HEALTH SAVINGS ACCOUNTS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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HEALTH SAVINGS ACCOUNTS

WEDNESDAY, JUNE 28, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:38 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
June 21, 2006
FC–23

CONTACT: (202) 225–1721

Thomas Announces Hearing on Health Savings Accounts

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on Health Savings Accounts (HSAs). **The hearing will take place on Wednesday, June 28, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on health insurance issues, health savings accounts and members of the business community. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On December 8, 2003, the President signed into law the Medicare Modernization Act (MMA, P.L. 108–173), which created tax-preferred savings accounts for health care expenses that utilize health plans with high deductibles and limitations on annual out-of-pocket expenses. These accounts are commonly referred to as HSAs.

Under current HSA law, workers under the age of 65 can accumulate tax-free savings for lifetime health care needs if they have qualified health plans with a minimum deductible of $1,050 for self-only coverage and an annual out-of-pocket limit not to exceed $5,250. These amounts are doubled for family coverage. Individuals can make pre-tax contributions of up to 100 percent of the health plan deductible, and the maximum annual contribution is the lesser of 100 percent of the insurance deductible or $2,700 for individuals with self-only policies and the lesser of $5,450 or 100 percent of the overall deductible, with some exceptions, for families (indexed annually for inflation). Importantly, the individual owns the account, and the savings follow the individual from job to job and into retirement. Upon death, HSA ownership may be transferred to the survivor on a tax-free basis.

The use of HSAs has grown rapidly since their inception on January 1, 2004. Recently released statistics indicate that approximately 3.2 million people are using HSAs to obtain health care coverage, determine how and where they spend their health care dollars, and save for future medical needs. This data also indicates many of the people using HSAs were previously uninsured prior to buying into their HSA plan, and that almost half of HSA plan purchasers have annual incomes of less than $50,000. Finally, some argue consumers should be provided with accurate, relevant data on quality and prices in order to make informed decisions on how to spend their health care resources and save for the future.

In announcing the hearing, Chairman Thomas stated, "For years, too many Americans have struggled with the rising costs of health care, and too many Americans are entirely without insurance. Health savings accounts are helping families and individuals gain better access to affordable, quality health care, while encouraging savings for medical costs through tax-deductible contributions. Various proposals to promote the continued development of HSAs have been offered, but obstacles remain in getting consumers relevant information. It is important to explore whether more can be done to give Americans access to affordable health insurance coverage."

FOCUS OF THE HEARING:

In continuing the Committee's consideration of health care financing, the hearing will focus on real world examples of people and businesses with experience using or providing HSAs. This real world experience will provide valuable insight in the Committee's future consideration of HSA adjustments. The panel witnesses will describe the key components of HSAs and HSA-eligible health insurance plans. Also, the witnesses will provide information on key demographic trends in HSA use, insurance premium costs and affordability, and health insurance benefit levels. Finally, witnesses will provide testimony regarding the impact of HSAs on consumers and business.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Wednesday, July 12, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Good morning. The Chairman has been detained in traffic, so we are going to start; he will be along shortly.

Today, the Committee will be exploring the growing popularity of Health Savings Accounts (HSAs). These tax preferred accounts are a tool created by Congress in 2003 to give consumers more control over their health care dollars and to help combat the rising costs of health insurance.

Health Savings Accounts, created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173) provided an opportunity to set aside money on a tax-free basis for health costs either now or in the future. Contributions can be made by the account owner and the employer. Not only is the money tax-free on the way into the account, but as long as it is used for health costs, it is also tax-free when it is spent. Most importantly, this account is the individual's own regardless of whether he or she changes jobs, is between jobs or doesn't work at all.

To contribute to an HSA, you must also purchase a high deductible health insurance policy. This type of policy protects individuals from catastrophic costs.

Despite the fact that these accounts have been available for little more than 2 years, they are increasingly popular. A recent census done by America's Health Insurance Plans found that almost 3.2 million people are now covered by HSA plans, triple the number a year ago. In addition, the Federal Employee Health Benefit Plan began offering an HSA option this year to thousands of Federal employees throughout the country.

Health Savings Accounts can play a major role in reducing the number of uninsured Americans. They provide a more affordable insurance option without sacrificing quality of care. In fact, a recent study by eHealthInsurance found that HSAs have broad appeal. For example, it found that almost half of HSA purchasers have incomes of $50,000 or less and that individuals paid about $114 a month in premiums. Compare that premium with the Kaiser Foundation estimate of $335 per month for premiums in traditional health plans.

The Chair believes these accounts can change the way Americans consume health care, the President agrees and has proposed ideas to increase the attractiveness of HSAs, such as making the health insurance premiums tax deductible. As this Committee looks at the successes of HSAs, we will explore this concept and other proposals.

I would just like to comment that HSAs have a couple of unique strengths. One is that you can spend that money on anything under the Tax Code, which provides a far more generous series of options than any employer plan, even though in terms of what counts toward the catastrophic is constrained. So, it gives us a chance to enable families to tailor their health care choice to their own families' needs; and that is not a benefit to be underestimated in today's world. Fundamentally, it simply spends less money on insurance and more money controlled by families on health.

I have had some outstanding experience with HSAs among small manufacturers in my district. Success depends on the seriousness of the employer in providing resources in the HSA account so the

employee actually does have a chance to not only be kept whole, but also to experience the value of saving for large health costs that may come in the future.

I would now like to recognize the gentleman from New York, Mr. Rangel, for an opening statement.

Mr. RANGEL. Thank you, Madam Chairlady.

I first would want the panel to know that our colleague, Richard Neal, will have to leave at some time before the hearing is over. He is going to Arlington to attend the funeral of one of our beloved warriors in Iraq that was killed at the site when his two colleagues were captured and, of course, beheaded; and as tragic as it is, he still is with us. When he does leave, that will be the reason.

I want to thank you for having this hearing because it is going to help us find out just how effective these health saving plans are; whether or not the employees are indeed cooperating; how much would an employee have to save if they didn't have disposable income; and what is the cost of the medical insurance plans.

So, helping me with understanding all of this, of course, is Peter Stark, and I would like to yield my time to him.

Thank you, Mr. Stark.

Mr. STARK. Thank you, Mr. Rangel.

I think it is time that we had a reality check. These HSAs are very much like weapons of mass destruction, and I don't think that misinformation is necessarily a lie; it is usually just a lack of understanding.

While it is true that there are over 3 million people enrolled in HSAs, the laughable part of that is, according to the Treasury figures, or the most recent ones we have, less than 100,000 of those 3.2 million people actually opened an HSA savings account. They just bought into a high deductible, but there wasn't anybody putting any money in their savings account, largely because 70 percent of the people who might qualify are in the income brackets below 10 percent and the tax deductibility wouldn't do that much good anyway, even if they had the money to put into it.

Employers contributing to the HSAs, less than a third do, and of the two-thirds who contributed anything, they only contribute between 10 and 25 percent of the total deductible; and among low-income people, that basically leaves them unable to afford particularly the preventive care that they need.

You have to go to the HSA Finder, Inc. This is some group that put out a primer for employers, and basically you score should you as an employer offer these things to your employees.

I would like, Madam Chair, to make this a part of the record because it is something put out by the HSA promoters to employers, and it proves the point. If you have younger, high-wage workers, go for it; and what happens, companies with older and lower-wage workers are stuck in traditional insurance where the rates will go up ever and ever faster. Providers will be underpaid, providers will get stuck with the bills, as we will learn later from the only witness I think who doesn't have a financial interest in these HSAs; and the Administration wants again to solve a plan by throwing extra dollars at the very rich and ignoring the middle class, as they have done so well.

[The information is being retained in the Committee files.]

I guess the only thing better to improve the health care of this country would be a constitutional marriage ban or a constitutional ban on burning the flag. That would do more than anything the Republicans have offered, and particularly more than hsas.

I look forward to most of the nonsense we will hear from witnesses with big financial interests in this program.

Thank you, Madam Chair.

Mrs. JOHNSON OF CONNECTICUT. Now I would like to recognize Representative Beauprez to introduce Harold Jackson from Buffalo Supply, Inc., in Colorado. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Madam Chair. It is a pleasure to have an acquaintance, a friend, a constituent of mine from Colorado, Mr. Harold Jackson. He is the President and CEO (chief executive officer) of Buffalo Supply in Lafayette, Colorado; they are a medical supply company. He actually has, I think, a very positive, very real, hands-on, practical story to tell us today about the success of participating with HSAs at his company and on behalf of, especially, his employees. So, I look forward to his testimony and welcome him to this Committee.

Mrs. JOHNSON OF CONNECTICUT. I would like to recognize Congresswoman Tubbs Jones, who will introduce Ms. Jean Therrien, a constituent from Cleveland.

Ms. TUBBS JONES. Thank you, Madam Chair.

Good morning. Welcome to Capitol Hill. I am so happy; as I look at your face, I remember having visited the west side practice when you first opened up the new facility and how beautiful it was.

I would like to let everyone know that Ms. Therrien is the Executive Director of the Neighborhood Family Practice, a family practice on the near west side of Cleveland.

She has been a member of the practice since 2003 and takes an active role in meeting the health care needs of Cleveland residents as you will hear in her testimony. She has a degree from the University of North Carolina in Nursing and a Master's degree in Public Health from the Harvard School of Public Health and has completed a program at the Weatherhead Professional Fellows Program at Case Western Reserve University, my alma mater.

Welcome to Capitol Hill, and we look forward to hearing your testimony.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I would like to recognize Representative Weller, who would like to introduce Larry Lutey of Lutheran Social Services of Illinois (LSSI).

Congressman Weller.

Mr. WELLER. Thank you, Madam Chair. It is a real privilege for me to welcome and introduce a gentleman from Illinois—who happens to be a constituent of the Speaker of the House—Larry Lutey, who is Vice President and Chief Human Resources Officer for LSSI.

The LSSI is an affiliate of Lutheran Services in America, that serves 65,000 Illinois residents every year through behavioral health services, owns and manages senior housing, senior home care services, skilled nursing facilities, traditional and specialized foster care, domestic and international adoption services, developmental disability services, and a ministry with incarcerated women and their children.

The LSSI has an annual operating budget of nearly $107 million and employs 2,100 people in Illinois. It is a real privilege to have Mr. Lutey here, who is, of course, representing a very respected social service agency in Illinois.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Weller.

Let me just mention that there is a vote on. It is a single vote. Members will come and go to vote, but we will proceed with the panel.

I would like to recognize Mr. Cava. Mr. Cava, I recognize you for 5 minutes.

For all of the panelists, your entire statement will be in the record, but you each have 5 minutes to summarize your testimony.

Mr. Cava, you have to pull the microphone quite close so we can hear you and be sure it is turned on.

STATEMENT OF JEFFREY CAVA, EXECUTIVE VICE PRESIDENT OF HUMAN RESOURCES AND ADMINISTRATION, WENDY'S INTERNATIONAL INC., DUBLIN, OHIO

Mr. CAVA. Yes. Thank you.

Mr. Chairman and Members of the Committee, I am Jeff Cava, Executive Vice President of Wendy's International, Inc. Thank you very much for your invitation to testify today. It is an honor to be here on behalf of our great American company to discuss an issue about which we feel so strongly.

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 become an employer of choice.

Wendy's International is one of the world's largest restaurant companies. We are an enterprise of more than 9,900 restaurants and three quality brands—Wendy's Old Fashioned Hamburgers, Tim Horton's and Baja Fresh Mexican Grill. Wendy's was founded by Dave Thomas in 1969 and has grown to more than 6,700 restaurants in North America and internationally. We are a heavily franchised system with about 80 percent of Wendy's independently owned and operated by over 430 franchise entities.

Three years ago we began to explore the idea of introducing consumerism principles in our health plan. We sought a better way to spend valuable resources for health care, manage our costs, but more importantly, 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 that they make.

After exploring a variety of approaches, we knew a full replacement, high deductible health care plan with HSAs was the answer. The 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 carryover from year to year, allowing an employee to buildup a reserve for an unexpected injury or illness.

In a business with frequent turnover, portability was also important, and HSAs 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 quickly, 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 and 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.

This communications piece was an enormous project. Our communications strategy included a multilingual 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, and we wanted to be sure to include family members who desired to learn more about their options.

The Wendy's plan includes HSAs and offers several choices. To each HSA, we contribute approximately 60 percent of the deductible. Importantly, our plans cover preventive care at 100 percent. This includes annual routine physicals, flu vaccines, child care immunizations, Pap smears, mammograms, prostate exams and colonoscopies.

In 2004, approximately 50 percent of our employees indicated this they received an annual physical. In 2005, the first year of our consumer health plan, that increased to 75 percent. Also, we had a significant increase in employee use of our online health care information and management of their health plan, exactly the type of result we were looking for.

Our participation levels have remained essentially constant, at approximately 84 percent 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 percent of our participants contributed personal funds to their HSAs, and at the end of the year over 90 percent of our participants had a favorable account balance. Today, that figure is 95 percent.

At the end of the year, the average account balance was $600; today, the average account balance is $760. At the end of 2005, the combined funds in our employees' HSAs totaled approximately $4 million.

Now, instead of paying 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 10,200 eligible, the company insures approximately 7,000 people, covering 20,000 lives. In the first year of the plan, Wendy's health care claims decreased by 14 percent. If you include company contributions to the employee HSAs, our costs increased by 1 percent in 2005 over 2004.

There are four key areas we believe warrant government action as addressed in Congressman Cantor's bill: Modify the comparability rules to allow us to provide larger contributions to health care savings accounts for the chronically ill. This helps participants

with recurring high claims to get the health coverage they need. We encourage an increase in the limits of out-of-pocket expenses beyond the deductible. This gives participants the option to fund their accounts at higher levels. There is confusion among our employees about the rules for Flexible Spending Accounts (FSAs) and how they relate to HSAs. We would like our plan participants to be able to integrate these accounts so unused FSA dollars may roll into HSA accounts without penalty or loss of contribution.

Finally, as was permitted last year, allow a carve-out of prescription drugs from deductibles. This is a concern 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 our company's contribution to their HSAs to help cover their drug costs up front.

Mrs. JOHNSON OF CONNECTICUT. Mr. Cava, your time has expired, if you could conclude that sentence.

Mr. CAVA. Thank you.

[The prepared statement of Mr. Cava follows:]

Statement of Jeff Cava, Executive Vice President of Human Resources and Administration, Wendy's International, Inc., Dublin, Ohio

Mr. Chairman and Members of the Committee, I am Jeff Cava, Executive Vice President of Wendy's International, Inc. Thank you for your invitation to testify today. It's an honor to be here on behalf of our great American company to discuss an issue about which we feel so strongly. 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

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A Full Replacement, Consumer Driven, High Deductible Health Plan Based on Health Savings Accounts Work 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. This communications piece was an enormous project.

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 approximately 50% of our employees indicated they received an annual physical. In 2005, the first year of our consumer health plan, that increased to 75%. Also, we had a significant increase 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 84% 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 $760. At the end of 2005 the combined funds in our employees' Health Savings Accounts totaled approximately $4 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 10,200 eligible, the company insures 7,000 covering 20,000 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

There are four key areas we believe warrant government action. As addressed in Congressman Cantor's bill, 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.

We encourage an increase in the limits for out of pocket expenses beyond the deductible. This gives participants the option to fund their accounts at higher levels.

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.

Finally, as was permitted last year, allow a carve out of prescription drugs from deductibles. 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. At a minimum, we encourage a modified approach such as using co-insurance for drugs in certain categories.

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. 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.

