSAs for its high-risk pool plan for the medically uninsurable. What is the progress in other states of incorporating HSAs into their high-risk pool plans?"

While our report did not examine HSA-eligible health plans in the context of state high risk pools, the Council for Affordable Health Insurance reported in July of 2006 that 12 of the 33 state high risk pools had adopted HSA-eligible plans. The 12 states were Alabama, Arkansas, Colorado, Idaho, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Nebraska, South Dakota, and Wyoming.

Responses for Senator Rockefeller

"...GAO's findings seem to suggest that higher-income individuals are more likely to enroll in HSA-eligible plans.... Does this mean that people are using HSAs mainly as a tax shelter?"

Data we reviewed for our study do not indicate the primary motivation behind the contributions individuals make to HSAs. The data do suggest that HSA accountholders are using their HSA account funds to accumulate savings and to pay for their current medical expenses. For example, for 2004, more than half of tax filers (about 55 percent) reporting an HSA contribution indicated that they did not withdraw any HSA funds during the year. However, we were unable to determine whether these accountholders accumulated balances because they did not have any health care expenses during the year or because they chose to save their HSA funds and paid for care from other out-of-pocket sources. The other 45 percent of tax filers reporting HSA contributions in 2004 withdrew funds from their accounts, mainly to pay for qualified medical expenses. IRS data show that about 40 percent of all funds contributed to HSAs in 2004 were withdrawn from the accounts by the end of the year.

Anecdotally, many focus group participants reported that they considered their HSAs to be tax advantaged savings vehicles. For example, one participant reported using out-of-pocket funds to pay for a costly surgery in order to accumulate HSA funds for future use. In a prior GAO report, we noted that representatives from 3 of 6 financial institutions among the most active in the HSA marketplace told us that HSA accountholders fall into 2 categories—savers and spenders. Savers, who according to financial institution representatives tend to be higher-income individuals, use their accounts as a tax-advantaged savings vehicle and pay for their health care from other out-of-pocket sources, whereas spenders use their HSA funds to pay for health care expenses.

"...how appropriate are high-deductible health plans and HSAs for the average American, including those with low to moderate income or those with chronic conditions?"

As we noted in our concluding observations, as more individuals face the choice of enrolling in HSA-eligible health plans, they will likely weigh the savings potential and financial risks associated with these plans in relation to their own health care needs and financial circumstances. While it is difficult to identify an average American, some will likely be attracted to the lower premiums and tax-advantaged savings potential of the savings accounts, while others will be reluctant to change health plans or potentially face higher deductibles.

Lower income individuals who enroll in HSA-eligible plans face tradeoffs. The plans typically have lower premiums than traditional plans, which may be attractive to lower-income individuals, including those who were previously uninsured. However, lower-income individuals may not be able to contribute money to an HSA. We found that about 45 percent of those enrolled in an HSA-eligible high-deductible health plan did not report any contributions to their HSAs in 2004. Thus, some lower income individuals could face high out-of-pocket health care costs before meeting their deductible and not have savings in an HSA to help pay those costs, which could raise concerns as to whether these individuals would be considered underinsured.

There are several cautions for individuals with chronic conditions. IRS guidance currently does not permit individuals with chronic illnesses to make larger HSA contributions than healthy individuals, and also requires that most prescription drugs, including those intended to treat existing conditions, be subject to the deductible. Thus, those with a chronic condition and higher health care costs may not fund their HSAs to pay these higher costs to a greater extent than healthy individuals. For the three employer groups we studied, individuals with high annual health costs would face higher health care expenses in an HSA-eligible plan than in PPO, and participants in our focus groups at the three employers cautioned that they would not recommend the plan to individuals with chronic conditions.

"[A September 25th Wall Street Journal article]... discussed the experience of an employer who provides HSAs to his employees. The article pointed out that since instituting HSAs his employees have shared a lot more information about their medical conditions with him... [and] he expressed unease about having so much detailed medical information about his employees.... Do you have any concerns about employers having so much medical information, recognizing that there may be some employers who would use it in inappropriate ways?"

Although privacy issues related to HSA-eligible health plans were outside the scope of our report, HSAs or HSA-eligible health plans in and of themselves do not provide employers greater access to employees' health status information than do traditional health plans. The employees profiled by the Wall Street Journal were reported to have voluntarily shared personal health information with their employer in an attempt to solicit the employers' assistance in optimizing their health care spending. However, if an employer used an employee's personal health information for inappropriate purposes, the employer could be subject to legal action. More generally, this story highlights the importance of information on the cost and quality of health care providers and services for enrollees enrolled in high-deductible health plans and the likely need for improved decision-support tools that provide enrollees with such information.

National Center for Policy Analysis

Statement on

Health Savings Accounts

by

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Testimony
Before the
Senate Finance Committee
Subcommittee on Health Care

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An Unsustainable Path

Government at all levels in the United States currently spends about 7.2 percent of gross domestic product (GDP) on health care, mainly on Medicare and Medicaid. Yet Christian Hagist and Laurence J. Kotlikoff have shown that if benefits expand at the rate of the past 30 years and if the population ages the way demographers predict, government health care spending will equal one-third of national income by mid-century, when today's college students reach the retirement age.[1] If that is not immediately alarming, note that one-third of GDP is about equal to all government spending for all purposes today. If private spending on health care keeps up with public spending, the nation will devote about two-thirds of national income to health care by mid-century — an amount roughly equal to the total consumption of all goods and services today.

So in the public sphere, health care is on a course to crowd out every other government program — from education and roads and bridges to Social Security and national defense. And for the economy as a whole, health care is on a course to crowd out every other form of consumption, including food, clothing, housing, etc.

Clearly we are on an impossible path. And the longer we stay on it, the more painful it will be to get off of it. Yet it is impossible to get off of it unless someone is forced to choose between health care and other uses of money. The question is: who will that someone be?

Choosing Between Health Care and Other Uses of Money

Busy people are often unaware of how easy it is to spend other people's money on health care. Let me give you a few examples. The Cooper Clinic in Dallas offers an extensive checkup (with a full body scan) for about $2,000 or more. Its clients include Ross Perot, Larry King and

[1] Christian Hagist and Laurence J. Kotlikoff, "Health Care Spending: What the Future will Look Like," National Center for Policy Analysis, NCPA Policy Report No. 286, June 2006.

other high-profile individuals. Yet if everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by almost one-third. More than 1,000 diagnostic tests can be done on blood alone; and one doesn't need too much imagination to justify, say, $6,500 worth of tests each year. But if everyone did so we would double the nation's health care bill. Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought professional advice before making such purchases, we would need 25 times the number of primary care physicians we currently have.[2] Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another. At a conservative estimate of, say, $1,000 a test, it would cost more than $1 million for a patient to run the full gamut. But if every American did so, the total cost would run to about 30 times the nation's annual output of goods and services.

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. We are simply collecting information. If in the process of searching we actually found something that warranted treatment, we could spend even more.

One of the cardinal beliefs of advocates of single-payer health insurance is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free, people would have an incentive to obtain each and every service so long as it had any value at all to them. In other words, everybody would have at least an economic incentive to get the Cooper Clinic annual checkup, order dozens of blood tests, check out all their genes and consult physicians at the drop of a hat. In short order, unconstrained patients would attempt to spend the entire gross domestic product on health care even though, as a practical matter, that would be impossible.

To control the growth rate of health care spending, someone must choose between health care and other uses of money. That is, someone must decide that useful, beneficial health care

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[2] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2, Summer 1990, pages 27-28.

procedures are not as valuable as other goods and services that could be purchased with the same funds. How can those decisions be made?

In principle there are only a limited number of ways choosing between health care and everything else. Three especially interesting approaches would have these choices made by: (a) government (national health insurance), (b) employers and insurers (managed care) or (c) patients in consultation with their doctors (consumer-driven health care).

Given the large number of devotees of all three approaches, you would think there would be a rich literature on how each allocates resources by comparing the costs and benefits of different types of care. In fact, the reverse is true. The very subject is virtually taboo.[3] Take positron emission tomography scanners, for example. At last count there were more than one thousand in the United States, but only three in Canada.[4] So how did Canada decide that the benefits of the 4th PET scanner (in terms of lives saved, diseases cured, etc.) was not worth the monetary cost? Is there some cost-benefit comparison in a paper or official document somewhere? None that I can find.

The PET scan example is not unique. Around the world, managers of government-run health care systems rarely discuss rationing decisions and how they are made.[5] The advocates of single-payer national health insurance are even worse. Scan their literature and you will search in vain for any discussion of how we should trade off health care benefits against monetary costs.[6]

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[3] An exception is John C. Goodman, Gerald L. Musgrave and Devon M Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, Md.: Rowman & Littlefield, 2004).

[4] Of the 12 PET scanners in Canada, two are owned by private providers and seven are available only for research and clinical trials. See Laura Eggertson, "Radiologists, physicians push for PET scans," *Canadian Medical Association Journal*, Vol. 172, No. 13, June 21, 2005. Also see ; "What is PET?" Society of Nuclear Medicine, 2006.

[5] An exception is the Oregon Medicaid program, which prioritized 300 services and pledged to provide only those that the budget would allow. See Martin A. Strosberg, Joshua M. Wiener, Robert Baker and I. Alan Fein (editors) *Rationing America's Medical Care: The Oregon Plan and Beyond, edited by* (Washington, D.C.: The Brookings Institution, 1992).

[6] See Marcia Angell and the Physicians' Working Group, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Physicians for a National Health Program, August 13, 2003.

The advocates of managed care are not much better. Think how many trees have been felled to support the huge volume of literature on this subject. But where in all this text is there a discussion of how managed care organizations are suppose to make cost-benefit tradeoffs? I have yet to find it.[7]

Surprisingly, the advocates of consumer-driven health care (CDHC) are also reluctant to broach this subject. In fact, some of the most ardent supporters of Health Savings Accounts (HSAs) on Capitol Hill flatly deny that their purpose is to facilitate choices between health care and nonhealth care consumption. Indeed, this is the main reason why the law discourages people from removing their end-of-year HSA balances for nonhealth purposes.[8]

There is, however, this difference: Whether the supporters admit it or not, the United States is the first developed country to set up a formal, institutional mechanism that allows people to choose between health care and other uses of money on a rational basis.[9] As such, HSA accounts have the potential to revolutionize the health care system. Yet they will succeed in doing so only if they free patients to perform consumer functions that they have not been hitherto performing: (1) make tradeoffs between health care and other goods and services; (2) become savvy shoppers in the medical marketplace; and (3) become managers of their own care.

Patients as Choosers

Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We don't want a parent to choose not to

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[7] There is of course a large and growing literature on cost effectiveness (e.g., how much does a procedure cost in terms of years of life saved?). These studies can serve as the basis for decision-making but they do not tell us how to make decisions.

[8] Withdrawals for nonhealth purposes are subject to income taxes and a 10 percent penalty (before age 65). As a result, the tradeoff is not on a level playing field. For a family in the 25 percent tax bracket, $1 of health care trades against 65¢ of other goods, at least in the current period.

[9] Note, however, that South Africa's Medical Savings Accounts were introduced more than a decade ago and Singapore's medisave accounts are now two decades old. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000; Thomas A. Massaro and Yu-Ning Wong, "Medical Savings Accounts: The Singapore Experience," National Center for Policy Analysis, NCPA Policy Report No. 203 April 1996.

have her child vaccinated, or an at-risk expectant mother to avoid prenatal care, or a heart patient to eschew aspirin or beta blockers. The reason: there is overwhelming evidence that the social benefits of the care exceed the social cost.[10] Yet instances where we can be absolutely sure that we know which alternative is the right choice are rarer than one might suppose. At the other extreme, there are literally thousands of cases where only the patient can make the right choice.

Take arthritic pain relief. The annual cost of brand-name drugs runs about $800 more than over-the-counter substitutes and they are riskier (Vioxx and Bextra, for example, have been removed from the market). Is the extra cost and risk worth the marginal improvement in pain relief offered by a prescription drug? Since drugs affect different people differently, we cannot determine for someone else whether the tradeoff is worthwhile. So it is appropriate and desirable for people to make these decisions themselves and reap the full benefits and bear the full costs of decisions they make.

The problem with the current system is that all too often patients have no opportunity to make such choices. The reason: most of the time they are buying health care with someone else's money. Ironically, most of the people who were taking Vioxx should not have been taking it; and the best predictor of whether a patient was taking it was whether a third-party was paying the bill.[11] This example is far from unique. For the health care system as a whole, patients pay only 14 cents out of pocket every time they spend a dollar, on the average. So the economic incentive is to spend on health care until its value to the patient is only 14 cents on the dollar. It's hard to imagine a more wasteful incentive structure.

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[10] See Tammy O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, Vol. 15 No. 3, 1995; and David M. Eddy (editor), *Common Screening Tests*, (Philadelphia: American College of Physicians, 1991).