Summary

In summary, we honor the legacy of our founder Dave Thomas. He built Wendy's on the simple promise to "Do the Right Thing." We firmly believe this is the right thing. The health and wellness of our employees and their families now and in the future will improve as they take more ownership of their health care decisions.

This strategy is not just about efficiency in health care spending but most importantly, it is about creating a sustainable improvement in the health of our employees.

We appreciate your focus on this important issue and welcome your questions.

Mrs. JOHNSON OF CONNECTICUT. Mrs. Ignagni.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLANS

Ms. IGNAGNI. Thank you, Madam Chair, Mr. Rangel, Members of the Committee, we appreciate the opportunity to be here. I have two objectives this morning; one is to provide information on what we know about HSA coverage and, second, to provide recommendations on where we should go from here.

First, the data that we have: We have surveyed all of the plans that are offering HSA coverage. They have all responded. We have a 100 percent sample. The number as of January 2006 was 3.2 million people. We know that right now it would be higher than that, and we are in the process of resampling so we will be able to provide additional data.

This is the third time we have surveyed the HSA offering plans. We did it once right after the regulations were issued by the U.S. Department of the Treasury. We did it the second time in March of 2005, and the numbers that we are reporting from January 2006 have indeed increased substantially since the March 2005 census.

What do we know? In addition to the 3.2 million people, we know that the numbers of firms offering HSA coverage are doubling annually. Thirty-three percent of companies offering this coverage previously had not offered insurance. It is also exceeded by the 37 percent of individuals who are purchasing HSA coverage that were not previously insured.

The age distribution is roughly even above and below age 40. There is broad access to providers. Indeed, individuals purchasing HSA coverage are taking advantage of our member discounts in terms of episodes of care as well as individual particular services they are accessing.

Premiums are 20 to 30 percent lower. About 50 to 60 percent, according to the U.S. Government Accountability Office (GAO), have actually created accounts and 30 percent have incomes lower than $50,000.

What do we know about utilization? Two important pieces of data: People are using preventive care, as you just heard from Mr. Cava. They are filling their prescriptions, in many ways, more than has been done under other types of coverage, particularly for chronic illnesses.

You can—if you are interested, we have a Web site: www.healthdecisions.org. All of our members have listed their products there. They are listed by State, by company. We were asked by a number of individuals in the small business community to create an opportunity for one-stop observing and to look at how they could look across States, across plans and have a handy reference. So, we have endeavored to provide that.

With the progress that is being made, we have identified five categories of opportunities. I will just highlight them. There are very specific details provided in our testimony, Mr. Chairman.

First, the unintended consequences that should be addressed. Right now we are penalizing families. If a spouse has an FSA, you can't—the other spouse can't have a HSA.

Second, we think there should be separate deductibles for individual family members. They may have different needs. Right now we are not able to do that. The second category of issues, we need more coordination between tax-based accounts—FSAs, HSAs and Health Reimbursement Accounts (HRAs). There should be rollovers that are allowed.

Third, in our view, there should be more flexibility in three areas: first, allowing early retirees to purchase; second, seniors who would wish to purchase Medigap; third, veterans to wish to set up HSA accounts right now that cannot.

The fourth category of issues, there should be a number of administrative changes. Let me just highlight two. We should increase the contribution limits so individuals can accumulate resources quicker. We should post cost of living adjustments (COLAs) midyear rather than waiting until November. There should be a special focus on how individuals with chronic conditions can more rapidly accumulate funds in their account.

We have urged that the Committee continue to explore and prioritize the issue of providing subsidies for low-income individuals notwithstanding the type of insurance they may purchase. We think that that is something that definitely needs to be attended to. We have provided very specific examples of transparency initiatives, which go hand in hand with some of the new types of products being offered in the HSA arena, in the Preferred Provider Organization (PPO) arena, and in other types of arenas as well. We hope that will be useful to you.

We have also highlighted an effort that we have under way with all of the physician specialty societies to come to consensus about performance, quality performance measurement, which is very, very important to have a uniform approach to that.

I would be happy to answer any of your questions on any of these areas, Mr. Chairman. Thank you.

[The prepared statement of Ms. Ignagni follows:]

Statement of Karen Ignagni, President and Chief Executive Officer, America's Health Insurance Plans

I. INTRODUCTION

Good morning, Chairman Thomas, Ranking Member Rangel, and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of innovative health insurance products, including high-deductible health plans (HDHPs) that are compatible with Health Savings Accounts (HSAs).

We appreciate this opportunity to testify on HSAs and their role in providing more Americans with access to high quality, affordable health care coverage that includes benefits for preventive care. We applaud Congress for authorizing this important new health care option as part of the Medicare Modernization Act of 2003 (MMA). Today, just three short years later, more than 3 million Americans are covered by HSA-compatible health plans. This innovative approach to health care financing is helping a substantial number of previously uninsured consumers purchase coverage, accumulate savings for their future medical needs, and access preventive health care services.

Our testimony today will focus on:

- the rationale for HSAs and their value as an option for consumers;
- consumers' initial experience with HSAs and HDHPs;
- opportunities for enacting legislation to further improve HSAs; and

- the need for greater transparency in health care prices and quality to help HSA account-holders and other consumers make informed health care decisions.

II. THE RATIONAL FOR HSAs

While HSAs are commonly recognized as accounts that consumers establish in combination with high-deductible health plans, it also is important to emphasize that access to preventive care is a central component of this approach. The MMA addressed this priority by specifically providing that preventive care services may be covered by HSA-compatible health plans and do not count against an individual's deductible. As a result, consumers who establish HSAs are covered on "day one" for a wide range of preventive health care services:

- routine prenatal and well-child care;
- immunizations for children and adults;
- periodic health evaluations, including tests and diagnostic procedures ordered with annual physicals;
- smoking cessation programs;
- obesity weight-loss programs;
- screening services for mammography, glaucoma, tuberculosis, etc.; and
- limited categories of medications that serve as preventive measures.

Along with this strong focus on wellness, HSAs also include an opportunity for consumers to take an active role in deciding when and how much to contribute to their accounts (subject to an allowable maximum) and how to invest the dollars in their accounts. The funds that individuals withdraw from their HSAs to pay out-of-pocket health care costs are not subject to taxation. At the end of the year, any unspent funds in an HSA remain in the account and can be used to pay medical expenses in following years. Interest and other earnings on HSA funds accumulate in the fund and are also tax-free. This approach to health care financing creates incentives for consumers to make decisions about their health care while at the same time allowing them to accumulate assets to meet their future needs.

III. CONSUMERS' INITIAL EXPERIENCE WITH HSAs

To learn more about consumers' experiences with HSAs, AHIP has conducted a comprehensive census of the HSA market three times in the past 21 months—in September 2004, in March 2005, and in January 2006. The most recent census [1] was based on responses from 96 AHIP member companies, representing nearly all health insurance plans offering HSA-compatible policies. This includes 53 companies offering plans in the individual market and 87 companies offering plans in the group market.

We found that HSA-compatible HDHPs covered 3,168,000 people in January 2006. This reflects a more than three-fold increase in enrollment in HSA products since March 2005. This represents a strong start for a new health care option that was unknown to most Americans just a few years ago. By comparison, a previous effort to encourage health care spending accounts—the Medical Savings Accounts (MSA) demonstration program that Congress authorized in 1996—resulted in only 250,000 consumers establishing MSA accounts from 1997 through 2001. While our census did not count the number of HDHP policyholders who have established HSAs, the Government Accountability Office (GAO) has reported [2] that approximately 50 to 60 percent of people with HSA-compatible plans have established accounts.

A closer look at AHIP's census data reveals a number of significant findings:

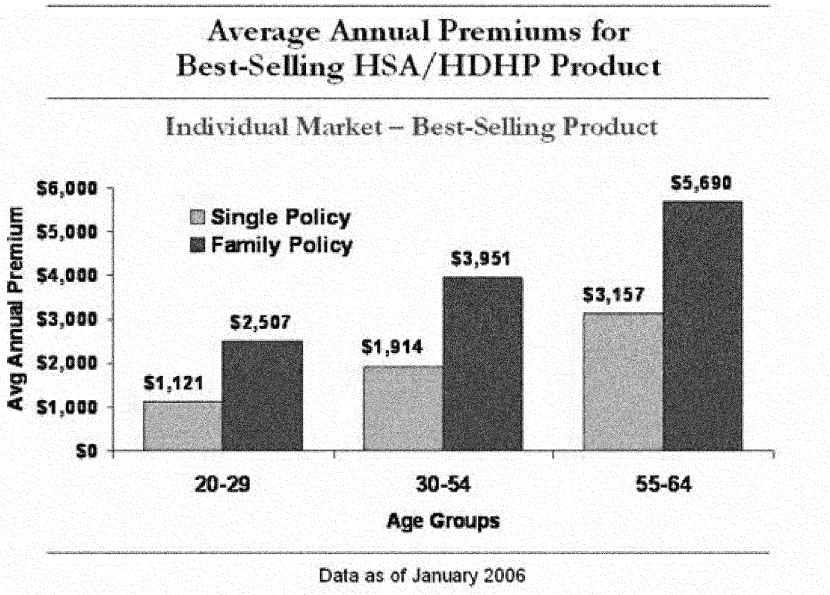
- Many consumers choosing HSA/HDHP coverage were uninsured before choosing this option. In the individual market, 31 percent of enrollees previously were uninsured. In the small group market, 33 percent of the companies offering HSA/HDHP coverage previously did not offer insurance coverage. This indicates that these options are achieving success in expanding coverage to the uninsured.
- The age distribution of people choosing HSA/HDHP coverage is evenly divided. In the individual market, 50 percent of enrollees (including dependents) were age 40 or older. In both the small group and large group markets, approximately 45 percent were age 40 or older.
- People who choose HSA/HDHP coverage have broad access to providers, much the same as persons with other types of health insurance. More than 90 percent of enrollees with HSA/HDHP coverage are enrolled in preferred provider organizations (PPO) that include both in-network and out-of-network coverage. Con-

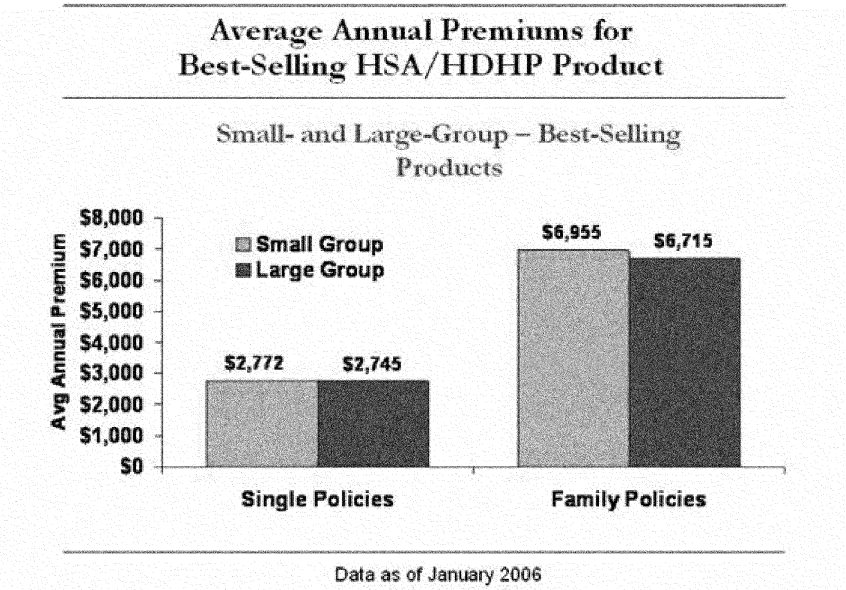
[1] AHIP, *January 2006 Census Shows 3.2 Million People Covered by HSA Plans,* March 2006

[2] Government Accountability Office, Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage, April 2006

sumers with PPO coverage have access to the discounts these plans negotiate with health care providers, which allows them to keep their out-of-pocket costs low both before and after they reach the deductible under their HDHP.

- HSA/HDHP coverage accounts for a notable share of new health insurance in the individual market (23 percent), in the small group market (11 percent), and in the large group market (7 percent).
- The fastest growing market for HSA/HDHP coverage is group coverage, which has increased from approximately 20 percent of the HSA/HDHP market in September 2004 to more than 60 percent in January 2006. This growth indicates strong employer interest in offering HSAs as an option for workers.
- Premiums for HSA-compatible plans are approximately 20 to 30 percent lower than average premiums in the employer market. The tables on the following page show the average annual premium for both single and family coverage for HSA-compatible plans in the individual, small group, and large group markets.





Additional research findings have demonstrated that HSAs are having a favorable impact on patient health and helping consumers to make cost-effective decisions. An analysis by Cigna [3] found that preventive care visits for members of its Choice Fund, an HSA product, were 13 percent greater when compared to other health care consumers. Choice Fund members also were found to be more consistent in refilling medications that manage chronic conditions. Other findings of this analysis show that the use of cost-effective generic prescription drugs increased 19 percent among Choice Fund members and that overall pharmacy costs were 5 percent lower than for members with traditional health coverage.

Two other studies—one by the Employee Benefit Research Institute (EBRI), another by the Blue Cross Blue Shield Association (BCBSA)—have demonstrated that the health status of individuals with HSAs is comparable to the health status of those with other types of coverage. The EBRI study [4] found that 86 percent of individuals with HDHPs and 87 percent of individuals with non-HDHP coverage reported their own health status as very good or good. The BCBSA study[5] yielded similar results, with 77 percent of individuals in both categories—those with HDHP coverage and those with non-HDHP coverage—describing their health status as very good or good.

The EBRI study also found that the income distribution is fairly similar for persons with HDHP coverage and with other types of coverage. According to EBRI, 31 percent of HDHP enrollees and 27 percent of non-HDHP enrollees have annual household incomes below $50,000. Similarly, Assurant Health found that 29 percent of enrollees in its HDHPs have annual household incomes below $50,000. Other data [6] from Assurant indicate that 43 percent of HDHP applicants did not have prior health coverage and, additionally, that 69 percent of HDHP purchasers are families with children and 62 percent are over the age of 40.

Consumer Information at HealthDecisions.org

Consumers interested in learning more about HSAs and HDHPs can visit AHIP's consumer-directed portal—HealthDecisions.org—which provides a national directory of health insurance plans. This site enables visitors to easily locate profiles of HDHP products in their state. The health plan information on this site is updated

[3] Cigna HealthCare, Choice Fund Results Analysis, March 2006

[4] Employee Benefit Research Institute, Early Experience With High-Deductible and Consumer-Driven Health Plans, December 2005

[5] Blue Cross and Blue Shield Association, Consumer Survey Shows High Rate Of Satisfaction With HSAs, Cites Increased Reliance On Decision-Support Tools, September 2005

[6] Assurant Health, Quick Facts: Health Savings Accounts

and re-verified on an ongoing basis by the health plans themselves, thus ensuring that consumers have access to most current, accurate, and complete information.

HealthDecisions also contains a wealth of easy-to-understand information in its "Learning Center," including educational materials, an online library, and a glossary to help consumers and small businesses better understand available HSA options. Visitors to the site also will find our HSA "Basics" and "Fast Facts" sections and can browse our "Question and Answer" section outlining the most frequently asked questions accumulated over time by the Treasury Department and other sources. HealthDecisions.org is being visited each month by 20,000 to 30,000 people who are interested in learning more about HSAs and other types of health insurance.

IV. OPPORTUNITIES FOR FURTHER IMPROVING HSAs

While HSAs are proving to be highly effective in helping many consumers meet their health care needs, there are a number of additional steps Congress could take. AHIP is recommending the following proposals to address the unique needs and circumstances of the chronically ill, early retirees, low-income persons, individuals without employer-based coverage, and many others for whom HSAs can be a valuable coverage option.

Expanding Coverage for the Chronically Ill

- *Increase HSA Contributions:* Congress should allow employers to assist employees or their family members who suffer from chronic conditions by permitting increased contributions into the HSAs of individuals who are enrolled in disease management or care coordination programs. These programs provide coordinated health care interventions and communications for populations in which patient self-care efforts are significant and are used to improve the health of individuals with chronic conditions such as diabetes, hypertension, chronic heart disease, and obesity. This proposal will help patients with chronic conditions use after-tax money in their HSAs to pay for health care costs.
- *Prescription Drugs:* High-deductible health plans should be allowed to cover certain prescription drugs used to treat chronic conditions without the patient first being required to satisfy the minimum annual deductible on the HDHP. Currently, HDHPs may not cover prescription drugs unless the annual deductible has been satisfied or the prescription drug is used for a narrow category of preventive services. This proposal will help patients with acute illness or injuries access prescription drugs and assure that they do not forego their medications due to cost concerns.

Encouraging Families to Participate in HSAs

- *Spousal FSAs:* Individuals should be allowed to establish an HSA if their spouse has a Flexible Spending Arrangement (FSA). Individuals currently are disqualified from setting up an HSA if they have a spouse with an FSA. This rule unfairly limits consumer choice, particularly in instances where the individual's medical expenses are not being covered with funds from the spouse's FSA.
- *Allowing Separate Deductibles for Individual Family Members:* HDHPs for family HSAs should be allowed to include separate deductibles, also known as "embedded deductibles," for individual family members below the family deductible set by the statute—but at least as high as the individual deductible set by the statute. Under current law, individual embedded deductibles are permitted only to the extent that they are not lower than the statutory family deductible. Allowing lower embedded deductibles for each family member will make it easier for families with HSAs to meet their health care expenses.

Helping Early Retirees and Seniors

- *Retiree Health Coverage:* Early retirees—those in the 55–64 age category—should be allowed to use HSA funds to purchase retiree health coverage. This proposal would make transitional coverage more affordable for individuals who sometimes struggle with the high cost of health insurance in the years just before they become eligible for Medicare. It also would give the near-elderly more flexibility as they plan ahead for changing circumstances.
- *Medigap Coverage:* Seniors should be allowed to use HSA funds to purchase Medigap coverage. Current law, which prohibits this use of HSA funds, fails to recognize the high value offered by Medigap policies and the fact that millions of Medicare beneficiaries are well-served by supplementing their basic Medicare benefits with Medigap coverage. Reversing this prohibition will make Medigap coverage more affordable for persons with HSAs.

Giving Employers More Flexibility in Offering HSAs

- Coordination With HRAs and FSAs: Employers should be allowed to combine HSAs with Flexible Spending Arrangements (FSAs) or Health Reimbursement Arrangements (HRAs) to cover medical expenses below the HDHP's deductible. Currently, employers face regulatory barriers that significantly limit their ability to combine these products. Allowing the coordination of these accounts will enable employers to develop innovative strategies for meeting their employees' health care needs.
- *FSA and HRA Rollovers:* Individuals with unspent funds in employer-based FSAs or HRAs should be allowed to transfer these funds into their HSAs. Current law allows such rollovers from Archer Medical Savings Accounts (MSAs), but not from other health care spending accounts. Allowing FSA and HRA rollovers would free up existing resources to help many individuals and families build up funds in their HSAs.

Promoting Tax Party and a Level Playing Field

- *Above-the-Line Tax Deduction:* Congress should enact an above-the-line tax deduction for all health insurance coverage, including HSA-compatible health plans, purchased in the individual market. This proposal would make health coverage more affordable for individuals by granting them the same tax-advantaged treatment that is available to Americans who receive employer-based coverage.
- *Tax Credits:* Congress should enact tax credits to help low-income persons purchase HSA-compatible health plans and other types of health insurance. Building upon the health care tax credits that Congress enacted in 2002, this proposal would put health insurance within the reach of many low-income Americans who are unable to afford coverage without assistance.
- *Contribution Limits:* The HSA contribution limits should be increased to allow consumers to contribute an amount equal to the out-of-pocket limits of their HDHP. Increasing this threshold will enable HSA account-holders to meet their health care expenses with after-tax dollars. Current law places an annual limit on the amount of funds consumers are permitted to deposit in their HSAs; this limit may be lower than the amount of the HDHP deductible.

Easing Administrative Complexities

- *Align Deductibles and Contribution Limits for Mid-Year Enrollment:* Current rules act as a disincentive for employees who want to enroll in an employer-provided HSA in the middle of the year. When employees establish an HSA in the middle of the plan year, they are not allowed to make a full year's contribution to the account—even though the employer is required to charge a full year deductible. This "mismatch" between the deductible and the contribution amount is a hardship for employees who want to sign up for HSA coverage mid-year. Employees should have the opportunity to make the full annual contribution when they enroll during the middle of a plan year, or the employer should be permitted to charge a smaller deductible.
- *Earlier Release of COLAs:* The annual adjustment of deductible amounts, out-of-pocket expense limits, and contribution limits should be announced by the Treasury Department earlier during the year to give employers sufficient time to determine their plan offerings for the new year. Instead of being announced in November, the adjusted figures should be announced by June 1.
- *Give Consumers More Time to Establish an HSA:* The current HSA law punishes consumers who may wait to set up their HSAs by prohibiting the use of HSA funds for any medical costs incurred before the account was set up. Experience has shown that some individuals may wait several months to complete the paperwork needed to establish an account at a financial institution—thereby delaying when they can use HSA funds to pay for medical costs. Consumers should have until the end of the tax year (April 15) to set up the account in order to pay for health costs incurred during that year.*Technical Change to ERISA COBRA Requirements:* Congress exempted the HSA financial account from the COBRA continuation of coverage requirements by amending the federal tax code to make clear that the COBRA law does not apply to the account. Continuation coverage is not necessary because the money in the account is "portable" and goes with the employee when he or she changes jobs. The HSA law, however, failed to enact a similar amendment to the ERISA law and there continues to be some confusion regarding the application of COBRA to the account. Therefore, a technical change is needed to provide an exemption for HSAs under the ERISA rules for COBRA continuation coverage. This change

would not affect the HDHP, which is subject to the COBRA continuation coverage requirements.

- *HSAs for Veterans:* Veterans who use VA health care facilities should be allowed to contribute money to an HSA. Under current law, any veteran who has accessed the Veterans Administration medical system within the past three months is prohibited from putting money into an HSA. This restriction hurts veterans—especially returning service personnel who have service-related injuries.

Progress at the State Level

Having reviewed these opportunities for further legislative improvements at the federal level, we also want to acknowledge the positive steps many states have taken to expand consumer access to HSAs. At the time HSAs were enacted by Congress in December 2003, many state laws impeded the offering or approval of HSA-compatible high-deductible health plans. For example, some state laws required coverage for certain types of benefits—or benefits for certain categories of individuals—before the minimum deductible amounts were reached. Other state laws prevented HMOs from offering HDHPs by either specifying the amount of deductibles and copayments or by interpreting requirements for "reasonable" deductibles or copayments as prohibiting these products. Still other states did not allow the HSA contributions to be deducted for state income tax purposes.

In the intervening years, most states have taken action to remove these impediments. In fact, as of June 15, 2006, all states except Illinois, Missouri, and New York have passed legislation to remove impediments to offering an HDHP in connection with an HSA. Moreover, only Alabama, California, New Jersey, Pennsylvania, and Wisconsin have not acted to make HSA contributions deductible for state income tax purposes.

V. THE IMPORTANCE OF TRANSPARENCY

Because HSAs provide an opportunity for consumers to be more actively engaged in their personal health care decisions, greater transparency—with respect to both the price and quality of health care services—is critically important in helping consumers and other purchasers make informed, value-based decisions. HSA accountholders are a catalyst for transparency and our efforts are evolving to meet their needs. AHIP and our members are strongly committed to making price and quality information more widely available and more easily understood for consumers with all types of health coverage.

Industry Efforts to Promote Transparency

In addition to implementing plan-specific initiatives, our members are working with other key stakeholders to give consumers information that will allow them to assess physician and hospital performance. In September 2004, AHIP joined a broad coalition of stakeholders, including the American Academy of Family Physicians and the American College of Physicians, to form a collaborative effort to determine how to most effectively and efficiently improve performance measurement, data aggregation and reporting in the ambulatory care setting. This broad-based coalition, the AQA, is now composed of more than 125 organizations representing physicians, consumers, employers, government, health insurance plans, and accrediting and quality organizations. In April 2005, the AQA endorsed a "starter set" of 26 clinical performance measures for the ambulatory care setting that are already being incorporated into provider contracts. The uniform starter set includes preventive measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and two efficiency measures that address the overuse and misuse of health care services. The AQA also has adopted new sets of measures for practitioners in the areas of cardiology (eight measures) and cardiac surgery (15 measures). These measures represent an important first step in establishing a broad range of quality standards to give consumers the information they need to make informed health care decisions.

Over the next few months, the AQA will be working toward identifying a starter set of efficiency measures. These measures will assess physicians' resource utilization when treating select conditions over a period of time. The AQA will seek to align these measures with existing clinical quality measures and ensure that they are appropriately adjusted for risk and case mix.

On another front, the AQA is receiving support from the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) to launch a pilot program in six sites across the country to combine public and private sector quality data on physician performance. This pilot program will test various approaches to aggregating and reporting data on physician perform-

ance, while also testing the most effective methods for providing consumers with meaningful information that they can use to make choices about which physicians best meet their needs.

This pilot program is being implemented in areas and through organizations that have a history of collaboration on quality and data initiatives among health plans and physician groups:

- California Cooperative Healthcare Reporting Initiative, San Francisco CA;
- Indiana Health Information Exchange, Indianapolis IN;
- Massachusetts Health Quality Partners, Watertown MA;
- Minnesota Community Measurement, St. Paul MN;
- Phoenix Regional Healthcare Value Measurement Initiative, Phoenix AZ; and
- Wisconsin Collaborative for Healthcare Quality, Madison WI.

A highly respected advisory committee of leaders in quality and performance design selected these six entities because they have the infrastructure and experience needed to support the combination of public and private data and, additionally, are positioned to implement the pilots within a short timeframe. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and public reporting of physician performance, which is an important step toward improving transparency and consumer decision-making.

Plan-Specific Initiatives to Promote Transparency

Individually, many AHIP members have taken steps to promote transparency. While plans use a variety of approaches, our industry is pioneering the next generation of consumer tools and resources to help Americans make value-based health care decisions. The following are examples of six plans that have implemented transparency tools to help their enrollees become better informed health care consumers.

Aetna has developed a suite of tools, called Estimate the Cost of Care, that allows its enrollees to estimate average in-network and out-of-network costs in the member's zip code for various health care services and products. These tools are a valuable resource for enrollees who are interested in cost information on prescription drugs, medical and dental procedures, office visits, medical tests, and a variety of diseases and conditions. For example:

- *Prescription Drugs:* Enrollees can access information about specific drugs, drug uses and interactions, and the cost of brand and generic prescription drugs at retail drug stores and through Aetna's mail-order program.
- *Office Visits:* Enrollees can receive estimates on the costs, by type and complexity level, for visits such as routine physicals and emergency room visits, and the potential cost savings if they choose participating physicians or hospitals.
- *Diseases and Conditions:* Aetna's Estimate the Cost of Care tools provide up to a year of estimated average total in-network costs for facility, doctor, pharmacy, and medical tests associated with specific diseases and conditions, such as asthma or diabetes, depending on their level of severity.

Building upon these tools, Aetna recently announced that effective August 18, it will provide online access to physician-specific cost, clinical quality, and efficiency information in Connecticut, Maryland and Washington, D.C. and in portions of Florida, Indiana, Kentucky, Ohio, and Virginia. This initiative will provide physician-specific pricing for up to 30 of the most widely accessed services by specialty along with indicators based on adverse events, hospital re-admit rates, and overall efficiency. In addition, Aetna will provide pricing information in Kansas City, Las Vegas, and Pittsburgh. These enhancements will provide Aetna members with clinical quality and efficiency information for more than 14,800 specialists and pricing information for more than 70,000 physicians.

Blue Cross and Blue Shield of Florida is broadening access to tools and resources to help its members find the information they need. With the following web-based, decision-support tools, members of this plan can access health care information, estimate health care costs, research a medical condition or procedure, and choose physicians and hospitals based on their needs.

- Hospital Advisor™—With this tool, members of Blue Cross and Blue Shield of Florida can find and compare hospitals based on major health topics, procedures, and/or type of care; compare hospitals based on clinical quality, outcomes, patient safety standards, reputation, and characteristics; and retrieve health care data from over 50 public industry and government data sources.
- Healthcare Advisor™—This interactive tool is designed to provide members access to personalized health care information to help them make well-informed health care decisions. Personalized information includes an educational assess-

ment for over 239 medical conditions and procedures, questions to ask a physician about managing a condition or preparing for a procedure, and links to resources including websites organized by health care topic.
- Physician Selection Advisor™—This tool provides members the ability to research and compare more than 700,000 physicians from the American Medical Association and other reliable sources. Physician attributes include various demographic, educational, and professional statuses.
- Treatment Cost Advisor™—This tool is designed to help members estimate the cost of specific health care services. It allows members to choose the type of service, provide some basic demographic information regarding age, region and gender and receive health care cost estimates.

CIGNA offers its enrollees a range of tools to assist them with their decision-making:
- *Hospital Value Tool:* Provides star-based health care ratings for in-network hospitals' patient outcomes and cost efficiency for 19 procedures.
- *Hospital Comparison Tool:* Provides side-by-side hospital comparison data for 200 medical and surgical procedures based on the individual's needs and preferences. This tool contrasts a number of factors including patient volume, hospital mortality and complication rates, average length of stay, and patient safety.
- *Prescription Drug Price Comparison Tool:* Provides real-time, actual out-of-pocket costs for brand name and generic prescription drugs, enabling CIGNA Pharmacy members to compare the actual costs charged by 54,000 retail pharmacies nationwide.
- *DrugCompare™ from WebMD:* Allows members to make side-by-side comparisons of medications or classes of medications for average drug costs, side effects, and drug interactions or contraindications.
- *CIGNA Care Network:* Offers members financial incentives for the use of select physicians who demonstrate superior health care outcomes. Members can access information on quality and/or efficiency for these specialists. Provider access is not limited as members can still select from any provider; however, members gain financial rewards for using providers within the CIGNA Care Network.

Harvard Pilgrim Health Care's member web site includes a section called "Understand Quality," which provides information, such as the Honor Roll, to help members make informed choices about their care. Harvard Pilgrim uses HEDIS measures to evaluate the quality of care provided by its contracted physician groups and has developed a Physician Group Honor Roll to recognize those groups that have provided outstanding care to Harvard Pilgrim members. Separate Honor Rolls are published for excellence in adult and pediatric care, and members are able to determine if an individual primary care physician is in a practice group that is on the Honor Roll. Harvard Pilgrim also promotes transparency in several other ways:

- An interactive on-line tool includes educational information about treatment options and what to expect for over one hundred different conditions and procedures. This tools allows members to rate the importance of various convenience, safety, and quality characteristics of hospitals and receive a display of hospitals that best fit their preferences.
- The Plan Cost Estimator allows Harvard Pilgrim members to estimate out-of-pocket expenses for themselves and their family members. Members enter projected utilization (doctor visits, prescriptions, etc.) based on history and expected utilization during the following year. They then indicate any chronic conditions, for which the Cost Estimator calculates typical expenses. The tool is pre-loaded to include the employee's contribution to the premium and any employer contribution to a reimbursement vehicle (Health Reimbursement Arrangement or Health Savings Account).
- The Harvard Pilgrim Independence Plan (a PPO offered for Massachusetts government employees and retirees) features consumer cost-share differentials based on a two-tiered physician network. Five high-volume specialties—cardiology, dermatology, general surgery, orthopedics, and gastroenterology—are tiered based upon variability in cost-effectiveness. Quality information is not part of the tiering, but is disclosed separately to members.