[11] A recent study found that two-thirds of patients on Cox-2 inhibitors were not at risk for gastrointestinal conditions like ulcers or bleeding, and most of them had not tried cheaper alternatives. See Emily R. Cox et Al., "Prescribing COX-2s for Patients New to Cyclo-oxygenase Inhibition Therapy," *American Journal of Managed Care*, Vol. 9, No. 11, pp. 735-42, November 2003. A separate study found that seniors with generous drug coverage but moderate risk of gastrointestinal problems were more likely to be on a COX-2 inhibitor than seniors with high gastrointestinal risk but no drug coverage. See Jalpa A. Doshi, Nicole Brandt and Bruce Stuart, "The Impact of Drug Coverage on COX-2 Inhibitor Use In Medicare," *Health Affairs*, Web Exclusive W4-94, February 18, 2004.

With HSAs, people will not spend a dollar on health care services unless they get a dollar's worth of value. In this respect, HSAs greatly improve patients' incentives. If there is a problem, however, it is that the law is too rigid — requiring an across-the-board deductible for all services, other than preventive services. The answer to the critics is to allow plans to create high deductibles where the exercise of patient discretion is both possible and desirable and create low deductibles where discretion is not possible or, in any event, not desirable.

How do patients react when they are asked to manage their own health care dollars? We actually have far more experience with consumer-directed health care than many scholars realize. For example, we have more than a decade of experience with Medical Savings Accounts (MSAs) in South Africa, and in this country seven years experience with the MSA pilot program, four years of experience with Health Reimbursement Arrangements (HRAs) and two and a half years with HSAs. The problem is: the data mainly resides with insurers who regard it as proprietary and, therefore, the results are reported by entities with a financial self-interest in the outcomes.

Even so, reported results of MSAs in South Africa (Discovery Health)[12] and HRAs in the United States (Aetna)[13] are consistent with common sense. Patients cut back in areas where there is presumed to be a lot of waste and substitute less expensive treatment options for more expensive ones. That is, there are fewer trips to primary care physicians; brand-name drug purchases are down; generic purchases are up, etc. These findings were also evident in an Employee Benefit Research Institute study.[14] Consumers were more cost-conscious — about one-third of consumers with high-deductible or consumer-driven health plans avoided or delayed seeking care.

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[12] Matisonn, "Medical Savings Accounts in South Africa."

[13] "Aetna HealthFund First-Year Results Validate Positive Impact of Health Care Consumerism," Press Release, Aetna, June 24, 2004.

[14] Paul Fronstin, and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute, Issue Brief No. 288, December 2005.

A McKinsey study (based on a year's experience with HSAs) found that CDHC patients were twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option. Further, chronic patients were 20 percent more likely to follow treatment regimes very carefully.[15] A South African study suggests that CDHC patients can control drug costs as well as managed care, but without the cost of managed care.[16]

Early critics of CDHC worried adverse selection of young, healthy workers would destroy traditional risk pools. Yet there is no evidence that CDHC attracted disproportionate numbers of young people. When adjusted for retirees who were not eligible, a recent GAO report of government workers found those joining CDHC plans were about the same age as enrolling in more traditional plans.[17] Two additional GAO reports came to similar conclusions.[18] A recent survey by the health insurance industry trade group found adult enrollees evenly distributed with nearly one-quarter between the age of 40 and 49 and one quarter above that age group and one-quarter below.[19]

Assurant Health (formerly Fortis) reported on its enrollees with health savings accounts in 2005. It found:[20]

- Nearly one-third (30 percent) had less than $50,000 annually in family income.
- About 44 percent had previously been uninsured shortly before obtaining an HSA.

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[15] "Consumer-Directed Health Plan Report – Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[16] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002.

[17] GAO, "Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan," U.S. Government Accountability Office, Publication GAO-06-143, November 2005.

[18] GAO, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," US Government Accountability Office, Publication GAO-06-271, January 2006; GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," US Government Accountability Office, Publication GAO-06-798, August 2006.

[19] Hannah Yoo and Teresa Chovan, "January 2006 Census Shows 3.2 Million People Covered By HSA Plans," America's Health Insurance Plans, AHIP Center for Policy and Research, 2006.

[20] "Who's Taking Advantage of Health Savings Accounts (HSAs)? Who's Taking Advantage of Health Savings Accounts (HSAs)?" Assurant Health Quick Facts, 2006. Available. Internet. http://www.assuranthealth.com/corp/ah/AboutAssurantHealth/HSAFactSheet.htm. Accessed September 22, 2006.

- More than half (61 percent) were older than age 40.
- More than two-thirds (69 percent) were families with children.

The results on enrollee satisfaction have been mixed. A recent GAO report found strong satisfaction[21] as did reports by Lumenos[22] and Aetna.[23] However, reports by McKinsey and EBRI reported lower satisfaction than those enrolled in traditional health plans.[24] It's not clear what this means. A study in the *Annuals of Internal Medicine* found satisfactions is not related to quality.[25] In fact, this phenomenon is not uncommon among consumer goods. Satisfaction is generally more closely related to good communication and met expectations.[26] Moreover, surveys where enrollees rate their CDHP lower than managed care may be sampling unrepresentative enrollees or people who perceived they've lost benefits when switched to a full-replacement CDHC plan.[27] Or it may point to the need to have better consumer education and about the merits and uses of the plans in addition to greater price transparency.[28]

What about preventive care? McKinsey, Aetna, National Center for Policy Analysis (Discovery Health) and Humana[29] all report an increase in preventive care — even as they report

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[21] GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," US Government Accountability Office, Publication GAO-06-798, August 2006.

[22] "Survey Reveals Lumenos Customers More Satisfied than Members of Traditional Health Plans," Press Release, Lumenos, 2004.

[23] About 90 percent of enrollees said plan met expectations and would enroll again. See "Aetna HealthFund Fact Sheet," Aetna, 2006. Available at http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_factsheet.html. Accessed September 22, 2006.

[24] Paul Fronstin, and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute, Issue Brief No. 288, December 2005. "Consumer-Directed Health Plan Report – Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[25] John T. Chang, "Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care," *Annals of Internal Medicine*, Vol. 144, No. 9, May 2, 2006.

[26] Holman W. Jenkins, "No, Consumer Theory Isn't a Cure-all for Health Care," *Wall Street Journal*, September 20, 2006.

[27] Devon Herrick, "Experts Doubt Survey Findings on Health Plan Owners' Satisfaction," *Health Care News*, February 1, 2006.

[28] "Brokers Predict Massive Change: Results from the 2006 NAHU/Chapter House Benefit Buying Trends Study," National Association of Health Underwriters/Charter House, 2006.

[29] "Healthcare Consumers: Passive or Active?" Humana, June 28, 2005.

other, significant cost-reducing changes in patient behavior. Note, however, that many CDHC plans contain extra incentives to seek and obtain preventive care. Discovery Health tried to determine whether skimping on care in the short run caused higher costs in later years and found no evidence to support the claim.[30]

Creating Opportunities for the Chronically Ill[31]

The chronically ill are responsible for an enormous amount of health care spending. In fact, almost half of all health care dollars are spent on patients with five chronic conditions (diabetes, heart disease, hypertension, asthma and mood disorders). This is where HSAs have the greatest potential to reduce costs and improve the quality of care.

Healthy people tend to interact with the health care system episodically. Once in awhile they go to the emergency room or take a prescription drug. On these occasions, they gain knowledge that improves their skills as medical consumers. But it may be several years before they use that knowledge again, by which time it may be obsolete.

The chronically ill are different. Their treatments are usually repetitive, requiring the same procedures, visits and/or medicines, week after week, year after year. Consequently, cost-saving discoveries by these patients are not one-time events. Rather, they pay off indefinitely. Suppose a diabetic patient learns how to cut the costs of her drugs in half, by comparing prices, shopping online, bulk buying, pill splitting or switching to a generic brand. Such a discovery could be financially very rewarding to a patient who must pay these costs out of pocket.

Numerous studies have found the chronically ill can reduce costs and improve quality by managing their own care. But health care management is difficult and time-consuming. So

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[30] Refuting the criticism that the reduction in spending reflects MSA holders' tendency to forgo appropriate health care would require a randomized longitudinal study with far more clinical data than is currently available. However, a comparison of catastrophic claims under the two different health plans did not show more catastrophic claims under the MSA plan than under the non-MSA plan. Apparently MSA-holders are not healthier as a group. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000

[31] John C. Goodman, "Making HSAs Better," National Center For Policy Analysis, Brief Analysis No. 518, June 30, 2005.

patients should reap both health rewards and financial rewards from making better decisions. Insurers should be able to create versatile HSA accounts for patients with differing chronic conditions. They should be able to adjust the accounts' funding to fit specific circumstances. A typical Type II diabetic, for example, might receive one level of HSA deposit from his employer; a typical asthmatic patient another.

The problem is: The HSA law requires employers to deposit the same amount to each employee's HSA account, irrespective of medical condition. This is a strange requirement because employers who give employees choices of health plans are risk-rating their premium payments whether they are aware of it or not. If the sickest employees all choose Plan B and the healthiest choose Plan A, then the employer will invariably pay more premiums per employee to Plan B. Although employers risk-rate their premium payments, they are not allowed to risk-rate HSA deposits.

HSA architect sees more opportunities

Benefits expected for chronically ill

By Matthew DoBias

***Modern Healthcare*: At what point did you realize that you had 'fathered' a 'child' that could change the healthcare industry?**

John Goodman: I first went to Capitol Hill to propose the idea of a savings account similar to an IRA for healthcare in 1990. At that time, only five members of Congress would agree to meet with me.

However, in 1994, the Republican Party was searching for an alternative for 'Hillary care.' Senator Phil Gramm (R-Texas) invited me to Washington and ushered me into a room with about 20 Republican senators. Senator Gramm said, 'This is John Goodman and he has the only new healthcare idea I've seen in over 20 years.' Republicans in the Senate developed an alternative bill, the core of which was a medical savings account. The idea was successful in helping defeat Hillary Clinton's healthcare plan, but it wasn't clear whether the idea would have a life of its own.

ANDREW HARNIK/AP PHOTO

Goodman: "The biggest surprise was the complete sea change in the way the idea was viewed by employers and insurers."

Later that year, the GOP took control of the Congress, but (medical savings accounts) MSAs, the precursor to HSAs, were not a part of it. It wasn't until 1996 that a pilot program for MSAs was enacted, thanks to a bipartisan effort led by Representative Bill Archer (R-Texas), then chairman of the House Ways & Means Committee. However, the pilot program was very limited, and insurers did not aggressively sell the product.

It wasn't until the Medicare drug benefit legislation in 2003 that it was apparent that HSAs' time had come. As of January 2004, HSAs became available for all the nonelderly population. Since then, their adoption rate has soared faster than any other financial product, including IRAs.

***MH*: At what point did you realize that you have become the 'father' of the 'child?'**

Goodman: After the MSA pilot program was under way, the *Wall Street Journal* gave me that title.

***MH*: Did your 'child' grow up the way you expected?**

Goodman: The biggest surprise was the complete sea change in the way the idea was viewed by employers and insurers. In the 1990s, all the big players in the employer and insurer communities were opposed to HSAs. But by the end of the decade, all those opponents became supporters. In 1990, no one could have predicted that development.

***MH*: What factors had a positive or negative influence on how your 'child' grew up?**

Goodman: After a 10-year experiment with managed care, many employers and insurers concluded that either managed care cannot work, or the political system will not allow it to work. Since we cannot use managed care to choose between healthcare and other uses of money, those that were worried about controlling healthcare costs concluded that employees must be allowed to make those choices on their own.

***MH*: What do you see as your 'child's' future?**

Goodman: HSAs will continue to be popular and will continue to meet

GOODMAN

the needs of patients. Yet, we are not fully taking advantage of them. The greatest opportunity is with the chronically ill. Healthy people tend to interact with the healthcare system episodically. Once in awhile they go to the emergency room or take a prescription drug. On these occasions, they gain knowledge that improves their skills as medical consumers. But it may be several years before they use that knowledge again, by which time it may be obsolete.

The chronically ill are different. Their treatments are usually repetitive, requiring the same procedures, visits and/or medicines, week after week, year after year. Consequently, cost-saving discoveries by these patients are not one-time events. Rather, they pay off indefinitely. ...

Numerous studies have found the chronically ill can reduce costs and improve quality by managing their own care. But healthcare management is difficult and time-consuming. So patients should reap both health rewards and financial rewards from making better decisions. Insurers should be able to create versatile HSA accounts for patients with differing chronic conditions. They should be able to adjust the accounts funding to fit specific circumstances. ...

Goodman: **"HSAs will continue to be popular and will continue to meet the needs of patients."**

Responses to Questions for the Record From Dr. John C. Goodman

Answers to Senator Hatch

Q: Some suggest that employees are paying more out-of-pocket with these HSA plans, but do these estimates need to take into account the premium costs that employers are increasingly passing along to workers because of the unsustainable increases in premium rates with traditional plans? Does our employer-based health care system make it easier for critics of HSAs to contend that Americans will pay more under these plans?

A: Ultimately, workers "pay" for all their health benefits in the sense that they are an alternative to wages. Employers will tend to provide their employees with generous compensation packages, so they will not lose out in competition for labor. The result is a lower compensation package with more generous health benefits.

It is common to hear about employers "shifting costs" to employees, but there really is no such shift. The compensation package adjusts through time as employees and their employers adjust to increasing health costs and other market conditions.