Humana has developed a SmartSummary Rx tool that is designed to assist consumers in planning for their future spending on health care services and prescription drugs. This tool, which is available through monthly paper-based or on-line statements, provides Humana's members with:

- personalized guidance about cost-saving drug alternatives and care options that are triggered by their specific prescription drug claims;

- details on the costs of their medications and the value of their plan, along with additional guidance tools that can enhance drug safety and medication-taking compliance;
- information showing where they are within the different stages of their prescription drug plan to help budget future out-of-pocket costs;
- details on the amounts members have paid versus what the plan has paid, along with information on specific discounts and how much money they have saved; and
- the ability to track prescriptions, including dosage, previous refill dates, and information on the prescribing doctor and pharmacy.

Independence Blue Cross has developed a number of tools to make information on provider performance and health care costs more transparent to its members. This includes:

- access to information on hospital quality and costs through a "HealthGrades" tool;
- a treatment cost estimator that allows people to estimate costs for management of conditions, diagnostic tests, office visits, and select procedures;
- a tool to compare the costs of various health plan options and to model HSA expenses;
- 24/7 Health Coaching to help members make more informed health care decisions using a Shared Decision model, including coaching on chronic illnesses and more than 20 significant decisions regarding surgery for specific conditions, and other types treatments;
- a pharmacy cost estimator; and
- health risk appraisals, a full set of wellness and prevention tools, and access to general health information.

Independence Blue Cross also is working with the Hospital Association of Pennsylvania, its local affiliate (the Delaware Valley Healthcare Council), and hospitals to create a state-wide hospital performance measurement system to enhance data on hospital performance. On another front, Independence is developing integrated quality and efficiency reports for twelve specialties. Data from this initiative will be shared first with physicians and later with members.

VI. CONCLUSION

Thank you for this opportunity to testify about the value of HSAs and opportunities for further strengthening this important health care option. We appreciate the support many committee members have demonstrated for HSAs and we look forward to continuing to work with you to advance solutions for further expanding access to high quality, affordable health care.

Mr. MCCRERY. [Presiding.] Mr. Jackson.

STATEMENT OF HAROLD JACKSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BUFFALO SUPPLY INC., LAFAYETTE, COLORADO, ON BEHALF OF THE U.S. CHAMBER OF COMMERCE

Mr. JACKSON. Thank you, Chairman, Ranking Member Rangel, Members of the Committee. I am Harold Jackson, President and CEO of Buffalo Supply, a 20-employee, women-owned small business specializing in distribution of medical equipment and supplies. We are located in Lafayette, Colorado.

I am pleased to be able to be here today to submit the following testimony for the record, and I am here on behalf of the U.S. Chamber of Commerce.

As President and CEO of Buffalo Supply, one of my most important duties is to attract and keep highly qualified employees. Therefore, making changes to the health care coverage offering for me and my employees is one of the most challenging things that I face.

In the spring of last year, I was faced with a difficult decision on how to address the health care insurance needs for our employees in light of a 21 percent projected increase in our current premium. At that time, we had in place a preferred provider option plan that had 80 percent reimbursement with a 20 percent copay for the first $3,000 dollars per employee, or $6,000 per family. After that amount was used up in any year, the major medical picked up 100 percent.

The annual premium for that policy ending May 31, 2005 was $102,000 for the 13 employees—that I have that opted for coverage. If I elected to renew that same policy, the price was going to be just over $123,000.

After reading about the recently passed Federal provision known as HSAs, I asked my insurance broker to look into HSA-conforming plans for our company. He came up with a high-deductible conforming plan through United Health Care, which had a $2,000 per employee deductible and $4,000 per family. Once the deductible is met, it is 80 percent reimbursement with 20 percent copay coverage, with a maximum out-of-pocket expense of $4,000 per person or $8,000 per family.

I was surprised that the premium was only $75,300 for these 13 employees, an astonishing 39 percent reduction over the cost if we had renewed our PPO plan. With the cost of the savings of the insurance premium on the HSA plan, I was able to have Buffalo Supply fund the savings accounts at a rate of $2,000 per employee, or $3,000 per family, which equated to a $35,000 cost. This effectively reduced the out-of-pocket maximum, when considering company contributions to the HSA, to $2,000 per person and $5,000 per family; that is, $1,000 in each category less than our PPO plan. So, Buffalo Supply was able to realize a 10.8 percent savings over renewing the PPO plan and provide better coverage to our employees.

Early this spring, I polled my employees on what they thought of the HSA plan, and they overwhelmingly endorsed it and urged me to continue an HSA vehicle for our insurance coverage.

As we start our second year with an HSA, we have an $1,100 per employee deductible and $2,200 per family. After that deductible is satisfied, the employee or family has 100 percent coverage. There are no copays for prescriptions, doctor visits, hospitalizations. Our employees pick up the full cost of the deductible and bear the burden of contributing to the savings plan should they desire. Every employee opted to contribute the maximum amount possible.

This year, the total premium is $115,400, slightly more than last year's cost, but we have one additional insured.

My employees and I are delighted with the concept of HSAs that allow us to benefit from our health care spending decisions and using pretax dollars.

While my employees and my family are very satisfied with the HSA-compatible health plan, I would like to take this opportunity to thank the Members of the Committee for working with the U.S. Chamber of Commerce and the HSA Working Group to introduce legislation that will improve HSAs, and I have some suggestions in my written testimony to make those improvements.

Thank you.

[The prepared statement of Mr. Jackson follows:]

Statement of Harold Jackson, President, Buffalo Supply, Inc., Lafayette, Colorado, on behalf of U.S. Chamber of Commerce

Chairman Thomas and Ranking Member Rangel, members of the Committee, I am Harold Jackson, President and CEO of Buffalo Supply, Inc., a 20-employee, women-owned small business specializing in the sale and distribution of medical equipment and supplies located in Lafayette, Colorado. I am pleased to be able to submit the following testimony for the record. 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 commend the Committee for its interest in having this hearing on the benefits of Health Savings Accounts.

Buffalo Supply, Inc. has been in the medical equipment and supply business since 1983 and we are currently the exclusive source for Stryker, Gaymar Industries and Baxa Corporation products. I joined the company in 1990 at which time company revenues were at $1.2 million. By building a strong reputation for service with my customers, I have been able to grow our revenues to the current level of $45 million in 2005.

As President and CEO of Buffalo Supply, Inc., one of my most important duties is to attract and keep highly-qualified employees. It is the employees of Buffalo Supply that carry the banner of our company and maintain the level of customer service that allow us to effectively compete in the marketplace.

I find health coverage is the most sought-after benefit that an employer can offer. In many cases, both present and potential employees judge the organization on the quality of the health plan that a company provides. In some cases, I have seen the level and quality of health care coverage to be the major factor on whether or not an employee accepts a job with an organization.

Indeed, the decision to make changes to the health care coverage offering for me and my employees at Buffalo Supply is one of the most challenging I face since it can have a dramatic impact on the level of employee satisfaction. On the one hand, like most small business owners, I am faced with continued soaring annual increases and must seek ways to contain these costs in order to stay competitive. On the other hand, I must be very careful in my decisions to pass on these increases by raising deductibles, lowering coverage, or by implementing a new coverage product that might not have the same appeal.

In the spring of last year I faced the difficult decision on how to address the heath care insurance needs for the employees of Buffalo Supply in light of a projected 21 percent increase in my current premium. At that time, we had in place a standard preferred provider option plan that had 80 percent reimbursement with 20 percent co-pay for the first $3,000 per employee or $6,000 per family in coverage. After that amount is used in any given year, major medical then picked up 100 percent. The annual premium for policy year ending 5/31/05 was $102,119.28 for the 13 employees that opted for coverage. If I had elected to renew the cost would have been $123,647.04.

After reading about a recently passed federal provision known as Health Savings Accounts, I asked my insurance broker to look into a HSA conforming plan for Buffalo Supply. He came up with a high deductible conforming plan with United Healthcare called their "Definity HSA" plan which had a $2,000 per employee and $4,000 per family deductible. Once the deductible is met there is 80 percent reimbursement with 20 percent co-pay coverage—with a maximum out of pocket of $4,000 per employee or $8,000 family. I was surprised that the premium was only $75,369.48 for the same 13 employees, an astounding 39% premium reduction from the projected costs for the PPO plan.

With the cost savings in the insurance premium of the "Definity HSA" plan, I was able to have Buffalo Supply fund the savings account portion at $2,000 per employee and $3,000 per family which amounted to $35,000. This effectively reduced the out of pocket maximum when considering the company contributions to the HSA to $2,000 per employee or $5,000 per family, which was $1,000 less in each category over the conventional PPO. Buffalo Supply was able to realize a 10.8% savings over the projected costs of the conventional plan and provide better coverage to our employees.

Early this spring, as we approached our anniversary date of the United Healthcare's "Definity HSA"plan at Buffalo Supply, I polled my employees on what they thought of the new plan. They all overwhelmingly considered the HSA plan a success and urged me to continue with this vehicle for coverage.

We just started our second year with a $1,100 per employee deductible and a $2,200 per family deductible. After the deductible is satisfied the employee and fam-

ily has 100% coverage—no co-pays for prescriptions, doctor office visits or hospitalization. The employee picks up the full cost of the deductible and bears the burden to contribute to the savings plan should they desire. Every employee has opted to contribute the full amount to the savings portion of the plan. This year the total annual premium is $115, 414.92, slightly more that last year's costs, but we are also insuring one additional person.

My employees and I are delighted with the concept of Health Savings Accounts that allow us to benefit from our health care spending decisions with the use of pretax dollars. This type of health plan puts the consumer in charge of how he or she may elect to spend their health care dollars. The excess rolls over year after year, and employees can take it with them to a new job or if they retire. I understand that United Healthcare, the company that provides Buffalo Supply's plan and the nation's largest purveyor of HSA-compatible insurance, has over 54,000 HSA-style accounts out of nearly 1 million enrollees in Colorado where I am located.

On behalf of Buffalo Supply and our employees, I would like to thank this committee for the work you have done on enacting this legislation into law. Having Health Savings Accounts as a viable health care option allowed Buffalo Supply to stem the increases in our health care premiums while enhancing the coverage for my 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.

- Increase the amounts individuals and employers may contribute to HSAs. The President's budget proposal includes an increase in HSA contribution limits to allow HSA participants to set aside more funds on a tax-free basis for their current and future health care needs. Under this proposal, HSA participants could contribute up to the out-of-pocket spending limits for their HSA-eligible high deductible health coverage—limited by statute to no more than $5,250 for self-only coverage and $10,500 for family 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).
- Permit up to $500 in unspent funds in flexible spending arrangements to carry forward to the following year or to be rolled-over into an HSA.
- Permit employers to convert funds contributed to health reimbursement arrangements (HRAs) to employees participating in HSAs.
- Allow employers to contribute higher amounts to HSAs for their lower-paid employees.
- Permit individuals over age 65 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.

I appreciate the opportunity to comment on Health Savings Accounts in front of the Committee. I especially applaud the Committee's interest in having this hearing. Thank you again, Chairman, Ranking Member and members of the Committee.

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.

More than 96 percent of the Chamber's members are small businesses with

100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the

U.S. Chamber of Commerce's 105 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strength-

ened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

Mr. MCCRERY. Thank you, Mr. Jackson. Mr. Lauer.

STATEMENT OF GARY LAUER, CHIEF EXECUTIVE OFFICE, eHEALTHINSURANCE, MOUNTAIN VIEW, CALIFORNIA

Mr. LAUER. Good morning, Mr. Chairman, Members of the Committee. Thank you for the opportunity to testify today. I am Gary Lauer, the CEO of eHealth. We are the parent company of eHealthInsurance, the Nation's leading online health insurance for individuals, families and small businesses.

We market and sell health insurance in all 50 States and the District of Columbia. We have partnerships with over 140 of the Nation's leading health insurance carriers, and we offer more than 5,000 unique health insurance products nationwide online. We serve families, individuals and small businesses as they search for quality, affordable health insurance solutions.

Our strategy and business model has always been to present products in an unbiased, objective way. Our goal is to help people find the health insurance product which best meets their needs.

Several years ago we found that policymakers and influencers have a real need for accurate information about the cost and benefits of health insurance offered and purchased in the marketplace. Consequently, we survey our national member base on a semi-annual and annual basis to ascertain what people are really spending on health insurance and what they really get.

Last month, we released the most recent of several reports providing a snapshot of the national HSA market, defined as HSA-eligible plans purchased through our company, eHealthInsurance, by individuals and families.

I am encouraged and, frankly, somewhat surprised by the growing acceptance of HSAs in the market across many age and income brackets. When HSAs were first introduced in January of 2004, many believed these products would be for the young and the wealthy. The results of our most recent survey show they have a much wider appeal.

If somebody could turn the projector on for me. Can you see——

Chairman THOMAS. [Presiding.] Do we have our very expensive, high-tech digital equipment available?

Mr. LAUER. While we are doing that, why don't I keep moving. What you will find in the written testimony are several charts from our study. The first shows that in 2005, nationwide, 42 percent of all purchasers are at least 40 years of age, and in fact, the age distribution of HSA purchasers in 2005 closely approximates the age distribution of the population across the United States.

Secondly, 45 percent of purchasers have household incomes of $50,000 or less——

Chairman THOMAS. Are you referring to the charts you included in your testimony?

Mr. LAUER. Yes.

Chairman THOMAS. So, if anyone wants to follow them notwithstanding the failure of the high-tech digital equipment, they are in the testimony included by Mr. Lauer.

Mr. LAUER. In fact, on that point, I am on chart 3 right now. Twenty-five percent of purchasers, or one in four, earned $35,000 or less annually. Overall, 41 percent of purchasers were uninsured previous to buying their HSA plan; and interestingly, the lower the income level, the higher the rate of people being uninsured previously.

Nationally, individual purchasers paid $114 monthly in 2005 for an HSA plan; a family paid $261. Contrast that to premiums paid in 2004, which were actually more expensive than 2005.

Seven out of 10 Americans cite affordability as the main reason they are uninsured. Any action that makes health insurance more affordable, we believe will result in more uninsured people finding coverage. I believe our data supports this.

I have three quick ideas today on the affordability issue. First, employers are allowed to deduct the cost of health insurance from their taxes, yet individuals who purchase their own health insurance cannot. Individuals and families should be able to deduct the cost of health insurance from their taxes just like businesses do. This would make health insurance more affordable for individuals and families who purchase health insurance on their own. It seems to us that equal tax treatment here is about fairness and equality.

Secondly, provide tax credits to low-income people who buy their own health insurance but don't earn enough to make the tax deduction a financial benefit. This refundable credit should be provided regardless of the type of health insurance they buy. The point here is to simply get families covered who were previously uninsured.

Finally, almost 57 percent of small businesses don't offer any health insurance coverage to employees. They would be, maybe, willing to make a contribution to their employees' health coverage, but many small businesses don't want the hassle of offering employee benefits or find it is too expensive to offer.

Today, both employers and employees can contribute to an HSA tax-free, but the savings of the HSA account cannot be used to pay for individual health insurance premiums. Allowing employees to use this money to pay for health insurance that they buy would encourage more small businesses to provide simple, affordable and predictable funding to their employees who would then have the opportunity to use their savings account to pay for health insurance they buy.

We think it is a simple and affordable solution for small businesses to get back in the game of helping to fund health care for employees. It is also my understanding that this solution is potentially tax revenue neutral.

The debate over how to provide cost-effective health care for all Americans continues. I don't see a universal solution to this problem. I also don't pretend to believe that HSAs will solve the problem for everyone, but clearly HSAs appear to have broad appeal to a large segment of the American population. Thank you very much.

[The prepared statement of Mr. Lauer follows:]

Statement of Gary Lauer, Chief Executive Officer, eHealthInsurance, Mountain View, California

Introduction

Chairman Thomas and Congressman Rangel, thank you for the opportunity to testify today and let me thank you both, and the Members of this Committee, for your interest in, and work on behalf of, the nation's small businesses and uninsured. I am present today to tell you about the experience of eHealthInsurance with Health Savings Account-eligible health insurance plans and to provide information to help you address enhancements which may assist more individuals, families, and small businesses in taking advantage of these new plans.

If I may, I'd like to take just a moment to tell you my background and the reasons I saw such great opportunities at the intersection of the Internet and health insurance. I come from a long background in technology. I spent many years with IBM, Silicon Graphics, and Meta Creations before becoming CEO of eHealth almost seven years ago at the company's beginning. I have seen advanced technologies bring new efficiencies to old industries, and provide expanded access to new products and services for consumers who may have been excluded from markets in the past.

At eHealthInsurance's inception, we saw the opportunity to use the Internet to reach people who previously may not have known where to go to get health insurance, or who assumed health insurance was just too expensive. I became passionate about the chance to be part of the solution for one of the most debated issues confronting our great nation today. Just as I've come to believe that eHealthInsurance can be part of the solution by helping consumers find the right health insurance, I also believe that Health Savings Accounts can be a viable solution for many small businesses and families who are looking for a simple and affordable health insurance option. HSAs allow these small businesses and families to take more control over how and where their health care dollars are spent.

Helping Real People in Need

eHealthInsurance is the leading online source of health insurance for individuals, families, and small businesses. We are licensed to market and sell health insurance in all 50 states and the District of Columbia. Given our unique experience marketing various types of health insurance across the nation, we have been invited here to share our experience with HSA-eligible health insurance plans. As a company, we have invested significant time and resources in building a scalable, proprietary e-commerce platform, and we have developed partnerships with over 140 of the nation's leading health insurance carriers, enabling us to offer more than 5,000 health insurance products online. Our e-commerce platform can be accessed directly through our Web site addresses at www.eHealth.com and www.ehealthinsurance.com, as well as through our broad network of partners. We organize and present voluminous and complex health insurance information in a user-friendly and understandable format, enabling individuals, families, and small businesses to research, analyze, compare, and purchase health insurance products that best meet their needs.

Forty percent of the people who purchase plans through eHealthInsurance state on their application that they have been uninsured for a significant period of time. A number of people approach eHealthInsurance with the misperception that health insurance is prohibitively expensive, but when they see the range of options, starting with some very low prices, many of them find they can afford health insurance.

After using our Web site to find and compare various HSA plans, many of our customers have become champions of this innovative solution.

Here are some of their actual stories:

1. **Greg Heloski,** 37-year old construction worker from Philadelphia, knew he was throwing the dice for more than four years when he didn't have heath insurance. He was concerned something "major" would happen but thought the high cost of health insurance outweighed the benefits. Greg has seen accidents on the job and even on the neighborhood basketball court where he plays regularly. Greg was surprised to find an HSA-eligible plan for $120 a month with a $2,600 deductible. Greg has put enough money away to cover his deductible. So far, he hasn't needed his HSA funds, but he's comforted knowing they are readily available should he need to cover any qualified expenses before his deductible is met.

2. **Mark and Noreen Eccleston** from Greenwood, Ark. bought their own health insurance ever since Mark left his job to start his own business, some 20 years ago. They found a low-cost plan through an association for the self-employed. Over the years, the Ecclestons saw their premiums rise from $250 per month to $1,000 per month.

Now in their 60s and sick of the spiraling costs, they went to eHealthInsurance.com to shop for individual policies. They chose an HSA-eligible plan with a $2,500 deductible for about $330 a month and are making tax-favored contributions to their Health Savings Account to pay for out-of-pocket expenses. Because they've had few medical expenses since buying the policy, they've been able to save money they can use over the next few years, even after they qualify for Medicare.

3. **Bill Lomel,** who owns a roofing company in Atlanta, Ga., was an early convert to HSAs. "I was just so discouraged about the cost of health insurance," he told Kiplinger's. He was already struggling to pay $750 a month for insurance for himself and his three children when he got a notice that the cost of the group policy for his employees was going to soar. "I thought, 'There's no way I can charge enough for anything in my business to cover that expense. I want to offer good competitive benefits to my employees, but I can't.'"

Now he knows that he can. Bill started by searching eHealthInsurance.com for his options for his family. He selected an HSA-eligible plan, and is currently paying $250 per month for himself, his wife and three children. The deductible is $5,000 per year, but Bill is saving at least $6,000 a year in premiums from his previous health insurance. In more than two years of fully funding his HSA, Bill has saved about $8,000 in his Health Savings Account. He uses the HSA to pay for some extra out-of-pocket expenses, but since his family has been healthy, he is mostly using it to save for future healthcare expenses.

Bill was so impressed with his HSA experience that he offered an HSA-eligible insurance plan as an option to his employees alongside a "traditional" health insurance plan. For the majority who selected the HSA-eligible insurance plan, he gave them the money saved on the premiums plus some additional money to help fund their HSAs to use for out-of-pocket costs, or savings for the long term.

4. **Roman Botcharnikov** of Maryville, Tenn., is the business director for his family-owned hair salon. Roman was concerned about the rising cost of healthcare and when he kept receiving increases to his family health plan, he decided to shop around. Roman's prior health insurance that he had more than two years ago covering himself, his wife and his teenage son, was $485 a month, totaling $5,820 per year.

Roman went on eHealthInsurance.com in early 2004, learned about HSAs and purchased a health insurance plan. Today he pays $305.23 a month, or $3,662.76 a year, to cover his family with a $3,600 deductible plan. He contributes the maximum amount to his HSA bank account. Roman remains a staunch HSA supporter, appreciative of his health plan's simplicity and opportunity for savings. "I go to the dentist and I just write him a check from the HSA account, and I don't have to mess with the insurance," he said. Last year, Roman was especially grateful to have his HSA when his wife needed surgery. While it required them to use money from the HSA to pay the deductible, after that their health insurance paid 100% of the bills, saving thousands of dollars.

Roman has advocated switching his employees to HSA plans, but admits it's been a tough sell gaining support for change in something as complex as health insurance. In particular, Roman said his employees in lower-income brackets don't yet see an advantage in switching to HSAs.

Real Data about Real People Purchasing HSA-Eligible Health Insurance

eHealthInsurance serves individuals, families, and small businesses as they search for quality, affordable health insurance solutions. Our strategy and business model has always been to present products in an unbiased, objective way. Our goal is to help people find a health insurance product which best meets their needs. Because of this, we have had a keen interest, for many years, in the development of public policy and legislation related to health insurance, and the plight of the uninsured in America.

Several years ago we found that policymakers and influencers seeking to help uninsured individuals, families and small businesses have a real need for accurate information about the cost and benefits of health insurance offered and purchased in the market. Consequently, we survey our national member base on a semi-annual and annual basis to ascertain what people are really spending for health insurance, and what benefits they really get.

When HSAs were first introduced and the market was responding with new products following HSA guidelines, we knew it would be beneficial to those same policymakers and influencers to have information available on the adoption of HSA-eligible plans. Therefore, we have produced semi-annual and annual reports on the char-

acteristics of those individuals and families across the U.S. purchasing HSA-eligible plans from eHealthInsurance since they were first introduced to the market.

This leads me to new information I would like to share with the Committee today. In May 2006, eHealthInsurance released its most recent report providing a snapshot of the HSA market, defined as HSA-eligible plans sold by eHealthInsurance to individuals and families from January 1 through December 31, 2005. This report was created:

- To identify and compare key demographics of HSA-eligible health insurance plans;
- To present and compare the monthly premiums for HSA-eligible health insurance plans;
- To outline the health insurance benefit levels included in the HSA-eligible plans purchased by consumers from January 1, through December 31, 2005; and
- To compare the latest figures to those provided previously, highlighting key changes in 2005.

The report is based on a sample of more than 12,000 HSA-eligible plans purchased between January 1 and December 31, 2005 through eHealthInsurance.com by individuals and families across the United States. In our report, an HSA-eligible health insurance plan is defined as those health insurance plans designated by health insurance companies to be in concurrence with the U.S. Department of the Treasury's HSA guidelines. In 2005, these included:

- Deductibles of a minimum of $1,000 for individuals and $2,000 for families; and
- Out of pocket limits of $5,100 for individuals and $10,200 for families per year.

Premium data included in the report is based on actual premiums paid by the individuals and families who purchased plans through eHealthInsurance. The premiums shown in this report are not quoted premiums, but represent what real people paid in real premiums.

This report does not address consumers' participation in the Health Savings Account banking portion of the HSA solution, although my company is presently working on compiling survey results on our customers' HSA banking activities. We will, of course, make that information available as soon as it is ready.

HSA-Eligible Plans in 2005

Characteristics of HSA-Eligible Plan Purchasers

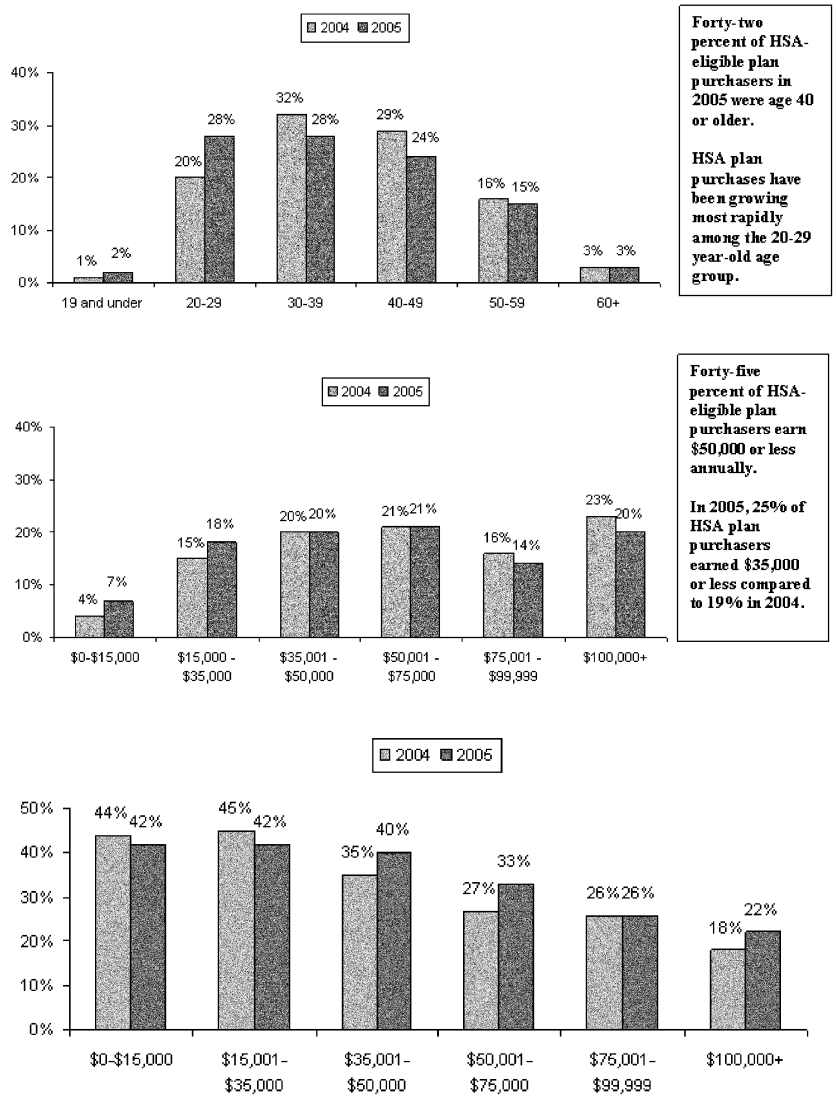
I am encouraged and somewhat surprised by the growing acceptance of HSAs in the market across many age and income brackets. When HSAs were first introduced in January 2004, many believed these products would be for the young and the wealthy. The results of our most recent study show HSAs have a much wider appeal.

Across 2005:

- 42% of purchasers are at least 40-years-old
- 45% of purchasers have household incomes of $50,000 or less
- 25% of purchasers have household incomes of $35,000 or less
- Overall, 41% of purchasers were uninsured previous to buying their HSA plan. Note, the lower the income level, the higher the rate of being previously uninsured.
- Nationally, individual purchasers paid $114 monthly in 2005 for an HSA plan, and a family paid $261. I'd also like to note that premiums paid in 2005 were less than premiums paid in 2004.

I realize that HSAs may not be for everyone. For those in the lowest income brackets these products may not be the solution without some kind of subsidy, but certainly these data indicate that HSA products can serve the needs of a broad segment of the American population.

Age Distribution of HSA-Eligible Plan Purchasers



Overall, 41% of 2005 HSA-eligible plan purchasers did not have prior health insurance.

The $35,001—$75,000 income brackets showed the largest increase in previously uninsured HSA plan buyers.

Percent of Previously Uninsured HSA-Eligible Plan Purchasers By Income Category ***HSA-Eligible Plan Costs and Benefits***

Key findings on pricing also indicate some encouraging news. Individuals paid 17% less for their HSA coverage in 2005 than consumers buying plans in 2004. These savings were achieved because more plans were introduced into the market, which provided individuals and families more choices and lower premium rates. In

2005, many consumers chose higher deductibles which resulted in lower monthly premiums.

Average Monthly Premiums for HSA-Eligible Plans

	Average 2004 Premium	Average 2005 Premium	% Change in Premium
Plans covering Individuals	$138	$114	–17%
Plans covering families	$277	$261	– 6%

The plans consumers purchased in 2005 continue to provide comprehensive benefits once the deductible is met. More than two-thirds of HSA plans cover regular office visits, and three-fourths cover OB/GYN office visits at 100% after the annual deductible is met. Nearly 80% of plans provide prescription drug benefits, and over 70% of plans cover benefits at 100% once the annual deductible is met.

Benefits Typically Included in HSA-Eligible Plans

Benefit	0% Co-Insurance	20% Co-Insurance	30% Co-Insurance	50% Co-Insurance	No Coverage	Other
Office Visits	69%	16%	3%	—	12%	—
Prescription Drug Benefits	71%	5%	3%	1%	17%	3%
Hospitalization, Lab and X–Ray Services	79%	18%	3%	—	—	—
OB/GYN Visits	79%	18%	3%	—	—	—
Emergency Room Service	79%	18%	3%	—	—	—

Recommendations

Seven out of ten uninsured Americans cite affordability as the main reason they are uninsured. (Source: Harvard School of Public Health, May 2004) Any action that makes health insurance more affordable, we believe, will result in more uninsured people finding coverage. I believe our data supports this.