In general, there has been a trend in recent years toward more direct, out-of-pocket payments by employees (greater share of the premium, higher deductibles, higher co-payments, etc.). The switch from conventional insurance to HSA plans usually results in less out-of-pocket spending by employees — and this is true for the sickest employees as well as the healthiest.

Q: Could you explain for me how some scholars conclude that the availability of HSAs will lead to a decline in the number insured? Is there any evidence for these conclusions?

A: Critics who claim HSA plans will lead to fewer people being insured are relying on idle speculation (and in one case, a faulty model) instead of looking directly at the evidence. Not only are HSA plans attracting the previously uninsured because they offer better value than traditional insurance, the HSA option appears to be a much more powerful weapon for spreading insurance than either tax deductions or tax credits.

Q: Would a cash-for-service system provide some benefits to lower-income workers who would have less need for working with a cumbersome health care bureaucracy?

A: Moving to a more competitive cash-for-service system would eliminate much of the bureaucracy that can be a barrier to timely care. Cash-for-service would benefit everyone, not just lower income patients. As competition for service spreads, patients will pick the most cost-effective treatments. This creates the added benefit of driving up quality as providers compete for their patient's business.

Q: Why should high-deductible health care be any different from other high-deductible forms of insurance?

A: The short answer is: health insurance shouldn't be different. While any high-deductible policy incurs risk to the policy holder, in many cases the policy holder prefers to play the odds that they won't get sick. In truth, for healthy individuals, it makes more economic sense to pay a lower premium. The additional benefit of having more choice in their health care decisions leads many chronic patients to high-deductible plans, as well. Each patient has to assess their own needs against their willingness to pay for health insurance.

Q: To increase the number of HSAs among HSA-eligible individuals, should we consider authorizing automatic enrollment in an HSA as the default option when one elects an HSA-eligible plan?

A: I have no problem with the practice of automatic enrollment in HSA plans as a default option. HSA plans may not be ideal for everybody. Some may prefer an HMO. Automatic enrollment would not mean they have to stick with an HSA plan. But plans that empower employees are likely to do a better job of meeting patient needs, on the average.

Q: A recent study suggested both that HSAs are being used as tax-shelters by wealthy Americans and that by increasing the contribution limit, Congress would actually increase health expenditures. Are these conclusions at odds with one another? Moreover, does the suggestion that increased contribution limits will lead to an increase in expenditures mistakenly assume that the behavior of HSA owners will parallel that of FSA owners?

A: The study has it backwards. Through the tax system, we are lavishly subsidizing the Cadillac plans of the highest paid workers while providing very skimpy tax subsidies to the lowest paid workers.

Many higher-income workers have first-dollar coverage for virtually every medical expense. Under such plans, they have an incentive to over-consume health care — through unnecessary doctor visits, unnecessary tests, wasteful purchases of brand-name drugs, etc. And taxpayers subsidize up to one-half of all this wasteful spending.

With an HSA option, these workers are allowed to self-insure for many of their own medical expenses and manage their own health care dollars. Relative to first-dollar coverage, these HSA plans will almost certainly lead to a reduction in unnecessary care and when HSA dollars are eventually withdrawn and used for non-medical purposes, they will be taxed as ordinary income.

For the record, a much fairer way of encouraging health insurance (both third-party insurance and individual self-insurance through health accounts), is through fixed-sum, refundable tax

credits — giving the same dollar subsidy to every family.[1] But regardless of how we subsidize health insurance, third-party insurance and self-insurance need to trade against each other on a level tax playing field.

In contrast to HSAs (which encourage people to be prudent consumers of care), FSAs all too often encourage imprudent purchases. The reason: Unspent FSA funds are forfeited at year's end. To avoid such forfeits, people buy designer eyeglasses and make other purchases they would not have made if the funds were allowed to roll over to future periods.

Answers to Senator Rockefeller

Q: Do you have any concerns about employers having so much medical information, recognizing that there may be some employers who would use it in inappropriate ways?

A: I am concerned about employee privacy and about potential abuses of information by employers and insurers. However, my concern is an across-the-board concern, covering all forms of insurance. Health plans are increasingly getting involved in the health decisions of patients (e.g. prompting people to take certain drugs, alerting them to ways of reducing drug costs, etc.). Although the motivation is generally good and the outcomes are probably also good, there is always a potential for abuse.

Other things equal, HSAs give employees some measure of protection and insulation from third-party intrusions (much more so, for example, than being in an HMO).

The *Wall Street Journal* article was a good description of some of the growing pains involved when there is a switch to CDHC plans. However, the article focused too much on

[1] Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, Vol. 14, No. 1, Spring 1995, pp. 126-139.

the problems and not enough on the payoffs. It neglected to mention that the employees voted unanimously to keep their CDHC plans rather than return to traditional coverage.[2]

In fact, Nick Bond, the company owner interviewed for the article, contacted us through our consumer-driven health care website. His comments reiterate that the article missed the point:

"We are the subject of the recent article that is discussed above, originally published by the *Wall Street Journal.* I'm writing this to comment that we found the article that Sarah Rubenstein published to have missed the ultimate point, that being the conversion to a consumer driven high-deductible plan has worked. All the work that was discussed in the article was accurate (although it did not discuss the large amount of the work that our broker & his representatives helped with), but for our 2006 renewal, we had approx 5% reduction in our premiums and redirected this savings back in to the employees health savings accounts. This was the first time we had a reduction in 10 years and we presented the employees with several HSA plan choices and they chose an increase in plan deductible because of the premium savings available. We consider our conversion to HSA health plans a complete success."

Q: I would like to explore the argument that health savings accounts would drive down the costs of health care by having consumers be more price sensitive. Will the HSA model impose any pricing pressure on those patients who have already exceeded their deductible?

A: When patients face real prices, they cut back on unnecessary care and choose low-cost services over higher-cost services, other things equal. This is one way health care spending

[2] See Grace-Marie Turner, "The Rest of the Story," Galen Institute, October 12, 2006. Available at http://www.galen.org/ccbdocs.asp?docID=928. Accessed October 16, 2006.

is lowered. But far more important changes occur on the supply side. When walk-in clinics, RX.com and Wal-Mart compete on the basis of price and quality, patients experience cost reductions of 50 percent or more.

Moreover, the benefits of this type of competition are not confined to the relatively healthy. They also accrue to the chronic patients who spend most of the health care dollars. In fact, the overwhelming bulk of the benefits of this type of price and quality competition will be realized by the chronically ill. That said, the HSA laws need to be far more flexible if we are to realize the potential of HSAs for the chronically ill.

Finally (and this is a technical point), many HSA plans these days have co-payments above the deductible, exposing patients to monetary outlays even when total spending is $10,000 or more. So yes, there are often financial incentives long after the deductible is met.

In my opinion, however, these insurance designs are not ideal. There are better ways to create economic incentives for patients with high health care costs.[3]

Q: If the data are correct that 70% of costs are incurred by a small share of the total patient population, then is it realistic to expect that price pressure – if it actually happened – would affect more than one third of health care expenditures?

A: Yes it is. I believe we are on the verge of a radical transformation in the medical marketplace. In this new world, there will be a lot more self-management of care and significantly more price and quality competition.

The most radical changes will occur in the market for the chronically ill — where we will see centers of excellence competing for chronically ill patients (rather than trying to avoid them,

[3] John C. Goodman et al., "Ideal Health Insurance," in *Lives at Risk* (Dallas, Texas: National Center for Policy Analysis, 2004).

as so often happens today). Chronic patients will be able to get many needs met (at lower costs) by phone and e-mail, and in some cases, there will be off-site electronic monitoring. Electronic medical records will lead to higher quality, and patient education services will lead to better patient self-management of care. These transformations can be speeded along with better designed and more flexible HSAs.

Q: What tools do individuals have to be informed health care consumers? Is data available in any usable form?

A: Lack of transparency is a significant problem and is caused almost entirely by third-party payment of medical bills. In markets where there are no third-party payers (e.g. cosmetic surgery and lasik surgery), there is perfect price transparency and no medical inflation (i.e. real prices are dropping).

Transparency generated on the supply side will emerge as direct patient payment becomes more important in medical markets. Again, walk-in clinics, RX.com and Wal-Mart generic drug prices are all examples of a revolution in transparency that is well underway.

Currently, we are seeing an increase in usable price and quality data, but much of the needed information is held by the third-party insurance companies, who claim privacy issues keep them from releasing it.

Q: By encouraging so-called price transparency, don't we also run the risk of encouraging patients to forgo important medical tests or treatment that would ultimately lower their long-term health care costs?

A: Studies have shown HSA patients are able to reduce expenditures through eliminating unnecessary physician's visits, reducing drug purchases and ordering fewer diagnostic tests. However, there is no evidence that patients, on the average:

- Make short-run, money-saving decisions at the expense of long-term health care.
- Make decisions today that cause future health care costs to be higher.

These issues have been studied over many years in South Africa — which has had HSAs since the early 1990s.[4]

Answers to Senator Baucus

Q: Do you have any information other than AHIP's enrollee data to support your dismissal of GAO's findings (that HSAs are disproportionately selected by higher-income workers)?

A: The only sources we have seen that report the income of consumer-driven health care enrollees are from the GAO, Assurant, AHIP and the IRS. We know of no other surveys that asked for income of enrollees. The relevant comparison population is not people in general, but people with private insurance. In general, the higher one's income the more likely one is to be insured. Also, higher-income families tend to have more generous health plans and they get more generous tax subsidies from the government. This is true of all insurance — HMOs, PPOs, HSAs, etc.

Given this pattern, do HSA plans disproportionately attract higher-income families? Apparently not. When HSA enrollees are compared with enrollees in traditional plans (a comparison that has been made by a number of insurers in different contexts), the distribution of enrollees looks very much the same — by income, age, educational attainment and other factors.[5]

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[4] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002; Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000.

[5] A survey of its members by the insurance industry trade group, Americas Health Insurance Plans, found that nearly one-quarter of adults covered by high-deductible health plans are between the ages of 40-49. The proportion above

Q: Assuming other policy features are similar, does being smart about spending one's money not lead healthier consumers to choose higher deductible policies than their less healthy counterparts?

A: A number of comparisons have shown that enrollees in HSA plans are not, on average, significantly healthier than enrollees in traditional health insurance plans.[6] While it is true that a person who has no health expenses will gain financially from HSA enrollment, it is also typically true that most people with high health care costs also gain. This is because relative to a typical PPO plan, HSA plans tend to have lower limits on the total out-of-pocket exposure. (This is not because of any legal requirement; it is because of the way these plans are usually structured).

Answers to Senator Bunning

Q: Do you think opening HSAs to all Americans, regardless of age or health insurance status, would encourage more Americans to budget for their own health needs?

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and below that age group are roughly equal – with 27 percent between the age of 20 and 39 and 27 percent between the age of 50 and 60. See Hannah Yoo and Teresa Chovan (AHIP), "January 2006 Census Shows 3.2 Million People Covered By HSA Plans," Americas Health Insurance Plans, AHIP Center for Policy and Research, April 2006. Findings were similar for FEHBP plans. When retirees ineligible for Consumer Driven Health Care plans were excluded, the age of those enrolling in consumer-driven plans was very close to those in traditional plans. See U.S. Government Accountability Office, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans," GAO-06-798, August 2006; U.S. Government Accountability Office, "Federal Employees Health Benefits Program: First-Year with High-Deductible Health Plans Health Savings Accounts," United States Government Accountability Office, GAO-06-271, January 2006: U.S. Government Accountability Office "Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan," United States Government Accountability Office, GAO-06-144, November 2005. The health insurer Aetna reported similar findings after comparing four years worth of enrollee data.

[6] "Blue Cross and Blue Shield Association Consumer Survey Shows High Rate of Satisfaction with HSAs, Cites Increased Reliance on Decision-Support Tools" BlueCross BlueShield Association, September 2005; Paul Fronstin (EBRI) and Sara R. Collins (The Commonwealth Fund), "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute, Issue Brief No. 288, December 2005. For a discussion of why risk segmentation might occur under HSAs and why it is not as big a problem as critics might think, see Michael F. Cannon, "Health Savings Accounts: Do the Critics have a Point?" Cato Institute, Policy Analysis No. 569, May 30, 2006.

A: Yes, everyone should be allowed to open an HSA. Seniors should be allowed to set aside money to cover Medicare's coverage gaps. The uninsured should be able to save pre-tax money for medical expenses regardless of their lack of an insurance policy. Additionally, lifting the restrictions that tie HSAs to high-deductible policies would allow those under traditional insurance plans to save for future needs as well.

Q: Why is it important to the marketplace to facilitate consumer choice between health care spending and non-health care spending?

A: If no one chooses between health care and other types of spending, medical spending has the potential to crowd out all other spending, leaving no money for other goods and services. The system is likely to work better for patients if they make these decisions in consultation with their doctors. If not patients, the choices will have to be made by insurance companies, employers or the government. Patients will do better if they, rather than impersonal bureaucracies, make the (sometimes very difficult) choices.

Statement of Sen. Orrin G. Hatch
Chairman of the Subcommittee on Health Care,
Senate Finance Committee
Introductory Statement for Hearing on
"Health Savings Accounts: The Experience So Far"

September 26, 2006

I strongly believe that government should encourage—rather than stand in the way of—individual responsibility for critical decisions involving one's livelihood and economic choices. This freedom of opportunity is a core commitment of American democracy, and has led to a quality of life that our forebears may have anticipated, but would nonetheless have a difficult time comprehending. Facilitating these opportunities is usually preferable to an unwieldy, top-down government solution. The federal government does not always have the right answer or the appropriate solution for everyone, and all of us can admit that often times, the federal government's solutions are inflexible and unyielding.

That is the beauty of health care savings accounts, or HSAs. HSAs give individuals the ability to take responsibility for their health care needs. Who knows best – the federal government or the person needing the care? I believe the answer is fairly obvious.

I know that some are uncomfortable with the HSA approach but I believe that today's hearing will help answer many of the valid questions surrounding the details of HSAs.

Both our Subcommittee Ranking Minority Member, Senator Rockefeller and I want to take the time to address this important issue and ask relevant questions regarding HSAs. Senator Rockefeller, it is always a pleasure to chair a hearing with you at my side.

Often times in the Senate, it is difficult even to agree on the existence of a problem. That is not the case when it comes to our nation's health care system. Everybody in this institution understands the frustration of ordinary Americans, insured and uninsured, who have to navigate our health care system.

As is evident in the report released yesterday by the Citizens' Health Care Working Group, which I worked on with my good friend and Finance Committee colleague Senator Ron Wyden, Americans want an improved health care delivery system, with better access for those who cannot afford care. They are tired of insurance that is too expensive, benefits that are too difficult to decipher, a bureaucracy that many times lacks a human touch, and a system that is too unresponsive for a mobile twenty-first century workforce.

The administration believes -- and a number of our congressional colleagues and I concur -- that Health Savings Accounts are a part of the answer. By combining lower premiums with higher deductibles, they have the potential to make health care costs more manageable for individuals and for employers.

The idea is easy to grasp.

When individuals are more responsible for their own health care decisions, they will make better and more cost-conscious health care decisions. When someone else is paying the whole bill, there is no incentive to monitor one's spending. No wonder that the yearly premiums for traditional, first-dollar coverage have exploded. By making health care more affordable, these plans will provide moderately priced insurance to those who are currently uninsured or underinsured and reduce the nation's health care expenditures as well.

That is the theory.

Today, we hope to hear how these plans work in practice.

One thing seems certain to me. HSAs are here to stay. Their growth has been remarkable. They were only created in 2003 through the Medicare Modernization Act. I served as member of that House-Senate conference committee and to this day believe that the creation of HSAs was probably one of the important aspects of that legislation.

By March 2005, one million individuals were covered under HSA-eligible plans. Only nine months later, that number had grown to 3.2 million. Not only are individuals and small businesses turning toward HSAs, but some of the giants of American industry and retail are as well.

These plans appear to be gaining in popularity. They are definitely growing. And I think it is incumbent upon us to take the task of improving them seriously.

For me, just picking up the paper in the last few weeks confirms their promise and shows the way forward.

The GAO has released its latest in a series of studies, demonstrating that both HSA-eligible plans and high premium plans cover similar services, including preventive services, and that for many people there are substantial savings associated with participation in these plans.

The decision by some companies to offer almost 300 generic prescription drugs at $4 for a 30-day supply to those living in Tampa, Florida, is an important step in the right direction. Let us hope that this decision will be expanded to other parts of the country because it will have a significant impact for HSA participants who may have to pay for some prescription drugs out-of-pocket.

And yesterday's Wall Street Journal had two stories that provided a balanced vision of the future of consumer-driven health care.

The first was an account of one small-business' experience with HSAs. The bottom line is that the plan has been good for the bottom line—for both the employer and his employees. This story shows that we need to be careful to compare apples to apples in this debate.

For the employees at Russ Moore Transmission, the choice was no longer between paying more out-of-pocket with an HSA plan or sticking with the status quo of a low employee deductible and premiums paid for by the employer. Faced with a 29 percent premium increase to renew the traditional plan, employees were going to face out-of-pocket expenses one way or another. They could either accept the certain cost of increased premiums,

picking up this tab themselves to the tune of $165 a family each month, or, they could switch to a low-premium, HSA plan where they would be responsible for a higher deductible

The company transitioned to HSAs, saving the employees from these premium increases and even contributing to their yearly deductible. The evidence suggests both that there have been cost savings, and that employees have become cost conscious. But this transition has not been without struggles. Taking charge of one's health care decisions can be a jolt, and just as challenging for these new consumers is the shortage of available pricing information.

But in a related story that same day, the Journal reported that WellPoint, the nation's largest health insurer, at the encouragement of General Motors, has established a pilot program for the Dayton, Ohio area. They have created an internet tool that will allow health care consumers to compare the itemized cost for 40 common procedures at Dayton-area hospitals.

As more individuals and businesses elect HSA-eligible plans, I do not doubt that private consumer pressure will correct some plan deficiencies on their own.

At the same time, I believe that Congress has an opportunity to improve HSAs for those already participating in them.

HSAs are still in their infancy. The evidence is starting to come in, however, and our excellent panel should help us to navigate through some of these critical issues.

Statement on
Health Savings Accounts
Hearing before the
THE SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH
on behalf of the
U.S. CHAMBER OF COMMERCE
by
Joe Knight
September 26, 2006

Chairman Hatch and Ranking Member Rockefeller, members of the Subcommittee, I am Joe Knight, Chief Financial Officer and co-owner of Setpoint Companies, a small manufacturing firm comprised of six subdivisions: Setpoint Systems is our automated systems division, Setpoint Inc is our roller coaster division, Leanwerks a precision machining company, Setpoint Spectrometers, Rocky Mountain Testing Solutions, an environmental test lab, AutoPack, which was just purchased a few months ago and is a packaging automation company, selling tables to nutraceutical companies. I am also here on behalf of the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region. Over ninety-six percent of the Chamber members are small businesses with fewer than 100 employees. I am pleased to be able to submit the following testimony for the record and commend the Committee for holding this hearing and for its interest in the benefits of Health Savings Accounts.

Originally founded as Setpoint Engineered Systems in 1992, after initially operating out of a garage, the company has grown into an over $15 million per year business. Although our companies offer a range of products, they share our philosophical commitment to open book finance where all of our financial information is shared with our employees, and a "no surprises" way of doing business. We apply this philosophy to serve our customers both internally and externally. As CFO and one of the owners of Setpoint Systems, one of my most important duties is to attract and keep highly-qualified employees. It is the employees of Setpoint Systems that carry the banner of our company and maintain the level of customer service that allow us to effectively compete in the marketplace. We are one of the fastest growing companies in Utah, going from 20 employees in 2000 to 60 full and part time workers today. I am also pleased to tell you that our company was voted one of the Best Companies to Work for in the state by Utah Business Magazine. We were recognized by INC Magazine as one of the 500 fastest growing private companies in America (the Inc 500) and for four consecutive years we were in the Utah 100 ranking for the fastest growing companies in the state. We have grown this company without any outside investors. My partners and I grew this company with our own savings and sweat.

Setpoint is a high tech engineering company. Consequently, our average compensation is over $20.00/hours. We have many key professional employees in our organization. These types of employees expect health care, 401K, vacation and holiday benefits. Our strategy is to provide these benefits and match what large company employers offer in the area. This strategy has served us well because we have been able to attract top-notch engineering talent. We have always paid 100% of single coverage and 75% of family coverage for all of our full-time employees.

To recruit and keep the types of employees we need, we have to keep all of our benefits competitive. Starting in 2003, this became a serious challenge with our health care coverage. One member of our group had a wife with cancer and another has some serious health issues with a child. Unfortunately, in a small group like Setpoint's these issues can be a disaster for health coverage. In 2004, our PPO premiums went up over 20% with a higher deductible and co-pay. Then in 2005 we were hit with a 49% increase in our current plan. The 49% percent increase was devastating to our business because our health care cost was much higher than the large employers in our area. Consequently, even though we still would cover these higher premiums and lose profit, the employee portion of the health care and level of coverage was not competitive and we had trouble recruiting talent. In some cases, we had to offer above market salaries to compensate for our health care plan.

After considering the options for the 2004 plan, my agent informed me about the new Health Savings Account (HSA) High Deductible Health Plan alternative. After looking at this option we found that we could offer plans with a deductible of $3,500 for singles and $7,000 for a family plan to our employees through United HealthGroup. These plans would have slightly lower premiums than our PPO plan before the 49% increase and would cover 100% of preventive medicine. I am a finance guy so I went to work comparing our options using a spreadsheet. After modeling single and family medical needs and considering several different scenarios, I was surprised to find that the HSA option was far better financially for my people, even for my employees with medical situations.

We rolled out the new plan with a lot of education because initially some of my employees were skeptical. Now that we are nearly through our second year with an HSA, everyone is happy with the change. As an employer, we were able to save money on the plan and contribute $1,200 a year to each employee's HSA for families and $600 per year for singles. For 2006, we were able to offer our employees two different family plans: one with a $7,000 deductible and one with a $4,000 deductible plan. Given our group situation, our premiums are still very high but the HSA has made it much easier to recruit and keep our employees.

On a personal note, I have been very pleased with this new type of coverage. I have 7 children. Consequently, my wife is a good budgeter and is very careful with our money. The HSA has made my wife a real shopper when it comes to health care. When we needed a small surgery for one of my children, my wife shopped for the doctors and the cost that she was comfortable with. She is able to save on our health care costs by

managing our use. Whether it's finding the right doctor or asking for generic medication when possible, she is in control of our spending with the HSA. If the doctors are aware that you have an HSA and will be paying cash for services, we have found they will offer a cash discount. I think this new type of plan is putting decision making back into the hands of the consumer, which will lead to more prudent utilization and ultimately help to control increasing health care costs.

Both my employees and I are delighted with the Health Savings Accounts that allow us to benefit from our health care spending decisions with the use of pretax dollars. The health plans that are paired with these HSAs put the consumer in charge of how he or she may elect to spend their health care dollars. Any money remaining in the account accrues and accumulates year after year and employees can take the account and money in it with them to a new job or if they retire. I understand that United HealthGroup, the company that provides Setpoint's plan and the nation's largest purveyor of HSA-compatible insurance, has over 8,435 HSA-style accounts in Utah and a nationwide total of 786,047 HSA account membership.

On behalf of Setpoint Systems and our employees, I would like to thank this committee for the work you have done on enacting this legislation into law and considering possible improvements. Having Health Savings Accounts as a viable health care option has allowed Setpoint to curb the increases in our health care premiums, while enhancing our ability to hire and retain employees.

While my employees and my family are very satisfied with the HSA-compatible health plan, I would like to take this opportunity to thank members of this Committee for working with the U.S. Chamber and the HSA Working Group to introduce legislation that will improve HSAs and to offer some suggestions to further strengthen the current law. This broad range of potential improvements to HSAs will make them more attractive to both consumers and employers including:

- Increase the amounts individuals and employers may contribute to HSAs –
    - Allow HSA participants to set aside more funds on a tax-free basis for their current and future health care needs. HSA participants should be able to contribute up to the out-of-pocket spending limits for their HSA-eligible high deductible health coverage – limited by statute to no more than $5,450 for family coverage and $2,700 for individual coverage in 2006;

- Allow employees with HSAs to also participate in other tax-favored health care accounts such as health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs);

- Require the Treasury Department to provide earlier inflation indexing of statutory annual deductible, out-of-pocket and contribution limit amounts;

- Allow employers to contribute higher amounts to HSAs for their lower-paid employees;

- Permit individuals over age 65 who are still working to continue to contribute to their HSAs;

- Allow early retirees to pay for their health insurance needs on a tax-free basis with funds from their HSAs, and;

- Allow a prescription drug plan to be offered alongside an HDHP and HSA without being subjected to the high deductible.

Giving individuals more direct control over their health care dollars will encourage more prudent use of health care services, will help make the health care system more responsive to consumers' needs and will improve access to health coverage for the uninsured. I believe that these new Health Savings Accounts represent the most positive health care legislation for small businesses in 20 years. After experiencing this plan for nearly two years as a business owner and plan member, I am convinced that the Health Savings Account/High Deductible Health Plan pairing is the best way to manage our out of control health care costs. It is a great way to give the power of choice back to the consumer of medical care while still protecting them from the serious consequences of major medical problems.

As a small business owner, I look to you to continue to protect our ability to be competitive and create jobs by solving one of our biggest challenges. Certainly, the Health Savings Account is a tremendous step in the right direction. Please expand and improve this offering to make it stronger. Finally, consider my plight as a small employer that can be decimated when one or two of my employees have medical problems. There must be a way to resolve that problem as well.

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SETPOINT

Responses to Questions for the Record From Joseph V. Knight
October 18, 2006

Senator Hatch:

1. *Critics suggest that HSA's are difficult to navigate for small businesses. Do you believe this to be the case?* No. However it does take some education to understand how the HSA works. I think this will get better as the industry gets familiar with this new offering. My agent has improved greatly in his ability to explain and work with us on this plan during these last two years.