My ideas today are focused on the affordability issue:

1. Employers are allowed to deduct the cost of health insurance from their taxes, yet individuals who purchase their own health insurance cannot. I suggest equal tax treatment of health insurance premiums for everyone. All individuals and families should be able to deduct the cost of health insurance from their taxes, just like business can. This would make health insurance more affordable for individuals and families who must purchase health insurance on their own. It seems only fair that people who need the health insurance the most have the same tax treatment as employers.
2. Provide tax credits to low-income people who buy their own health insurance but don't earn enough to make the deduction a viable option. This refundable credit should be provided regardless of the type of health insurance they buy. The point is to get these families covered.
3. Finally, 56.8% of small businesses don't offer any health insurance coverage to their employees. (Source: Kaiser Family Foundation, 2003) They may be willing to make a contribution to their employees' health coverage, but many small businesses simply don't want the hassle of offering employee benefits or they find it is too expensive to offer. Many small businesses simply avoid employee benefits because they fear they will be exposed to double-digit premium increases in the future.

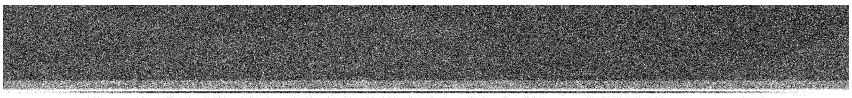
Today, both employers and employees can contribute to an HSA tax free, but the savings in the HSA cannot be used to pay for individual health insurance premiums. Allowing employees to use this money to pay for health insurance they buy would encourage more small businesses to provide simple, affordable, and predictable

funding to their employees, who would then have the opportunity to use their savings account to pay for their health insurance premiums.

It's a simple and affordable solution for small businesses to get in the game of helping to fund health care for their employees. And it assists employees by providing an additional funding mechanism for their health insurance premiums. It is my understanding that this solution is essentially tax revenue neutral.

Conclusion

The debate over how to provide cost effective health care for all Americans continues. I don't see a universal solution to the problem. While HSAs may not meet the needs of every American, they appear to have broad appeal to a fairly large segment of the American population. HSAs more and more appear to be a viable solution for many people and businesses looking to have affordable access to care, while insuring themselves against catastrophic financial loss.

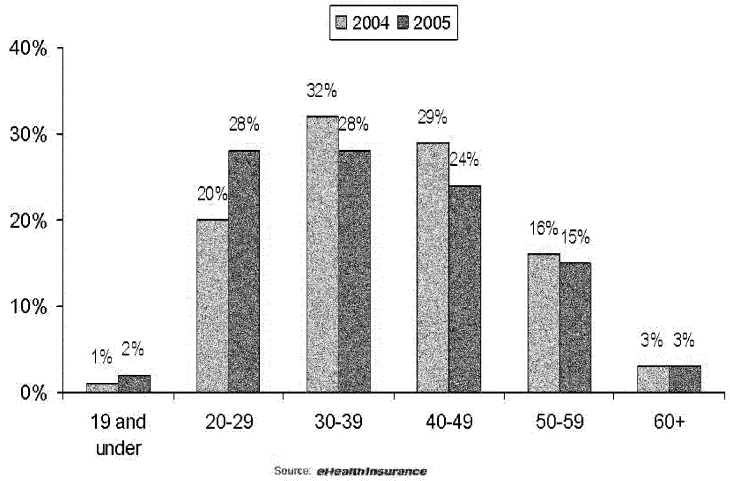


Committee on Ways and Means

Gary Lauer
CEO and Chairman eHealthInsurance

Wednesday, June 28, 2006

Age Distribution of HSA-Eligible Plan Purchasers



Source: eHealthInsurance

eHealth

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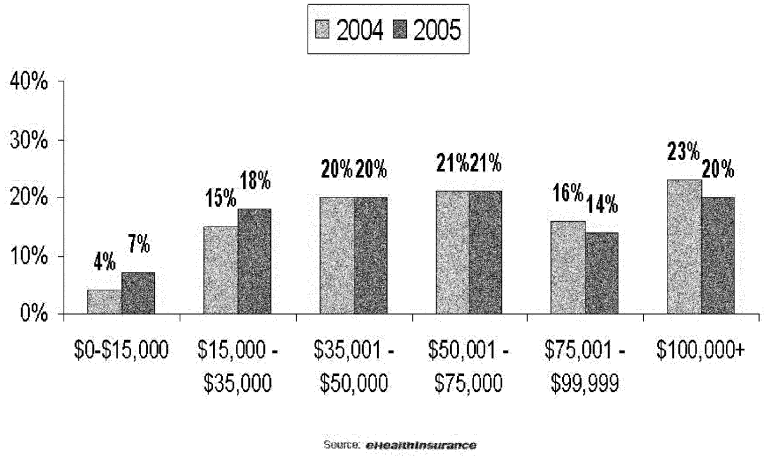
Annual Income Level of HSA-Eligible Plan Purchasers



Source: eHealthInsurance

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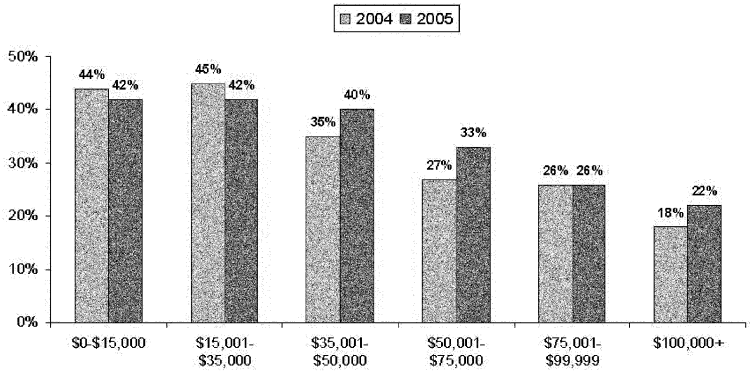
Percent of Previously Uninsured HSA-Eligible Plan Purchasers By Income Category*



Source: eHealthInsurance

- The U.S Census Bureau estimated that 45.8 million Americans (15.7%) did not have health insurance coverage in 2004.
- * Note: "Previously uninsured" is defined as a policyholder not having health coverage for a period of at least 6 months prior to purchasing the current coverage.

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Average Monthly Premiums for HSA-Eligible Plans

	Average 2004 Premium	Average 2005 Premium	% Change in Premium
Plans covering individuals	$138	$114	- 17%
Plans covering families	$277	$261	- 6%

Source: eHealthInsurance

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Benefits Typically Included in HSA-Eligible Plans*

Benefit	0% Co-Insurance	20% Co-Insurance	30% Co-Insurance	50% Co-Insurance	No Coverage	Other
Office Visits	69%	16%	3%	-	12%	-
Prescription Drug Benefits	71%	5%	3%	1%	17%	3%
Hospitalization, and Lab and X-Ray Services	79%	18%	3%	-	-	-
OB/GYN Visits	79%	18%	3%	-	-	-
Emergency Room Service	79%	18%	3%	-	-	-

Source: eHealthInsurance

*The benefits listed are commonly covered after the annual deductible is met and may require co-payments.

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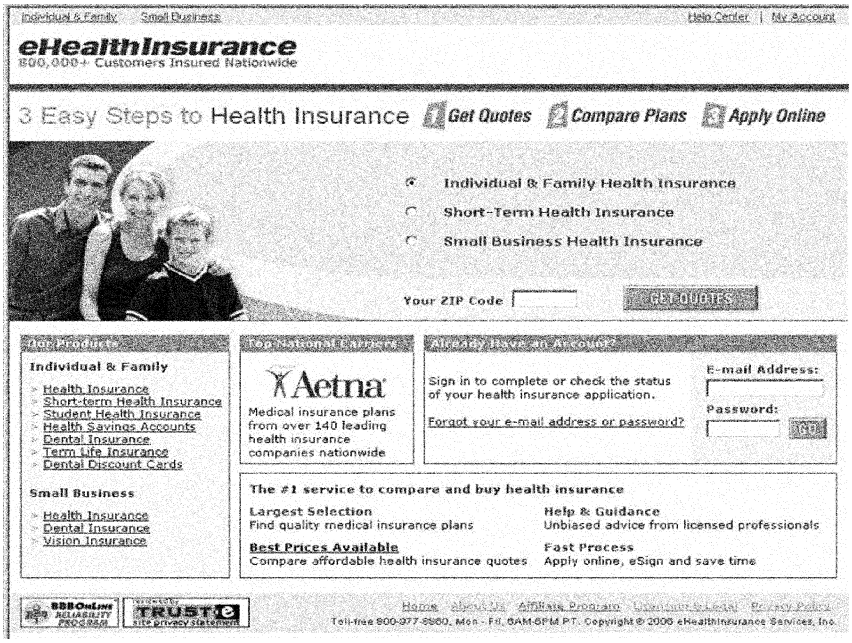

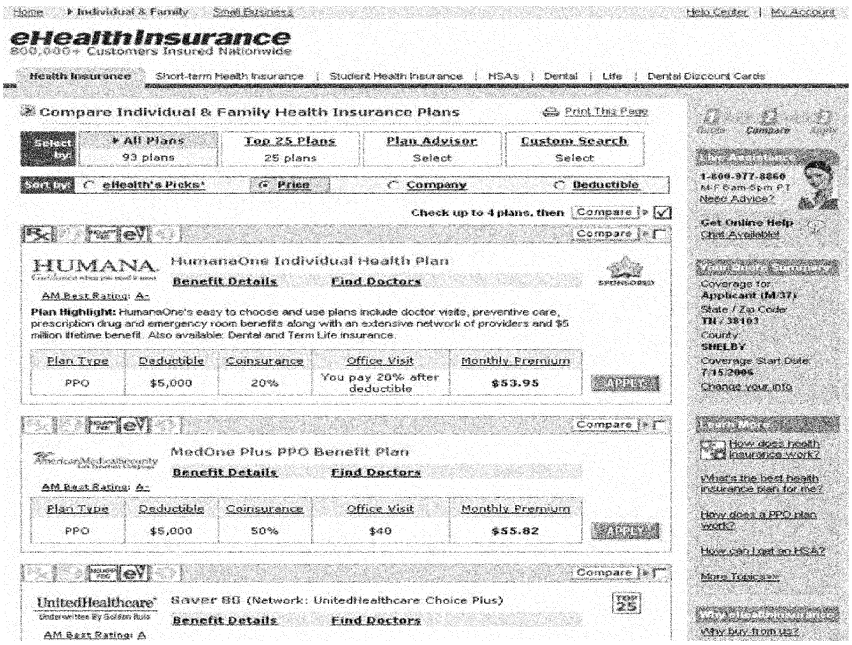

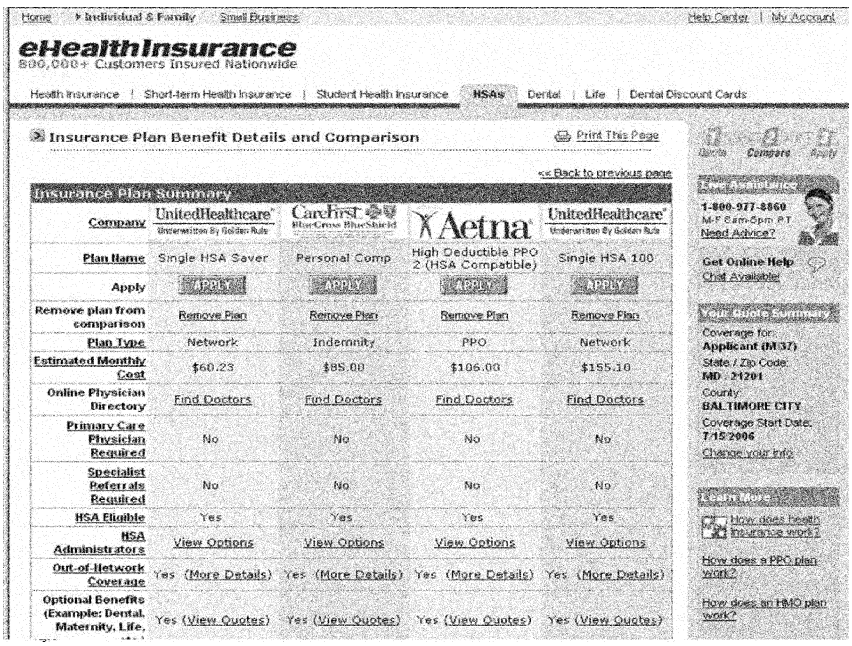

Chairman THOMAS. Thank you very much. Mr. Lutey.

STATEMENT OF LARRY W. LUTEY, VICE PRESIDENT OF HUMAN RESOURCES, LUTHERAN SOCIAL SERVICES OF ILLINOIS, DES PLAINES, ILLINOIS

Mr. LUTEY. Chairman Thomas, Ranking Member Rangel, Mr. Weller, distinguished Members of this historic Committee, I am Larry Lutey, Vice President of Human Resources of LSSI, a not-for-profit, and with some prayer and good management, a not-for-loss social services agency in the beautifully diverse State of Illinois. I am privileged to be here today, representing the 2,100 employees who are the most effective and committed individuals I know doing social services in that State.

The LSSI made the shift to a full replacement, high-deductible plan with an HSA due to a health care death spiral that was leading our organization into uninsurability. As health care trends began to rapidly increase, we looked at our mix of high- and low-risk employees in our current Health Management Organization (HMO), and we shared, as the increases went up, those increases with our plan participants, reducing coverage, and were unfortunately in a position where we had to raise deductibles to a place that become unaffordable for many of our individuals.

As our medical premiums increased 15 percent annually, employees began to leave the plan, primarily low-risk employees, leaving employees with significant health risk still in our plan. Once again, premiums soared, benefit levels were reduced, deductibles were raised and the cycle repeated itself.

The unintended, but most significant negative impact of this cycle was on those in our organization who made less than $30,000 per year, who were left with the choice of choosing salary over and against health insurance. Today, 47 percent of our individuals who are still insured fall into that income category.

Last July, I am pleased to say that the death spiral was broken, when we implemented a full-replacement HSA plan; and since that implementation, our annual rates have held to about 5 percent each year. The LSSI employees received real back-to-back cost-of-living increases as the agency was able to absorb the more modest increases in premiums.

We moved to HSAs because we had to; we remain there because we choose to. The unexpected result is a new sense of partnership and collaboration around health care that we have not seen before. In honesty, as I am representing all of our employees, I must tell you the other side of the story as well.

Some have found the plan expensive and difficult to manage and difficult to understand and have chosen to leave it for other options. Contrary to popular critique, this has little to do with income level or chronic illness.

I would recommend three changes to effect greater success of HSAs for those who employ the working poor. First, allow me to contribute higher amounts of money into the HSA accounts of my lower-paid staff who can't afford pretax contributions into the plan. We contribute 50 percent of the deductible into the HSA for every HSA participant, but the problem is that for those who make less than $30,000, contributing the remaining half is still too much to ask.

During orientation, the choice that my employees have is not between high plan or low plan; it is between health insurance and rent. While there is pending legislation to allow employers to place more dollars in the accounts of the chronically ill, it seems to me that HSAs can have an even greater impact if the comparability rules were also adapted to provide flexibility for the employer to make contributions on the basis of income level as well.