2. *Employees were resistant at first to transitioning to these plans, and that you rolled out the new plan with a lot of education. Was your insurance provider helpful in educating your employees during this transition?* Our insurance broker was accessible to our employees during this time. While they were accessible, they helped very little with education. This first year we were on the plan, our carrier's web site did not help much either. Now in our second year the web site is really improved and has become a valuable tool for our employees to check their accounts and control their costs.

3. *What types of materials and educational opportunities did they provide you and your employees, and did this effort reach out and explain this new coverage include education of spouses?* Our broker came during business hours and held a meeting for all employees on the HSA/HDHP plan. He handed out an explanation of benefits document. There was also an after hours meeting to discuss HSA's for spouses that we sponsored on our own. We provided them with financial models showing the savings our employees would receive by switching to an HSA/HDHP plan. This education process has turned out to be a critical part of making our HSA offering successful.

4. *Have all of your HSA-eligible participants opened an HSA?* Yes. Since we put money into the HSAs, everyone has opened an account. We also added a matching function; our employees could either elect to have a greater employer contribution to the HDHP's premium or have matching funds put in their HSA. For the employees that took the matching option, we put $1,800 into their HSA account for families, provided they contributed at a minimum $600 toward their HSA. For those who elected to enroll in the high deductible health plan with the $4,000 deductible, with employer contribution and matching their HSA account has $2,400 in it, which covers most of their deductable.

5. *Are your contributions to HSA's matching or automatic contributions?* Both. When we rolled out the HSA for 2005, we were concerned with the high deductible plan. Because of this, in January of 2005 we made a year's worth of contributions to all employees on the HSA/HDHP option at that time. This contribution amount varied according to family

or individual status. For 2005, that was an automatic contribution. For 2006, we have a dual option plan. The employee can either choose an automatic contribution or a matching contribution, which is made monthly.

6. *Are they paid month-to-month or are they a lump sum?* In 2005, it was a lump sum payment. In 2006, they were paid on a month-to-month basis.

Senator Baucus:

1. *To what extent do you think the success is attributable to the tax-favored treatment of HSA's?* It helps encourage savings. I think many of our employees see the HSA as an opportunity to save more money. It becomes a type of a 'forced savings' program. We also offer our employees a 'safe harbor' 401K where we match 4% on contributions for an employee contribution of 5% vested immediately. With the HSA and the 401K-plan we offer, we believe that we have provided a great opportunity for our employees to save and plan for the future with tax deferred and/or tax free dollars.

2. *How many of your workers are at an income level where they have no income tax liability anyway?* Since we don't know our employees full tax situation, it is difficult to answer this question. As far as employees in the zero percent tax bracket, we have only 1 that we are aware of.

Senator Rockefeller:

1. *Do you share this employer's concerns about having so much information about your employee's health problems?* No, due to HIPPA laws our employees do not contact us regarding their health problems. They contact their doctor or our insurance broker, who is HIPPA certified.

   This WSJ article is very troubling to me. I know several business owners and don't know any that would get so involved with their employee's health issues. In my opinion, this article is not based in reality. There are so many problems beyond HIPPA that would preclude me from getting involved in my employee's health care, first and foremost is personal privacy. I knew about a couple of serious issues in my group because employees were missing time and needed our support while they were dealing with their family health issues. My employee who lost a wife to cancer this year was allowed to work from home for a time to get through a tough time. I have never been involved in any way in personal health choices of my employees.

   The one real problem we face with small businesses is the fact that we are underwritten as a small group. That means these serious health issues can cause incredible increases to our premiums. In Utah if my group has health problems, we can have rates that are 85% higher than the normal base rate a carrier offers. HSA/HDHP option or not, this can make our health care costs skyrocket while a competitor down the road or in another county can have a huge cost advantage over us. I figured that due to the problems in our group our annual costs were nearly $300,000 higher than the normal rates would have been. For a small business, that cost disadvantage can be devastating. One thing the HSA/HDHP did

do is lower our cost ratio relative to premiums. It is true that a small employer is punished in this way for having employees with health problems on the payroll. The HSA/HDHP option helps with this problem but because of the nature of insurance does not, and cannot be expected to, solve it.

2. *Have your employees expected you to help them make medical choices?* Again, the answer is no. Our employees have a network of doctors with whom they communicate their health concerns. Our agent handles any health related questions. Any questions related to coverage or specific issues are referred to him.

3. *Can you tell me how much each of your employees contributed to their HSA's last year?* I sent an excel spreadsheet to be included with this document.

4. *Did those employees with catastrophic health events meet their deductibles?* Yes

5. *Based on your knowledge, did any of those employees have trouble meeting their deductibles?* No.

6. *Please also tell me how many of your employees have gotten all of their benefit requests honored over the last two years?* Because of HIPPA, I can not fully answer this question. As far as I know they have had their benefit requests honored.

7. *Have there been any benefit disputes?* Again, because of HIPPA laws I can not properly answer this question. However, as far as I know there are not any unresolved issues.

Name	Employee Contribution 2005*	Employer Contribution 2005	Total 2005 HSA Contributions	Employee Contribution thru 9/30/2006*	Employer Contribution thru 9/30/2006	Total 2006 HSA Contributions	
Deleted	4,050.00	900.00	$ 4,950.00	3,325.00	747.50	$ 4,072.50	
Deleted	-	-	$ -	300.00	747.50	$ 1,047.50	
Deleted		1,200.00	$ 1,200.00	-	650.00	$ 650.00	
Deleted	1,950.00	1,200.00	$ 3,150.00	1,425.00	650.00	$ 2,075.00	
Deleted	1,200.00	1,100.00	$ 2,300.00	-	-	$ -	No longer at Setpoint
Deleted	-	-	$ -	285.00	520.00	$ 805.00	
Deleted	4,050.00	1,200.00	$ 5,250.00			$ -	No longer at Setpoint
Deleted	1,375.00	900.00	$ 2,275.00	468.75	517.50	$ 986.25	
Deleted	-	900.00	$ 900.00	-	487.50	$ 487.50	
Deleted	-	1,200.00	$ 1,200.00	380.00	747.50	$ 1,127.50	
Deleted	1,140.00	1,200.00	$ 2,340.00	1,140.00	625.00	$ 1,765.00	
Deleted	100.00	-	$ 100.00	-	650.00	$ 650.00	
Deleted	-	600.00	$ 600.00	45.00	120.00	$ 165.00	
Deleted	4,050.00	1,200.00	$ 5,250.00	1,900.00	1,137.50	$ 3,037.50	
Deleted	-	900.00	$ 900.00	380.00	747.50	$ 1,127.50	
Deleted	4,050.00	1,200.00	$ 5,250.00	-	650.00	$ 650.00	
Deleted	-	900.00	$ 900.00	-	-	$ -	No longer at Setpoint
Deleted	1,300.00	1,200.00	$ 2,500.00	-	-	$ -	No longer at Setpoint
Deleted	-	1,200.00	$ 1,200.00	712.50	1,137.50	$ 1,850.00	
Deleted	-	650.00	$ 650.00	1,012.50	1,137.50	$ 2,150.00	
Deleted	1,400.00	1,200.00	$ 2,600.00	1,900.00	1,137.50	$ 3,037.50	
Deleted	-	-	$ -	135.00	360.00	$ 495.00	
Deleted	-	-	$ -	337.50	787.50	$ 1,125.00	
Deleted	-	600.00	$ 600.00	502.50	957.50	$ 1,460.00	
Deleted	-	1,200.00	$ 1,200.00	562.50	1,137.50	$ 1,700.00	
Deleted	-	-	$ -	-	75.00	$ 75.00	
Deleted	200.00	-	$ 200.00	712.50	1,137.50	$ 1,850.00	
Deleted	1,300.00	900.00	$ 2,200.00	675.00	520.00	$ 1,195.00	
Deleted	-	1,200.00	$ 1,200.00	-	900.00	$ 900.00	
Deleted	-	1,200.00	$ 1,200.00	712.50	1,137.50	$ 1,850.00	
Deleted	-	1,200.00	$ 1,200.00	-	650.00	$ 650.00	
Deleted	325.00	900.00	$ 1,225.00	285.00	520.00	$ 805.00	
Deleted	600.00	600.00	$ 1,200.00	950.00	520.00	$ 1,470.00	
Deleted	750.00	1,200.00	$ 1,950.00	-	-	$ -	No longer at Setpoint
Totals	**$ 27,840.00**	**$ 27,850.00**	**$ 55,690.00**	**$ 18,146.25**	**$ 21,112.50**	**$ 39,258.75**	

*All totals are deductions made through payroll. If an employee made a contribution on their own we would have no way of knowing.

Senate Finance Subcommittee Hearing
"Health Savings Accounts: The Experience So Far"
Written Statement of Senator John D. Rockefeller IV
September 26, 2006

Health insurance makes a substantial difference in the amount and kind of health care people are able to obtain. The consequences of not getting needed medical care are not trivial and can result in unnecessary hospitalizations and serious health problems, not to mention the effect it can have on a person's or a family's finances.

According to the Census Bureau, over 46 million Americans were uninsured in 2005, including 8.3 million children. Even more troubling, the number of uninsured children increased last year for the first time since 1998. The weak economy, unemployment and the increasing cost of health care all made it harder last year for American workers and their families to retain affordable, comprehensive health insurance coverage.

The growing uninsured problem in this country deserves immediate attention by Congress, if not this last week of session, then when we return. We should get started before the recess for the year. Unfortunately, I do not believe Health Savings Accounts (HSAs) are the answer, and I remain concerned that these tax-preferred accounts continue to be pushed by the Administration as a meaningful health insurance option.

We know that the majority of uninsured Americans are in working families with low to moderate incomes. Recent research indicates that 71 percent of the uninsured are in a 10 percent or lower income tax bracket and more than half (55%) of the uninsured have no income tax liability at all. This means they would benefit very little from health savings accounts. According to the GAO, the vast majority of people who purchase HSA policies are healthy, affluent workers – with an average adjusted gross income of $133,000 in 2004. That's not the average citizen from West Virginia, Utah, Iowa or Montana. These individuals are betting on not getting sick, and they are using their HSAs primarily as a tax shelter.

Furthermore, the use of HSAs could significantly undermine the employer-based insurance system on which most people (60 percent of workers) rely. As healthier and more affluent workers shift to HSAs, older and sicker workers will be left in traditional employer-sponsored policies. This type of adverse selection will drive up premiums for traditional employer-based coverage, further encouraging firms to provide less desirable coverage or to drop health coverage altogether.

Indeed some research has even concluded that if the savings limits for HSAs were increased, they would also undermine employer provided *retirement* savings programs. This perverse incentive would be dangerous. As small business owners have the option of saving more money, tax preferred, in an HSA, they would have less incentive to provide 401(k) accounts to their employees. We need to do more to encourage small businesses to provide retirement and health care benefits.

Our experience with the Trade Adjustment Assistance Health Care Tax Credit is instructive regarding the limitations of trying to use the tax code to expand coverage. Even with a tax break, health insurance is still too expensive for many, if not most, people to purchase, and therefore the take-up rate on the Health Care Tax Credit has been very low. I believe that HSAs present the same problems. Many people will not be able to afford health insurance in the private market even if they receive some tax subsidy.

Finally, a note about the ability of HSAs to encourage consumer responsibility. Patients generally lack both the medical expertise and complete information about costs and quality that would be necessary to "comparison shop" as we are accustomed to doing for other goods or services. What patients are doing instead is cost avoidance. Many HSA enrollees are avoiding needed care because they cannot afford the high deductibles. And, anyone who knows anything about healthcare knows that this will lead to greater costs to our health care system down the road.

If the current purchasers of HSAs would not recommend these plans to people who have chronic conditions, have children, are on medication management, or cannot afford the high-deductible, then why should we with a strong tax advantage? These are the characteristics of most uninsured Americans. We must find a better solution to address this growing problem, one that helps the majority of the uninsured instead of a privileged few. I am eager to learn more about the experience so far; I think it tells us a lot about we should and shouldn't do.

I look forward to the testimony of all the witnesses here today. I also ask unanimous consent that a statement from one of my constituents, Mr. Timothy S. Millne, be added to the Record. I thank the Chair.

COMMUNICATIONS

Statement of the
Coalition to Promote Choice for Seniors

Before the
Senate Finance Committee
Subcommittee on Health Care

"Health Savings Accounts: The Experience So Far."
September 26, 2006

Chairman Hatch, Ranking Member Rockefeller and distinguished Committee members:

The Coalition to Promote Choice for Seniors ("Medigap Coalition") appreciates the opportunity to submit this statement for the Committee's consideration during its hearing on health savings accounts ("HSA"). The Medigap Coalition is comprised of national employers and insurers committed to ensuring seniors' continued access to Medicare Supplement insurance coverage ("Medigap"). To that end, the Medigap Coalition supports policies -- such as the designation of Medigap premiums as HSA qualified medical expenses -- that promote seniors' ability to choose Medigap coverage for their health care needs.

Medigap's popularity among America's senior citizens is irrefutable. At least 10 million seniors, or one-in-four Medicare beneficiaries, currently rely on Medigap for protection against the out-of-pocket costs Medicare does not cover. In addition to the ability to budget their health care dollars, seniors enjoy the hassle-free, paperless delivery of benefits that Medigap provides. It is no wonder the Medigap Coalition found a 90% satisfaction rate among the Medigap policyholders it surveyed in 2005.

Despite its clear value, current law discourages consumers from using their HSA funds to purchase Medigap. As enacted, the Medicare Modernization Act defines HSA qualified medical expenses to include the cost of coverage provided under a qualified long-term care insurance contract and any health insurance *other than Medigap* provided to Medicare eligible beneficiaries. For instance, HSA withdrawals used to pay premiums for Medicare Advantage plans or employer-sponsored plans are permissible (i.e., not subject to taxation). Of all the health insurance options available, only HSA withdrawals used to fund Medigap premiums are subject to taxation.

The oft-stated goal of HSAs is to help individuals take more responsibility for their health care; an especially critical objective as Americans continue to enjoy longer lifespans (along with their accompanying health ailments). As Medicare covers less than approximately 50% of the medical costs seniors incur, Congress should encourage consumers to make appropriate arrangements to finance the difference. Congress should not discriminate between the types of health insurance coverage that HSA withdrawals may fund. Retaining this arbitrary exclusion punishes responsible consumers.

As the Committee considers future HSA adjustments, the Medigap Coalition respectfully urges its members to amend the definition of HSA qualified medical expenses to include Medigap premiums. To do so would be consistent with the Administration's efforts to offer seniors as many choices for their health care as possible, could make HSAs more attractive to all consumers before they reach their Medicare eligibility (which also could reduce the number of underinsured Americans), would encourage consumers to plan adequately for their future health care needs, and, most importantly, would assure that seniors can afford needed health care services. Removing the current exclusion is a simple yet essential remedy that our seniors deserve and a free market economy demands.

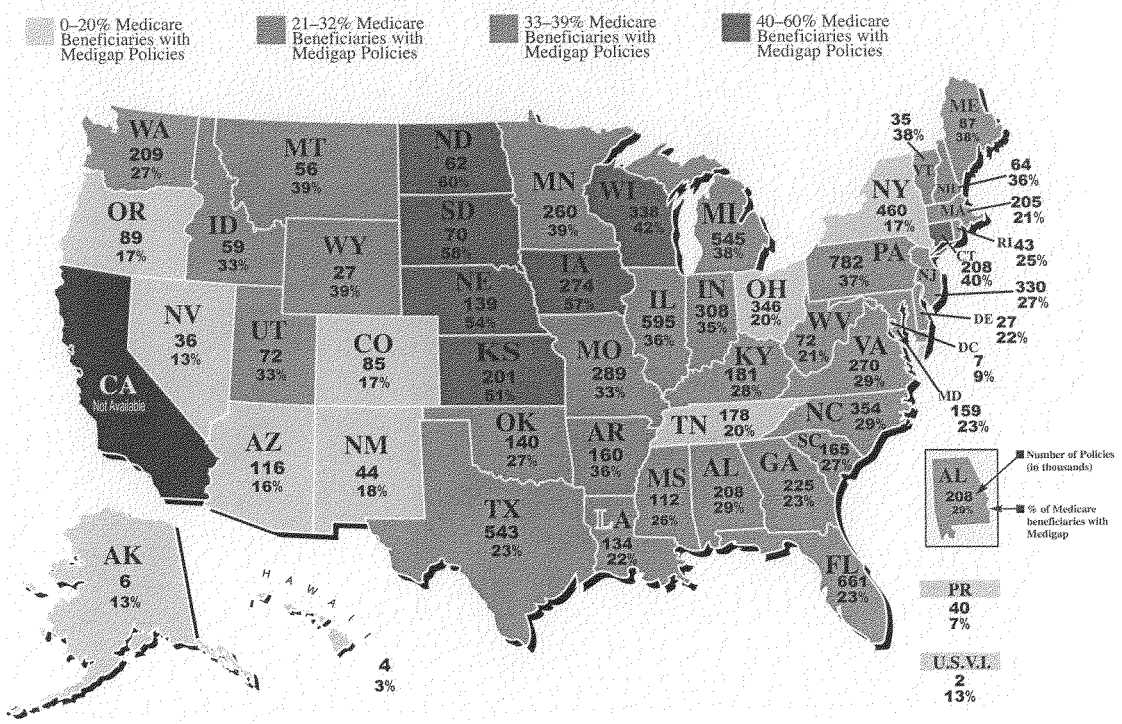
The Medigap Coalition appreciates the Committee's consideration of its statement and stands ready to assist in this important endeavor.

Attachment:
Medigap Market Penetration Map

Market Penetration of Medigap in 2003

10.5 million Medicare Beneficiaries (26%) have Medigap Policies Nationwide

AHIP
America's Health Insurance Plans



Source: National Association of Insurance Commissioners October, 2004

Comments to the Senate Finance Committee,

Subcommittee on Healthcare

Regarding the September 26, 2006 Hearing on Health Savings Accounts

By Scott A. Sinder

on behalf of

The Council of Insurance Agents + Brokers

September 26, 2006

On behalf of the Council of Insurance Agents and Brokers (The Council), thank you Chairman Hatch, Ranking Member Rockefeller, and members of the subcommittee for this opportunity to submit comments regarding Health Savings Accounts (HSAs).

The Council has a unique role in the health insurance marketplace. Operating both nationally and internationally, Council members conduct business in more than 3,000 locations, employ more than 120,000 people, and annually place more than 80 percent – well over $200 billion – of all U.S. insurance products and services protecting business, industry, government and the public at-large, in addition to administering billions of dollars in employee benefits. Since 1913, The Council has worked in the best interests of its members, securing innovative solutions and creating new market opportunities at home and abroad. Towards this end, The Council is a strong supporter of HSAs as an option in the health insurance marketplace and actively works to encourage its utilization in a variety of means. These efforts include The Council's membership in the steering committee for the HSA Working Group, a coalition that supports legislative and regulatory improvements to increase accessibility and the long-term viability of health insurance products, like HSAs.

To date, HSAs already have demonstrated success in the marketplace. According to a recent survey by America's Health Insurance Plans (AHIP), over 3 million people were covered by an HSA-qualified high-deductible health plan as of January of this year – more than triple the HSA/High Deductible Health Plan enrollment of approximately one million that was reported by AHIP a year ago.[1] Further, 31 percent of HSA-qualified policies sold in the individual market were purchased by individuals who were previously uninsured, and in the small group market, 33 percent of businesses who have HSA-qualified high-deductible policies previously did not offer coverage to their workers.[2] The study also found that HSA policies were purchased by all age groups.[3]

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1 *America's Health Insurance Plans, Center for Policy and Research*, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans," March 3, 2006, at http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf.

2 *Id.*

3 *Id.*

The Council also conducts a benefits market survey twice a year, in the Spring and in the Fall, to track trends in the benefits marketplace. As employers seek other ways to control costs, the high-deductible health plan (HDHP), coupled with an HSA, is increasingly being added as a coverage option. Sixty-eight percent of the respondents said they had sold a HDHP/HSA plan for either 2006 or 2007. The survey also showed that roughly one-third of employers who contribute to employee HSAs offer between $250 and $499, with 18 percent offering $500 to $749 and 17 percent contributing $750 to $1,000. Interestingly, the survey did not find the size of company to be a factor in the appeal of HDHP/HSA plan options, with small, medium, and large accounts implementing the option at roughly the same rate. Four questions taken from the Spring 2006 survey are attached at the bottom of these comments.

While this arc of success is promising, certain adjustments to the current HSA rules could help encourage more employers to offer this new health plan design and encourage more employees to select HSAs. For these reasons, The Council proposes the following additional improvements to the current rules for HSAs.

The Council's Proposed Modifications to Current HSA Rules

1. Align the HSA contribution limit and the health plan deductible for employees who enroll mid-year.

If an employee joins the high deductible health plan (HDHP) and HSA mid-year, current rules require the HSA contribution limit to be pro-rated, even though the employer may not prorate the deductible of the HDHP. This limitation creates a disincentive for new employees to elect the HSA when they start employment mid-year. This issue could be resolved by either: (a) allowing the full HSA contribution limit to be made consistent with the annual deductible of the HDHP; or (b) allowing employers to pro-rate the HDHP deductible to conform with the current requirements to pro-rate contributions.

2. Permit early adopters of Health Reimbursement Arrangements (HRA) to convert to HSAs

Many employers who were the early adopters of Health Reimbursement Arrangements ("HRAs") report that they would be more likely to offer HSAs if they were allowed a one-time opportunity to transfer individual HRA balances into HSAs. HRAs are very similar to HSAs, but are funded solely by employer contributions and HRA balances are often subject to forefeiture when an individual leaves employment. Allowing a one-time conversion opportunity would be enormously valuable for employees because the balances currently in HRAs would become employee-owned funds to which they could also contribute in the future and could keep as they change employment.

3. Permit individual family members to satisfy the individual deductible for HSAs ($1,050) rather than the family deductible ($2,100).

Most employer-sponsored health plans begin providing coverage as soon as a family member meets the individual deductible for the plan rather than the full family deductible. Current HSA guidance only allows this practice if the individual deductible is at least the minimum deductible for family coverage ($2,100). Allowing coverage to begin after a family member satisfies the individual deductible amount would help encourage more employees to elect HSAs for themselves and their families.

4. Allow an employer with an HSA to offer Flexible Spending Arrangements (FSAs) and/ or HRAs that could pay for benefits below the high deductible.

Many employers would like to combine HSAs with other similar health plan options, such as flexible spending arrangements (FSAs) and HRAs. Current rules significantly restrict the ability of employers and employees to efficiently use these other arrangements alongside HSAs. By permitting the use of FSAs and HRAs for health expenses below the deductible, many employees are likely to find HSAs more attractive for meeting both their current and future health care needs.

5. Permit early retirees to pay for health insurance coverage out of their HSA funds.

The HSA law permits retirees age 65 or older to pay their employer retiree health plan premiums out of funds from their HSAs. Allowing funds from HSAs to be used by retirees, regardless of their age, for retiree health plan purposes would be a sensible change that also could make HSAs more attractive to many individuals.

6. Permit an employee to contribute to an HSA even if his spouse has an FSA.

Currently an individual may not contribute to an HSA if his spouse has an FSA, even if the individual never seeks to be reimbursed for any medical expenses from the spouse's FSA. This situation could be easily corrected by allowing the individual in the HSA to certify that he will not receive reimbursement for any health expenses from his spouse's FSA.

7. Permit employees over age 65 to continue contributing to an HSA.

Active employees over age 65 are permitted to contribute to an HSA so long as the individual is not enrolled in Medicare. Individuals, however, are automatically enrolled in Medicare Part A (which covers hospital expenses) upon reaching age 65 even though their plan through their employer will typically continue to cover their medical expenses until they retire. Older workers who participate in HSAs should be allowed to continue to contribute to their accounts until they retire despite the fact that they were automatically enrolled in Medicare Part A at age 65.

* * *

Thank you for considering this submission. If you have any questions about this submission or the matters addressed herein, please contact our counsel, Scott Sinder (202-342-8425), at The Scott Group, or Alysa N. Zeltzer (202-342-8603), at Kelley Drye Collier Shannon.

Attachment: Excerpt from Spring 2006 Marketplace Survey of Council Employee Benefits Brokers

7. TYPE OF CLIENT IMPLEMENTING HSA – Please identify the size of client implementing the HSA option. Please check N/A if you do not handle the business or size account.							
Top number is the count of respondents selecting the option. Bottom % is percent of total respondents selecting the option.	1-10%	10-20%	20-30%	30-40%	40-50%	More than 50%	N/A
Small Acounts (50 or fewer employees)	28 29%	18 18%	14 14%	5 5%	1 1%	4 4%	28 29%
Medium Accounts (51 to 500 employees)	37 38%	21 22%	15 15%	1 1%	4 4%	1 1%	18 19%
Large Accounts (501 or more employees)	34 35%	15 16%	12 12%	6 6%	3 3%	1 1%	25 26%

8. HDHP-HSA ROLE – Of your clients choosing an HDHP-HSA product, are they using it as a plan option or to replace an existing plan?		
Plan Option	61	63%
Replacement of Existing Plan	8	8%
Both	28	29%
Total	97	100%

9. HDHP-HSA EMPLOYER CONTRIBUTION – What dollar contributions are employers typically making to the HSA?		
None	16	17%
Less than $250	10	11%
$250 to $499	30	32%
$500 to $749	17	18%
$750 to $1000	16	17%
More than $1000	5	5%
Total	94	100%

10. HDHP-HSA EMPLOYER RESISTANCE – What is keeping your clients from choosing an HSA product for their employees? (Check as many reasons as apply.)			
Difficulty coordinating HSA with existing FSA or HRA plans		48	48%
Inability to convert HRA to an HSA		5	5%
Inability to carve out prescription drugs		49	49%
Plan sponsors can't control how their employees spend employer contributions		29	29%
Concern that HSA contribution limits are too low for true retirement health savings option		21	21%
Restriction on embedded family deductibles		32	32%
Complexity of concept and education curve for plan participants		92	92%
Inability to pro-rate the deductible for mid-year enrollment		46	46%

S. Diane Turpin | Senior Director
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HERBALIFE INTERNATIONAL OF AMERICA, INC.'S TESTIMONY
BEFORE THE SENATE FINANCE COMMITTEE'S
SUBCOMMITTEE ON HEALTH

SEPTEMBER 26, 2006 HEARING

HEALTH SAVINGS ACCOUNTS: THE EXPERIENCE SO FAR

Contact Information:
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Herbalife International of America, Inc. (HLF) is a global network marketing company that sells weight-management, nutritional supplement and personal care products intended to support a healthy lifestyle. Herbalife products are sold in 62 countries through a network of more than one million independent distributors. HLF is pleased to submit comments on one way we believe Health Savings Accounts (HSAs) can be more effective and beneficial to current and future participants.