Second, allow me to incentivize my employees to wellness. Help me to prevent large health claims from even fitting the system by opening up the rules around prescription drugs. I will have the ability to ultimately lower premium costs for my employees and share with them the savings by making higher employer contributions into their HSAs. That is simply the best way that I know to make this model of health care accessible to lower-income families.

Finally, allow me the option to provide comparable coverage to the increasing number of retiring baby boomers who, instead of rocking life away on a porch, wish to contribute something back to their communities. I will be more than happy to hire those retiring baby boomers as they move from the work arena in their lives to the service arena, and I can do that if I can offer them health care in the form of an HSA that is complemented by their HRA, FSA or Medicare.

While it is true that consumer-driven health plans may not be an end in and of themselves, I firmly believe that they are the best option available for employers such as LSSI. More importantly, I believe they can positively influence the adverse selection issue facing the uninsured working poor by allowing individuals, at any level, access to health care and prescription drugs and wellness.

I would especially like to thank Representative Cantor this morning for his work and keen understanding of the changes that need to be made as reflected in H.R. 4511 and H.R. 5262. With these proposals and, I would suggest, a few additional tweaks, HSAs can have a positive impact on organizations such as LSSI.

I would like to thank the distinguished Committee for this opportunity to speak to them about this very important issue.

[The prepared statement of Mr. Lutey follows:]

Statement of Larry Lutey, Vice President of Human Resources, Lutheran Social Services of Illinois, Des Plaines, Illinois

Chairman Thomas, Ranking Member Rangel, and distinguished members of the Committee on Ways and Means, I am Larry Lutey, Vice President of Human Resources of Lutheran Social Services of Illinois, a not-for-profit, and with some prayer and good management, a not for loss social service agency in the beautifully diverse state of Illinois. We provide a full range of social services to 65,000 Illinois residents every year, through the dedicated work of our 2100 employees, on whose behalf I have the privilege to speak with you this morning.

LSSI is affiliated with Lutheran Services in America, an alliance of national Lutheran church bodies and their health and human service organizations. LSA has more than 300 members providing services throughout all 50 states and the Caribbean. Its members deliver over $8 billion in services to over one out of every 50 people in the United States. The network of organizations serves the elderly, children and families, people with mental and physical disabilities, refugees, victims of natural disasters, and others in great need. Through these efforts it is on the front lines of building self-sufficiency and promise in millions of lives.

Lutheran Social Services of Illinois, LSSI, made the shift to a full-replacement High Deductible Health Plan with an HSA on July 1, 2005 due to a health care "death spiral" that was leading our organization to uninsurability. Seven years ago, LSSI had a workable mix of low and high risk individuals covered under our tradi-

tional HMO health plan. As health care trends began to rapidly increase, LSSI, like many organizations, shared the premium increases with plan participants, reduced coverage, and raised deductibles to what became unaffordable levels.

As our medical increases reached double digits, for 7 consecutive years, the result was that employees began to leave the plan. Each year, more and more low-risk individuals shifted coverage to a spouse's plan, or purchased insurance on their own, while the higher risk employees remained. Our experience rates thus deteriorated, premiums went up, benefits continued to decline, and the cycle repeated itself. The death cycle for insurance coverage, is what we came to call it.

For seven years, we experienced a shift to providing coverage to a pool of high-risk participants, who, as costs escalated, had little alternative but to drive up experience ratios for our agency.

Contributions for both the employer and the employee escalated between 12 and 15% annually. The impact? You know it. Turnover, morale issues, pay increases absorbed by benefit expenses—but this too. The greatest impact was on those in our agency who made less than $30,000 per year. Over the seven year time frame, LSSI's participation in the plan dropped from 1320 participants, to 696 participating families today. Of the 696 families still insured, 90% of them still earn less than $50,000 annually, and 49% of those families earn less than $30,000.

New Employee orientation for benefits was not a conversation about whether the new employee would take the high plan, or the low plan, but rather, whether they would take health insurance, or pay for rent. In all honesty, we contributed to the pool of uninsured Americans in ways we did not intend, nor could control. As the July 1, 2005 benefit renewal period came to pass, the choice for us was not to provide a choice between HMOs and HSAs. The choice was between health insurance, and nothing.

Will Rogers once said, "Even if you are on the right track, you will get run over if you just sit there." The dangerous track LSSI was on, was a track leading to uninsurability, disparate impact for the working poor employed by our agency, and no relief for future cost containment.

On July 1 of 2005, the death spiral that was affecting LSSI was broken. Moving to a full-replacement HDHP with an HSA, premiums for last year, and the coming fiscal year, have been held to 5% annually. For the first time in 6 years, and now for the second consecutive year, LSSI employees received a pay increase while the agency was able to absorb the more modest increases in premiums. For 2 years, employees received a true cost of living increase. Turnover has begin to decline. That means jobs were not eliminated. It means programs were not cut, and it means employees had a viable option for quality heath care that was beginning to become affordable.

We moved to HSAs because we had to. We remain there because we choose to. Participation in the LSSI health plan has begun to stabilize. As our first open enrollment period ended only two weeks ago, I was eager to see how many of our employees would opt to leave HSAs, and how many, if any, would choose to come back to the plan after leaving the former model. 42 participants left. 33 returned. In short, our plan has begun to stabilize.

And while the process of education, promotion, and communication are continuous, there is a new sense of partnership and collaboration around health care that we have not seen before. LSSI moved from a parental health care plan to a collaborative effort of employer and employee working together to manage health care costs for our agency.

For us, it's not an employer thing. It's a partnership thing. To be frank, ultimately, I do not believe that HSA's are the magic solution to managing health care costs for our agency. *Reducing* claims, while still maintaining health is ultimately the solution. With this new model, every employee has a vested interest in making sound health care decisions, utilizing the nurse-care support services, health assessments, and other tools available to our staff. The plans works, not because employees are spending dollars of which they perceive they have a greater ownership, but rather because they value their own health, and now have resources to manage it. And the gains we make—together, employer and employee, are not money in our pocket. It is money shared with employees through increasing contributions to the HSA. That's the win, you see. For both of us.

To say it simply, HSAs have changed our focus. Wellness is understood as our primary tool for healing. Our communication and employee education strategy is simple: "One Employee At A Time," and to be honest, that's what open enrollment feels like when implementing an HSA. As well it should. For the focus is the person, not the group. That's what works for us in this plan.

But in truth, there is another side to this story as well. I don't want to leave you with the impression that our employees have fully embraced this plan, nor that they

are completely satisfied and supportive. I'm here today to also speak for those who are dissatisfied with the plan, who find it expensive, and complex. If my position were an elected one, I would not have remained in office the second year of our HSAs.

Some have found it difficult to manage, difficult to understand, difficult to access, and have chosen to leave the health plan for other alternatives. Contrary to many critics of HSAs, this has had nothing to do with income or chronic illnesses. Yet, their reasons are just. And I think we need to learn from them, what it is that can be done to improve these plans in the future.

LSSI contributes 50% of the high deductible into the HSA plan for every participating employee. For us, that's a $2500 investment in every employee's wellness. For those in the agency who are compensated more highly than others, who have discretionary income, this is a manageable set of circumstances. They withhold the balance from their paychecks to cover the remaining high deductible.

But for the 50% who make less than $30,000 annually, contributing the remaining half through pre-tax contributions is not attainable. The critics of the HDHP with the HSA say that the plan hurts lower income individuals, while assisting higher income individuals prepare a nest egg for future health needs.

And while there is pending legislation to allow employers to bend the comparability rules to place more dollars in the accounts of chronically ill employees, it seems to me that this can be a far more effective tool, if the comparability rules were also adaptable to income levels, especially for the working poor. It seems to me that this is, in fact, the very intent of HSAs: to provide savings for *future* health care needs for everyone.

Allow me to contribute more money into the HSA accounts of my lower paid staff, and lesser amounts into accounts of highly compensated employees, who can better afford their own contributions to the plan, and this model can work. Adjust the comparability rules, careful not to benefit higher paid employees, but rather assist lower income employees, and I believe that we can tame the disparate impact that is still far too present.

Allow me to incent my employees to wellness. Help me to prevent large health claims from even hitting the system by opening the rules around prescription drugs for preventive care. This is the best way I know to make this model of health care accessible to lower income families. Allow lower income individuals to acquire preventive medications as part of the preventive care component of HSAs, and I can then teach them how to use HSAs to save for more catastrophic health issues in the future. As an employer, I would much rather pay for the cost of preventive drugs in my premiums than pay for the escalating cost of significant health issues resulting from individuals perceiving they cannot afford to purchase and take preventive care prescriptions.

Help me to address the problem of lower income employees choosing to avoid taking basic, preventive medications because the negotiated discount rate between pharmacies and insurance companies is still not a discount for my staff when the cost comes out of their pocket because they cannot afford their half of the deductible. Allow my employees to manage their hypertension, cholesterol, diabetes and other diseases by making their drugs prescriptive preventive care items to be covered 100% from dollar one, and I'll have the ability to ultimately lower premium costs for all my employees, and share with them the savings in pay increases by making higher employer contributions to their HSAs.

Allow me to provide comparable coverage to the increasing number of retiring baby-boomers, who instead of rocking life away on a porch, wish to contribute back to their communities by serving LSSI and other employers as caregivers and valued employees.

Allow me to contribute to HSAs for our employees who are such an integral part of our organization, who happen to be 65 or older, and I will show you intergenerational communities who foster health in more ways than I can speak today. I'll be more than happy to hire those retiring baby boomers, as they move from the work arena to the service arena in their lives. And I can do that, if I can offer them health care in the form of an HSA that is complimented by their HRA, FSA or Medicare.

I am aware of the initiatives that have been brought to this distinguished House, specifically HR 4511 and 5262, and I would like to thank Representative Cantor for his work and understanding of the changes that need to be made. With these proposals, and I would suggest, a few additional tweaks, HSAs can truly impact the number of uninsured poor in our communities.

While it is true that Consumer Driven Health Plans ultimately may not be the end, in and of themselves, I firmly believe that they are clearly the best option available, and have the greatest potential, to assist employers in addressing the

growing number of uninsured employees in our workforce, in reducing disparate impact around health care for the working poor, and ensuring stability of organizations that seek to serve both our clients, and caregivers by allowing us to manage health care costs while still providing a quality health benefits plan at an affordable price. Affordable—for everyone. HSAs can do this.

I sincerely appreciate your investment of time in listening to these words, and I thank all of you who have worked to make the good things happen for my employees over the past two years. I eagerly seek to move into our future as an organization equipped for tomorrow, having learned from today.

Chairman THOMAS. Thank you, Mr. Lutey. Dr. Collins.

STATEMENT OF SARA R. COLLINS, PROGRAM FOR THE FUTURE ON HEALTH INSURANCE PROGRAM, COMMONWEALTH FUND, NEW YORK, NEW YORK

Dr. COLLINS. Thank you, Mr. Chairman, Ranking Member Rangel, Members of the Committee, for this invitation to testify on HSAs. The Committee is to be commended for focusing attention on the manifold problems currently 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 the delivery of care.

Some maintain that HSAs, coupled with high-deductible health plans are an important part of the solution for the cost, quality and insurance problems that plague the health system. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, 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 numbers of families without coverage.

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

Americans already pay far more out of pocket for their health care than citizens in any other industrialized country, and real per capita spending has been steadily rising over the last decade. When you combine that with sluggish growth in real incomes, families are spending increasing amounts of their income on medical costs. High out-of-pocket costs lead patients to decide against the health care that they need and reduce their ability to save for the future.

The early experience with HSA-eligible high-deductible health plans reveals low enrollment, low satisfaction, high out-of-pocket costs and cost-related access problems. Few people are currently enrolled in the plans; those who are enrolled are much less satisfied with them than those in more comprehensive plans. People in the plans allocate substantial amounts of income to their health care, especially those who have poor health or lower incomes. They are far more likely to delay, avoid or skip health care because of

costs, and problems are particularly pronounced among those with poor health or lower incomes.

People in the plans are more cost-conscious consumers of health care. They are more likely to ask for lower-priced drugs and to discuss treatment options and the cost of care with their doctors, yet few Americans in any health plan currently have the cost and quality information they need to make decisions.

Moreover, it is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of the health care system will be driven by patients' choice of provider. Patients are in the weakest position to demand greater quality and efficiency.

Most health care costs are incurred by very sick patients, often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances. Payers, Federal and State Governments, accrediting organizations and professional societies are much better position to insist on high performance.

Health Savings Accounts will not solve our uninsured problem. Under current law, fewer than 1 million currently uninsured people are expected to gain coverage as a result of HSAs. This is primarily because 71 percent of uninsured Americans are in a 10 percent or lower income tax bracket and would benefit little from the tax savings associated with HSAs. In fact, new proposals to expand HSAs may actually fragment group insurance markets and increase the number of people without coverage.

So, what needs to be done? We need to focus on more promising strategies for expanding coverage, improving affordability and lowering costs, and improving quality. These strategies include expanding group insurance coverage like employer-based coverage; eliminating Medicare's 2-year waiting period for coverage of the disabled; letting older adults buy into the Medicare Program; and building on Medicaid in the State Children's Health Insurance Program to cover low-income parents, young adults and single adults; ensuring affordable coverage for families by placing limits on health care costs as a percentage 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; high cost care management and disease management; improved access to primary care and preventive services; and investment in health information technology. Thank you.

[The prepared statement of Ms. Collins follows:]

Statement of Sarah R. Collins, Ph.D., Assistant Vice President, Program for the Future on Health Insurance Program, Commonwealth Fund, New York, New York

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 currently confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and premiums, wide variation in the quality and cost of care, and inefficiencies in the delivery and administration of 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. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, 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 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 might act as salt on a wound, exacerbating some of the very maladies that undermine our health care system's ability to perform at its highest level.

Higher Patient Cost-Sharing Is the Wrong Prescription

- Americans already pay far more out-of-pocket for their health care than citizens in any other industrialized country.
- Real per capita out-of-pocket spending has been steadily rising since the late 1990s. Combined with sluggish growth in real incomes, families are spending increasingly more of their incomes on medical costs.
- There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need.
- Rising out-of-pocket costs reduce people's ability to save for the future.

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

- Few people are currently enrolled in HSA-eligible HDHPs; those who are enrolled are 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.
- People in HDHPs are far more likely to delay, avoid, or skip health care because of cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- People in these plans are more cost-conscious consumers of health care: they are more likely to ask for lower-priced drugs and more likely to discuss with their doctors different treatment options and the cost of care.
- 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 on 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 even with adequate information and patient financial incentives, the transformation of health care system will be driven by patients' choice of provider. Patients are in the weakest position to demand greater quality and efficiency.
- Most health care costs are incurred by very sick patients, often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances.
- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.

HSAs Will Not Solve Our Uninsured Problem

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

New Proposals to Expand HSAs May Fragment Group Insurance Markets, Increasing the Number of Uninsured

- Additional tax incentives proposed by the Administration's 2007 fiscal year budget aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, with premium tax deductibility and tax credits. Economist Jonathan Gruber estimates that the Adminstration's proposals would actually increase the number of uninsured Americans by 600,000. While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small em-

ployers, would drop coverage. Some 8.9 million people would lose their employer-based health insurance.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and lowering costs. 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 low-income parents, 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.
  agement.
- Improved access to primary care and preventive services.
- Investment in health information technology.

HEALTH SAVINGS ACCOUNTS:

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 to solve them.

National health care spending is climbing by more than 7 percent per year and is expected to continue to outpace growth in the economy 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 or eliminating coverage altogether (Figures 2 and 3).[3]

Consequently, the number of people without health insurance in the United States is climbing steadily: in 2004, nearly 46 million people were uninsured, an increase of 6 million over 2000 (Figure 4).[4] An additional 16 million people 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.