We urge the Committee to allow consumers to use their pre-tax HSA dollars to pay for a narrow range of dietary supplements and meal replacement products. Currently, participants may purchase over-the-counter drugs – such as cough/cold lozenges -- with HSA dollars. Herbalife seeks tax parity for a narrowly-defined number of dietary supplements that are permitted under federal law to bear a health claim that has been evaluated by the Food and Drug Administration (FDA) and meal replacement products that are permitted under federal law to bear a health claim that bas been evaluated by FDA, are low in fat, and represent a good source of protein, fiber, and multiple essential vitamins and minerals.

Herbalife is grateful for the leadership shown by Senator Hatch and Senator Conrad in requesting the Department of Treasury to expand the regulatory interpretation of Section 213 of the Internal Revenue Code to allow these products to be eligible for inclusion in HSAs and Flexible Spending Accounts (FSAs). In the House, we strongly support H.R. 1545, the Dietary Supplement and Healthy Meal Replacement Tax Parity Act, introduced by Congressman Chris Cannon and cosponsored by 41 of his colleagues.

The narrow list of products we reference specifically includes multivitamin tablets that qualify for FDA's antioxidant vitamin health claim or B-vitamin health claim, soy protein-based meal replacements (that qualify for FDA's soy protein health claim), calcium supplements (that qualify for FDA's calcium health claim) and Omega-3 fish oil capsules (that qualify for FDA's Omega-3 health claim) and Folic Acid Supplements (that qualify for FDA's folic acid health claim).

The FDA, by authorizing the use of specific health claims, recognizes the health benefits of certain dietary supplements and meal replacement products. The Internal Revenue Code defines "medical care" under Section 213(d) as expenses "for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body." The tax regulations interpret "medical care" under Section 213(d) to include items that are "generally accepted as falling within the category of medicine and drugs," whether or not requiring a prescription, and other expenses "incurred primarily for the prevention or alleviation of a physical or mental defect or illness." Like over-the-counter drugs, dietary supplements and meal replacement products that are permitted to

bear FDA-approved health claims can contribute to health, and should be a permissible expenditure under HSAs.

According to an August, 2006 Ipsos-Public Affairs survey, an estimated 65 percent of adult Americans take dietary supplements each year. Combined with other healthy practices, dietary supplements play an important role in preventative healthcare and overall good health.

The Department of Health and Human Services (HHS) has sought to develop a comprehensive strategy to encourage healthful nutrition and weight management. Given that a relatively high percentage of all deaths in the United States is related to poor diet and physical inactivity, establishing tax deductibility for certain products that promote a healthy lifestyle, weight loss, and may help prevent disease should be an important public policy initiative. Such initiatives are increasingly important as society seeks ways to reduce the health care costs associated with diabetes, cardiovascular disease, and other costly and debilitating diseases.

The data shows that the use of dietary supplements can reduce future health care costs. On September 20, 2004, the Dietary Supplement Education Alliance (DSEA) released results of a study it commissioned from The Lewin Group showing the economic benefits from supplementation with calcium or folic acid. On November 2, 2005, DSEA released additional Lewin research showing the benefit of supplementation with omega-3 fatty acids. FDA has approved health claims for these three nutrients. Findings include these:

> Calcium: Using Congressional Budget Office cost accounting methodology, Lewin estimated that over five years (2005-2009), the net savings in hospital, nursing facility and physician expenditures resulting from a reduction in the occurrence of hip fractures among the over age-65 population through daily intake of 1200 mgs of calcium with Vitamin D would be $13.9 billion. Approximately 734,000 hip fractures could be avoided across five years.
>
> Folic Acid: The total lifetime cost to care for a baby with Neural Tube Defect (NTD) in 2004 was roughly $532,000, including direct medical costs, therapies, and equipment, plus special education. Out of about 4 million live births annually, NTDs occur in one of every 1,000 pregnancies in the U.S. Sixty four million American women are of childbearing age. If just 10.5 million additional women began taking 400 mcg of folic acid on a daily basis periconceptionally, approximately 600 babies would be born without NTDs, saving as much as $321,853,000 as a result. Over five years, taking into account the very low cost of the supplement, $1.3 billion in lifetime costs could be saved.

Omega-3 Fatty Acids: Experts estimate $3.1 billion in health care expenditure savings over five-years (2006-2010) if the over age-65 population would supplement their diets with approximately 1800 mg of omega-3 fatty acids daily. Greater use of omega-3 supplements would reduce the occurrence of coronary heart disease, thereby avoiding some 384,303 hospitalizations and physician fees.

As the Subcommittee on Health continues to examine the effectiveness of HSAs, we encourage it to look for ways to improve upon the existing programs and to make dietary supplements and meal replacement products with FDA-approved health claims eligible for inclusion. We thank you for the opportunity to submit testimony and look forward to working with you.

Statement of Timothy S. Millne
Senate Finance Committee's Subcommittee on Health
Hearing on Health Savings Accounts: The Experience So Far
September 26, 2006

Distinguished Committee:

As one of Senator Rockefeller's constituents, I am pleased to submit comments to the Health Subcommittee of the Senate Finance Committee on one way I believe we can improve upon Health Savings Accounts (HSAs).

First, it is important to note that I share many of the Senator's concerns about HSAs. As a labor leader with the Laborers' International Union of North America, I in no way endorse or support HSA accounts, however, I believe these plans are here to stay and I would like to see the inclusion of certain dietary supplements and meal replacement products in HSAs.

I have been an independent Herbalife distributor for one year. I not only sell Herbalife products, but I personally consume the dietary supplements and meal replacement products.

Less than one year ago my life was a mess. I was overweight at 275 pounds, had no energy and suffered from numerous health conditions. Since starting our business I have taken the products faithfully and consistently. I have lost 65 pounds and went from a size 44 inch waist to a 38 inch waist. My energy has gone through the roof and I no longer suffer from the related health conditions. My wife too has lost weight and inches and we have both kept the weight off for a year without fad diets or starving our selves. We are truly the product of our products!

Our products, I believe, have the highest nutritional value that could help millions of people suffering from obesity and the spin off diseases and conditions that come from this epidemic.

I support the testimony provided by Herbalife International of America to the Subcommittee and urge you to allow certain dietary supplements and meal replacement products – eligible for health claims that have been approved by the Food and Drug Administration – to be included in HSAs. Many people in the great state of West Virginia are looking for ways to improve their health and to maintain a healthy lifestyle. Not everyone participates in an HSA, but those who do would benefit from being able to use pre-tax dollars to purchase these products that FDA acknowledges can promote good health.

I thank you for the opportunity to share my comments.

National Association of Health Underwriters

America's Benefits Specialists

September 26, 2006

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage. As such, we know first-hand how much the cost of health insurance coverage is impacting our nation's employers and the overall economy. Correspondingly, our association's two principle public policy goals are: (1) to reduce the number of uninsured Americans through private health insurance market solutions; and (2) to make sure that Americans have as many affordable and accessible private health insurance options available to them as possible.

When Congress created Health Savings Accounts (HSAs) in 2003, due in large part to the leadership of this Committee, NAHU members were pleased that the HSA concept addresses both of our key policy goals. HSAs are an effective way for individuals to save for future health expenses, for employers to offer lower-cost coverage to their employees, and for generally improving access to affordable coverage for the uninsured. Of the more than 3.2 million Americans who have enrolled in such plans since they became available in 2004, more than 30 percent were previously uninsured.

Since their inception, NAHU members have helped millions of Americans establish HSA accounts and purchase qualified High-Deductible Health Plans (HDHPs). As our members work to help employers establish their health benefit plans for 2007, they report to us that many employers who have not previously offered HSAs as an employee benefit are now considering doing so. They have also reported to us that there are several improvements to HSAs that could really smooth out some of the bumps in the road experienced by insurers, employers and consumers. These improvements would also be an incentive for many more employers to offer the HSA option as a benefit.

Based on the recommendations of our members (the majority of whom are small business owners themselves) and their employer-clients, NAHU supports the following changes to HSAs, in order to make the accounts accessible to many more Americans:

Improvements for Employers and Employees

Allow adjustments to the HSA deductible requirements and contribution limits for employees who enroll at different times during the calendar year. Right now, if an employer wants to start offering an HSA option to employees mid-calendar year, or if an employee (such as a new hire) wants to join an existing employer-sponsored HSA plan mid-year, the current HSA rules require that account contribution limit be pro-rated. However, the employer cannot pro-rate the HDHP deductible amount. This is a major barrier for many employers whose plan years do not correspond to the calendar year, and also prevents many employees who join an employer offering HSAs mid-year from participating. This problem could be solved by either letting employers and health plans pro-rate the HDHP deductible or by letting the full contribution limit level be made consistent with the annual deductible of the HDHP.

Permit individuals with a family HSA policy to meet the individual deductible requirements, rather than the whole family deductible. The vast majority of employer-sponsored plans for families start providing full coverage for an individual once that person meets their individual deductible, not the full family deductible. This isn't the case for HSAs and our member agents report that this causes a major barrier for families when choosing whether or not to elect the HSA option.

Permit an employee to contribute to a HSA even if his/her spouse has an FSA. Right now this is not permitted even if the spouse does not receive reimbursement for his or her medical expenses under the FSA. This major barrier to employee participation could be easily remedied by a simple certification requirement that the individual not receive reimbursement for his/her medical expenses from the spouse's FSA.

Allow more flexibility in the area of deductibles to encourage more employers to offer HSAs. Particularly helpful would be a change to allow prescription drug coverage to be offered without a high deductible, since most employers do not currently subject Rx coverage to the overall plan deductible, and instead, require employee cost-sharing as Rx benefits are utilized. Our members report that making this change would both encourage more employers to offer HSAs as a benefit and encourage more employees to elect the option if presented to them.

Allow a one-time conversion of HRAs to HSAs. Many employers that originally established HRAs when they became available are interested in the HSA option for their employees. HRAs are very similar to HSAs, but they may only be funded employer contributions, they are owned by the employer and the monies in the account are often forfeited by the employee upon termination. Many of NAHU employer clients have expressed an interest in a one-time conversion opportunity to make their HRA plans into HSA accounts. Since HSAs are owned by the employee and are fully portable, legislation allowing for a conversion would not only expand HSA enrollment but also benefit employees by increasing their access to health savings funds.

Permit employers to reserve their contributions for health expenses. Employees can currently withdraw HSA funds to pay qualified medical expenses tax-free. They also can

make a withdrawal for any other purpose with a 10 percent income tax penalty. Many employers report if they could be assured that their contributions to an HSA account could be limited to disbursements to pay for qualified medical expenses only, they would be much more willing to contribute.

Permit employers to contribute more to lower-paid workers. Many employers realize that their lower-paid employees may not be able to make meaningful contributions to their HSAs and would like to fund the accounts to a greater level on their behalf. Amending the comparable contribution rules to allow additional funding for low-income employees would be a great benefit to lower-income workers and their families.

Require the Department of Treasury to provide indexing of contribution amounts, out-of-pocket limits and deductibles earlier in the calendar year. Currently the indexing is issued in December, which is too late for many employers who decide their benefit structures for the following calendar year much earlier.

Make HSAs more compatible with other consumer-directed health insurance options. NAHU would like to see individuals and employers participate in FSAs and HRAs in a more extensive way while also contributing to HSAs. NAHU believes that allowing individuals to participate in all three accounts, as long as an eligible expense is reimbursed from only one of the accounts, will encourage more employers to offer HSAs and encourage more employees to participate in them.

Improvements for Individuals at or Near Retirement Age

Encourage employees to save for health expenses in retirement by increasing contribution levels. HSAs were designed to not just help individuals and employers save money on their health care coverage, but also to help individuals save money for health expenses incurred during retirement. Since current contribution levels are limited to the HDHP deductible amount, individuals are unlikely to be able to save enough to cover their retirement medical expenses. Raising the limits would encourage more responsible saving.

Eliminate restrictions on the use of HSA funds for Medigap coverage. Many Medicare beneficiaries do not have health insurance coverage available to supplement basic Medicare, and only have the option of a Medicare supplemental policy to help fund their retirement medical expenses. This is particularly true in rural or urban areas where Medicare Advantage plans may not be available, and for people without retiree coverage. It seems unfair to penalize these beneficiaries by not allowing them to use the funds they may have accumulated over their lifetimes to pay for their supplemental coverage.

Allow individuals over age 65 to contribute to an HSA as long as they are not yet retired, even though they may automatically be enrolled in Medicare Part A. Many individuals are working past age 65 these days, and that trend is only expected to increase. These individuals often have employer-sponsored health insurance to cover their medical expenses until their retirement, even though they are automatically enrolled in Medicare Part A on their 65th birthdays. Current HSA rules do not allow individuals to

contribute if they are enrolled in Medicare, unfairly penalizing older workers who may want to utilize the HSA option to help save for medical expenses in their retirement. These rules also make HSAs difficult for employers to administer if they have older workers.

Technical Corrections

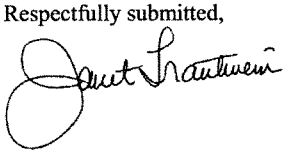
Exempt HSAs from COBRA for ERISA purposes as they are now exempt for tax code purposes. HSAs are exempt from COBRA continuation of coverage rules under current law, but there are parallel rules in ERISA that were not addressed. Since HDHPs are subject to both COBRA and ERISA continuation requirements, and since HSAs are fully portable, possibly subjecting HSAs to the ERISA rules is both unnecessary and confusing. Clarifying that HSAs are not subject to ERISA continuation requirements would go a long way toward easing plan administration.

Conform the definition of dependent for HSAs to the definition applicable for health plans. The Working Families Tax Relief Act of 2003 amended the definition of dependent, including limiting the amount of income an individual can earn and still qualify as a dependent. Most health plans were exempted, but HSAs were unintentionally left out. Amending the definition would allow eligible dependents to both contribute to and receive distributions from HSAs.

The majority of the HSA changes we have suggested are embodied in various bills introduced in the Senate and the House of Representatives. NAHU and its 20,000 members are extremely supportive of the legislative efforts of Senator Hatch, and Representatives Cantor and Ryan, and other Members of Congress, and we urge the Committee to give these bills prompt consideration.

Thank you for this opportunity to provide information about how the advent of HSAs has positively impacted our membership by allowing them to provide an innovative health insurance coverage solution to millions of their clients. It is our belief that by making the improvements we have suggested to the existing HSA structure, millions of more Americans would be able to benefit from access to these accounts. If you have any questions, or if NAHU could be of further assistance, please do not hesitate to either contact me directly at either 703-276-0220 or jtrautwein@nahu.org, or speak with Vice President of Congressional Affairs Peter Stein at 703-276-3801 or pstein@nahu.org.

Respectfully submitted,



Janet Trautwein
Executive Vice President and CEO

Senate Finance Committee – Subcommittee on Health Care
"Health Savings Accounts: The Experience So Far"

September 26, 2006

Statement of the National Business Group on Health (The Business Group)
50 F Street, NW
Suite 600
Washington, D.C. 20001

Congress Should Pass Legislation to Improve upon and Enhance the Value of Health Savings Accounts

Issue: Congress is considering legislation that would improve upon and enhance Health Savings Accounts (HSAs). Since Congress established HSAs in 2003, the response has been significant. By January 2006, an estimated 3.2 million Americans had enrolled in the low-premium health plans that are used with HSAs. Despite this rapid increase in enrollment, the current HSA regulations dissuade many employers and employees from deciding on HSAs. Several improvements, many of which have a minimal effect on federal revenue, would significantly expand the market for HSAs.

HSAs have proven to be an effective way to provide more Americans access to quality, affordable health care. More than 30 per cent of new enrollees in January 2006 previously had no other source of health insurance. Furthermore, these consumer-oriented health plans encourage individuals to directly participate in the cost and benefit decisions, to save for future needs, and to make a more conscientious use of health care services.

One way to enhance HSAs is to increase the amount that may be contributed. The current contribution limits do not allow an account holder to use tax-free money to pay for all of their out-of-pocket expenses. Furthermore, an employee's health expenses in retirement may exceed that which he or she is able to accumulate in an HSA during his or her career. Not only would increasing the contribution limits make HSAs more flexible, but also it would help many individuals save for their future health care needs.

To further encourage the adoption of HSA-compatible plans, Congress should amend the HSA statute and permit employers to contribute more to the HSAs of lower-income employees. This change would assist lower-income employees to accumulate funds in their HSAs and save for future health care needs.

Another way to improve HSAs is to permit individual family members to satisfy the individual deductible for HSA-compatible high deductible health plans rather than the family deductible. Unlike most employer-sponsored health plans, family coverage for HSAs does not begin until the employee meets the minimum family deductible. Impediments, such as this, deter employees from electing HSAs for themselves and their families.

Additionally, Congress can make the use of HSAs more widespread by allowing employers to coordinate HSAs with flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs). Because the current law does not permit an individual to have other health insurance while enrolled in an HSA-compatible plan, he or she cannot take advantage of FSAs or HRAs. By permitting employers and employees to use these other arrangements with HSAs, employees will be able to better meet their current and future health care needs.

Similarly, HSAs would be more attractive to employees if they could contribute to an HSA even though their spouse has an FSA. Currently, an individual may not contribute to an HSA if his or her spouse has an FSA. Congress could significantly enhance the current HSA statute by permitting employees to contribute even if their spouse has an FSA upon confirming that he or she will not receive reimbursement for health expenses from his or her spouse's FSA.

Moreover, employers are more likely to offer HSAs if the Treasury Department were required to release annual updates to the deductible amounts, to out-of-pocket expense limits, and to limits on contributions earlier in the year than the current statute requires. By the time the Treasury Department provides the annual updates, which is not until late in the year, it is typically too late for employers to modify their plan offerings by January. Requiring the Treasury Department to complete these updates earlier in the year will give employers more time to modify their plan offerings before the plan is to take effect.

Implementing the improvements listed, as well as others, would make it simpler and easier for employees to set up HSAs, to pay out-of-pocket medical expenses, and to be more practical health care consumers. Additionally, these changes would expand the number of employers offering HSAs and increase employers' flexibility to use HSAs. Changes to the statute would increase HSA participation at the workplace and in the individual insurance market.

Position: The National Business Group on Health, a member organization of over 240 primarily large employers who provide health care coverage for 50 million Americans, strongly urges Congress to pass legislation that would enhance the value of HSAs. Changes to the current statute would make HSAs more attractive to both employers and employees. Improving HSAs would make it easier for more people to pay for the companion high-deductible health plans, to save for future health care needs, and promote greater individual control over and responsibility for health care spending decisions.

The Business Group believes that legislation improving upon HSAs should include the following:

- Increase the limit on HSA contributions
- Permit employers to contribute more to the HSAs of lower-income employees
- Permit individual family members to satisfy the individual minimum deductible for HSAs ($1,050) rather than the family deductible ($2,100)
- Allow employers to offer HSAs along with flexible spending arrangements (FSAs) or health reimbursement arrangements (HRAs) that can be used to pay expenses below the deductible
- Permit an employee to contribute to an HSA even if his or her spouse has an FSA
- Require Treasury to provide earlier inflation-indexing of minimum deductibles and contribution limits
- Permit early adoptees of HRAs to convert to HSAs
- Permit employees over age 65 to continue contributing to their HSA
- Permit early retirees to pay for health insurance coverage with their HSA funds
- Exempt HSAs from COBRA for ERISA purposes as they are now exempt for Tax Code purposes

Improving HSAs is one clear way Congress can lower health care costs for all Americans and make our health care system much more responsive to consumers' decisions.

Wendy's International, Inc.

Tim Hortons WENDY'S BAJA FRESH

Jeffrey M. Cava
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October 6, 2006

Senate Committee on Finance
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Statement of Jeffrey Cava, Executive Vice President, Human Resources, Administration & Bakery, Wendy's International Inc., Dublin, Ohio

U.S. Senate – Health Subcommittee of the Finance Committee
Friday, October 6, 2006

Opening Statement

Mr. Chairman and Members of the Committee, the following comments are on behalf of Wendy's International Inc.. We have a passionate respect for our employees' ability to make good decisions about things that are important to them and their families. Competitive employee benefits are a top priority for Wendy's in our ongoing effort to be both innovative and an employer of choice.

Company Profile

Wendy's International is one of the world's largest restaurant companies. Wendy's was founded by Dave Thomas in 1969 and has grown to more than 6,700 restaurants in North America and international markets. We're a heavily franchised system with about 80% of Wendy's independently owned and operated by over 430 franchise entities.

A Full Replacement, Consumer Driven, High Deductible Health Plan Based on Health Savings Accounts Works Well for Wendy's and our Employees

Three years ago we began to explore the idea of introducing consumerism principles in our health care plans. We sought a better way to spend valuable resources for health care, manage costs and engage our employees and their families to adopt consumerism principles. We had to increase their level of involvement, unique to their personal needs, in the health care decisions they make.

After exploring a variety of approaches, we knew a full replacement high deductible health care plan with Health Savings Accounts was the answer. HSAs would allow our employees to fully own their accounts. While the company would contribute, plan participants may – but would not

be required to make contributions. Especially important is that these funds would carry over from year to year, allowing an employee to build up a reserve for an unexpected injury or illness. In a business with frequent turnover, portability was important. Health Savings Accounts would allow employees to set aside money for post retirement health care expenses that stayed with them regardless of where they were working.

Offering a high deductible health plan as an option to an existing managed care plan, would have limited our ability to address the issue of consumerism head on. To continue to offer a quality health care benefit, we had to change, fast. So we made the decision to fully replace our plan and it was the right decision.

With a decentralized workforce, it was imperative to deliver clear, concise information so our employees would select the best plan to fit their needs. We wanted to support changes in behavior necessary for them to become better health care consumers.

Our communications strategy included a multi-lingual information call center, web-based enrollment with modeling tools, and a comprehensive written guide. Our field Human Resources team was trained to hold informational meetings for employees and their families. For some employees, health care decisions are often made as a family. We wanted to be sure to include family members who desired to learn more about their options.

Profile of Wendy's Health Plan

The Wendy's plan includes HSA's and offers several choices. To each HSA, we contribute approximately 60% of the deductible. Importantly, our plans cover preventive care at 100%. This includes annual routine physicals, flu vaccines, child care immunizations, pap smears, mammograms, prostate exams and colonoscopies. In 2004, based upon a representative sample of our enrolled employees, approximately 50% indicated they received an annual physical. Based upon the same representative sample, in 2005, the first year of our consumer health plan, that increased to 75%. Also, we had a significant increase, from 20% to 42%, in employee use of on-line health care information and management of their health plan. Exactly the type of result we hoped to achieve.

Enrollment Results and Other Key Findings

Our participation levels have remained essentially constant at approximately 68% of those eligible since we introduced our new plan in 2005 and approximately the same participation rate as we experienced under our old plan.

During 2005, 60% of our participants contributed personal funds to their Health Savings Accounts and at the end of the year over 90 % of participants had a favorable account balance. Today that figure is 95%.

At the end of last year, the average account balance was $600. Today the average account balance is $735. At the end of 2005 the combined funds in our employees' Health Savings Accounts totaled approximately $4 million. Today the combined funds total approximately $6 million. Now, instead of paying high premiums in traditional plans, participants may use their money to save for future health care expenses. Again, the type of result we were seeking.

Out of 9,500 eligible, the company insures 6,500 covering 18,500 lives. In the first year of the plan, Wendy's health care claims decreased by 14%. If you include company contributions to employee Health Savings Accounts, our costs increased by 1% in 2005 over 2004.

Suggestions to improve Health Savings Accounts

We are generally supportive of Senator Hatch's bill, the Health Savings Accounts and Improvements and Expansion Act of 2006 and encourage the Senate to address four areas of particular importance. In particular there are four key areas we believe warrant government action.

1. Increase the contribution limits to the maximum total out of pocket limit. This gives participants the option to fund their accounts to pay their expected expenses.

2. Modify the comparability rules to allow us to provide larger contributions to Health Savings Accounts for the chronically ill. This helps participants with recurring, high claims to get the health coverage they need.

3. There is confusion among our employees about the rules for FSAs and how they relate to HSAs. We'd like our plan participants to be able to integrate these accounts so unused FSA dollars may roll into their HSAs without penalty or loss of contribution.

4. Finally, as was permitted last year, allow prescription drug expenses to be covered below the deductible. This is concerning for our participants, particularly those who need specialty drugs or drugs for which there are no generic alternatives. To support our employees this year we accelerated the company's contribution to their HSAs to help cover their drug costs up front. In 2007 we are considering excluding certain therapeutic preventive drugs from the deductible to encourage our employees to take the important steps to preventing future disease.

As a separate but related health care policy matter we have no doubt that a serious, national effort must be made to achieve true transparency in our health care system. Some recent advances have been made in this area and we believe more improvements should be made. Americans deserve easily understood information about the price and quality of health care prior to receiving treatment when possible. We urge you to begin now to require medical providers and insurance companies to release this information. Congress can develop a system of more affordable, portable, transparent and efficient health care in this country by taking these steps.

Respectfully,

Jeffrey M. Cava
Executive Vice President Human Resources and Administration

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