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.[6] 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

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[1] Stephen. Heffler, et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* Web Exclusive 23 Feb 2005; C. Smith, et al., "National Health Spending in 2004," *Health Affairs* (Jan/Feb 2006): 186–196.

[2] Jon Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24 (September/October 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) August 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.

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

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 numbers 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 act as salt on a wound, exacerbating some of the very maladies that undermine our health care system's ability to perform at its highest level.

Higher Patient Cost-Sharing Is the Wrong Prescription

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 citizens do in any other industrialized country (Figure 5).[7] Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 6).[8] Higher spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their earnings on medical costs. A Commonwealth Fund report by Mark Merlis found that the percentage of households spending 10 percent or more of their income on out-of-pocket costs rose from 8 percent during the years 1996—97 to 11 percent in 2001—02 (Figure 7).[9] Including premiums, 18 percent of all families spent more than 10 percent of income on health care.

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care.[10] Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs, and it increased the risk of adverse health events (Figure 8).[11] In addition, a review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.[12] Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found 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.[13]

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 Employee Benefit Research Institute (EBRI) and 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 9).[14] An additional 9 percent had an HSA-eligible HDHP but had not yet opted to

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

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

[9] M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.

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

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

[12] 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 (December 2004): 415—452.

[13] 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.

[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) December 2005. The EBRI/Commonwealth Fund Con-

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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 (FEHBP) (Figure 10).[15] A recent study by America's Health Insurance Plans 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.[16] 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.[17]

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. In addition, higher deductibles have also attracted those who are in better health. 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 11).[18] Rates of enrollment in the plans were higher among federal employees under age 54 than among those ages 55 to 64 (Figure 12). 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.[19]

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 a choice (Figure 13).[20] 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. Those in comprehensive plans chose them for low out-of-pocket costs.

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 14–15).[21] More than half of those in the plans were not satisfied with their out-of-pocket costs. Moreover, one-third of those in the plans 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 16–17).

High out-of-pocket costs. The high rates of dissatisfaction with the costs of HSA-eligible HDHPs likely stem from the substantial amount of income people in these plans allocate to their health care, particularly those individuals with health problems or in lower-income households. The Kaiser/HRET Employer Health Benefits Survey 2005 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

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sumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1200 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 1061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA.

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

[16] 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.

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

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

[19] 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; General Accounting Office, 2006.

[20] 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.

[21] 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.

other plans (Figure 18).[22] The EBRI/Commonwealth Fund survey found that two-thirds of adults who are enrolled in a HDHP with an HSA or HRA 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 19). 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.[23] 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.

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 individual HDHPs with accounts had deductibles of $2,000 or more.[24] 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.

Cost-related access problems. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay, avoid, or skip health care. 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 20). 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 medication were highest among people with health problems (Figures 21 and 22).

Risk of medical debt. When people with high-deductible health plans access health care, they are at risk of accumulating medical debt. Karen Davis and colleagues examined data from the Commonwealth Fund Biennial Health Insurance Survey (2003) and found that adults with deductibles of more than $500 were more likely than those in lower-deductible plans to report that they had problems paying medical bills or that they were paying off medical debt over time (Figure 23).[25] 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.

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 that 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 24).[26]

Information Currently Available to Enable Patients to 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 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 cost and quality information they need to make decisions and what 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 health plan on the quality

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

[23] 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.

[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

[25] K. Davis, M.M. Doty and A. Ho., *How High is Too High? Implications of High Deductible Health Plans* (New York: The Commonwealth Fund) April 2005.

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

of care provided by their doctors and hospitals (Figure 25).[27] 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 26). 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 Reduce Health Care Costs Dramatically or Improve Quality

It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care will be driven by patient choice of provider. Patients are in the weakest position to demand greater quality and efficiency. Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.[28] Most health care costs are incurred by very sick patients—those with heart attacks, strokes, cancer, mental illness, fractures, and injuries—often under emergency conditions. Ten percent of the sickest patients account for about 70 percent of all health care spending (Figure 27).[29] Shopping for the best physician or hospital is impractical in such circumstances. Moreover, to the extent that consumer-driven plans encourage people to skimp on preventive care or chronic disease management, they could fuel growth in health care costs over time.

Patients are also unaccustomed to seeking information on price or quality, or trusting the information that is available. The EBRI/Commonwealth Fund survey found that the most trusted source of information on the quality of providers is the patient's own physician (Figure 28).[30] The least trusted sources of information are health plans and government agencies—with only one of 20 trusting those sources of information. Yet health plans and government agencies are far more likely to be able to assemble the required information.

Still, studies regularly find that public information on quality is not used by patients. New York and Pennsylvania were pioneers in publishing information on cardiac surgery mortality by name of surgeon and hospital, yet few patients in these states avail themselves of this information.[31] The data were valuable because hospital CEOs investigated the reasons for poor performance and took necessary action—not because patients voted with their feet.[32]

Provider response to public information is, in fact, one of the strongest arguments for public reporting. The National Committee for Quality Assurance has found that those managed care plans that report their quality data publicly are more likely to improve.[33] Hospitals that report such information take steps to improve the care they deliver.[34] And a recent study found that the top-performing medical groups

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[27] 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.

[28] See also 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.

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

[30] 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.

[31] 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 (April 2000): 1866—1874.

[32] 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 (April 2000): 1866—1874.

[33] National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005).

[34] 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/August 2005 24(4):1150–60; J.H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs,* March/April 2003 22(2):84–94.

were those that reported quality data publicly, either voluntarily or because of local reporting requirements.[35]

HSAs Will Not Solve Our Uninsured Problem

The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people who are uninsured. 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 29).[36] 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 19 by Medicaid and the State Children's Health Insurance Program (SCHIP).[37] Nearly 70 percent of uninsured young adults are in families with incomes under 200 percent of poverty (Figure 30).

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 people in the EBRI/Commonwealth Fund Consumerism in Health Care Survey who had purchased an HSA-eligible HDHP, but not opened an account, had done 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 31).[38]

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.

New Proposals to Expand HSAs May Fragment Group Insurance Markets, Increasing the Number of Uninsured

In its most recent 2007 fiscal year budget, the Administration proposed additional tax incentives for people to purchase HSA-eligible HDHPs in the individual market. The proposals, which aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, would allow a tax deduction for premiums associated with HSA-eligible HDHPs in the non-group market, along with a tax credit of 15.3 percent to offset the premium cost. Or, low income individuals and

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[35] 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 (August 2005): 407–434.

[36] 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) April 2006.

[37] 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.

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

families could opt for a tax credit of $500 per child and $1,000 per adult, and up to $3,000 per family premium.[39] The proposal also includes a 15.3 percent tax credit to be applied to HSA contributions, which are already tax-exempt.

Jonathan Gruber, an MIT economist, estimates that the Adminstration's proposals would actually increase the number of uninsured Americans by 600,000.[40] While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would respond to the equal tax treatment of some policies in the individual market by dropping coverage. Consequently, Gruber estimates that 8.9 million people would lose their employer-based health insurance. While some people who lose their coverage would buy insurance in the individual market, about 4.4 million would become uninsured.

What Nees to Be Done?

Armed with the right information, patients can contribute in a small way to better 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 placing greater financial burdens on the sickest and poorest patients is not the right prescription for what ails the health care system. Nor is it the right prescription for people when they are ailing. High-deductible health plans increase the risk that patients will fail to get care early on, before a health condition becomes serious, and fail to get medications that could control their risk factors and chronic conditions.

Health care costs are high because of the fragmented way we organize and deliver health care, and because we provide the wrong financial incentives to hospitals and doctors. If we want to transform the health care system, we will need to make fundamental changes in current payment methods. Medicare's physician group practice demonstration (Figure 32) is a step in the right direction and should yield valuable insight into whether gains in efficiency and quality can be achieved simultaneously. Some state Medicaid programs, particularly Rhode Island's RIte care (Figure 33), have had excellent results in both slowing the rate of increase in premiums and improving quality.[41] A Fund-supported evaluation of the PacifiCare pay-for-performance initiative in California also found promising results.[42] Yet, these programs are just the beginning, and Medicare, Medicaid, and private payers need to do much more to change financial incentives for providers so that they systematically reward high quality and efficiency.

To achieve transparency in quality and costs in our health system, Medicare needs to take a leadership role in making total cost and quality information by provider and by patient condition publicly available. Medicare should also forge public—private partnerships to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs.

Conflicting quality metrics used by different parties, however, have the potential to add to administrative burden on providers. 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 set priorities, oversee the development of appropriate quality and efficiency measures, ensure the collection of timely and accurate information on these measures at the individual provider level, and encourage their incorporation in pay-for-performance payment systems operated by Medicare, Medicaid, and private insurers.[43]

Investment in health information technology is essential to ensure the right information is available at the right time to patients, providers, and payers. While many have called for such change, the current state of affairs is inadequate. Only about one of four physicians has electronic health records, demonstrating that the benefits of modern information technology (IT) are far from being realized.[44] Some private

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[39] These tax credits would be phased out at incomes between $15,000 and $30,000 for individuals and between $25,000 and $60,000 for families.

[40] J. Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals,* Center on Budget and Policy Priorities, February 15, 2006.

[41] S. Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations,* The Commonwealth Fund, January 2003.

[42] 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,* October 12, 2005, 294 (14): 1788—93.

[43] Institute of Medicine, *Performance Measurement: Accelerating Improvement,* National Academies Press, Washington, DC: December 2005.

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

insurers have begun to build rewards for IT into their payment systems. Medicare and Medicaid should consider doing the same, at least on an initial basis, to encourage the adoption and utilization of IT.

But we will never achieve a high performing health care system when millions of Americans are 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. 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 (Figure 34).[45] Uninsured adults are also far more likely to report inefficiencies in their care, such as receiving duplicate tests (Figure 35).

Health care needs to be made more affordable—not less affordable—for patients. We need to cover the nation's 46 million uninsured, building on group forms of coverage that we know pool risk and provide affordable, meaningful protection to people.

The individual market is not a solution for our uninsured problem. The administrative costs of individual coverage comprise 25–40 percent of each premium dollar compared to 10 percent of group coverage.[46] This means premium dollars buy fewer benefits in the non-group market than they do in employer 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.[47] A report by the Commonwealth Fund found that of adults who had considered purchasing individual insurance coverage, 35 percent said that it was very difficult or impossible to find a plan that met their needs.[48]

In addition, to remain competitive and to be responsible to their shareholders, insurers in the non-group market necessarily estimate risk and set premiums sufficiently high to cover risk. 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.[49] 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, 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 low-income parents, young adults, and single adults.[50]

In many cases, patient cost-sharing is far too high and deters access to needed care. Approximately 16 million adults in the U.S. are underinsured and report difficulty obtaining needed care as well as heavy financial burdens.[51] Rather than insisting on minimum deductibles of $2,100 per family, our nation's health policy should be geared toward setting maximum limits on family cost-sharing, for example, 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Guaranteeing affordability of care for all Americans will help ensure that patients receive appropriate preventive care, detect serious conditions in early stages, and control chronic conditions that would otherwise undermine health and functioning and lead to higher costs later in life.

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[45] 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) April 2006.

[46] 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.

[47] S. R. Collins, S.B.Berkson, D.A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund) December 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.

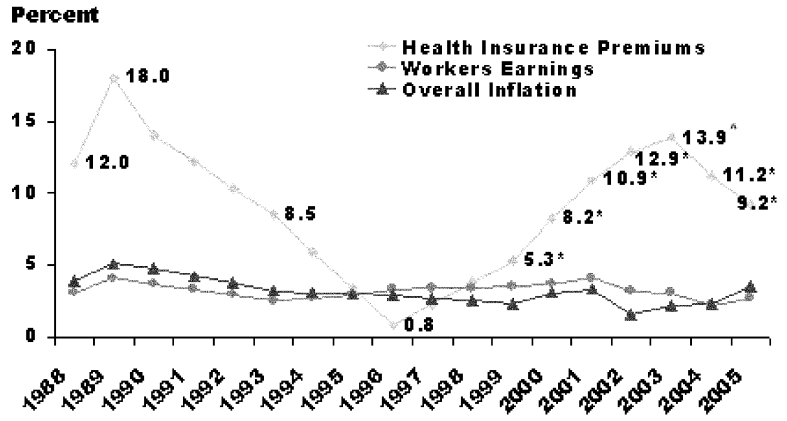
[48] L.Duchon and C. Schoen, *Experiences of Working Age Adults in the Individual Insurance Market: Findings from the Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund) December 2001.

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

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

[51] 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.

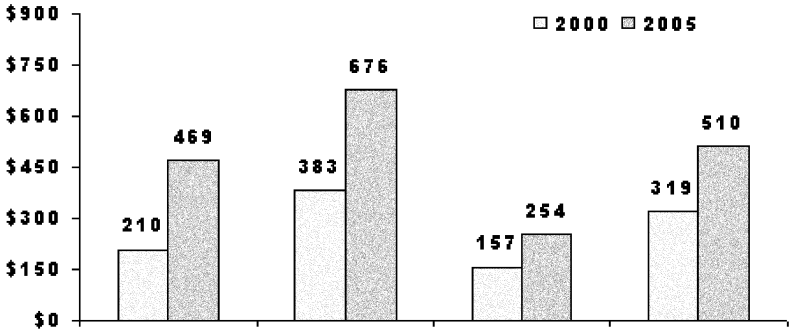
Figure 1. Increases in Health Insurance Premiums Compared to Other Indicators, 1988–2005



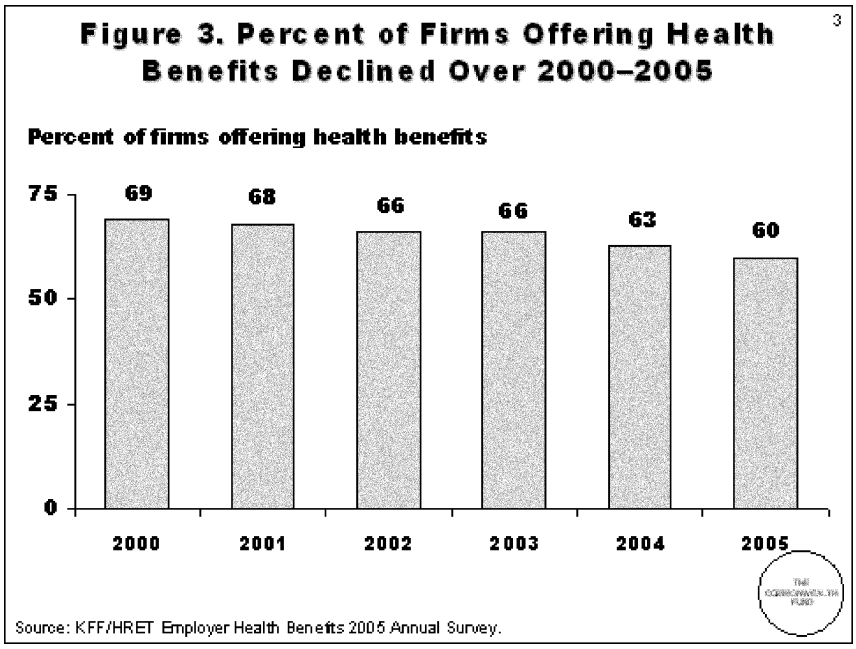
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2005.
*Estimate is statistically different from the previous year shown at p<0.05.
^ Estimate is statistically different from the previous year shown at p<0.1.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

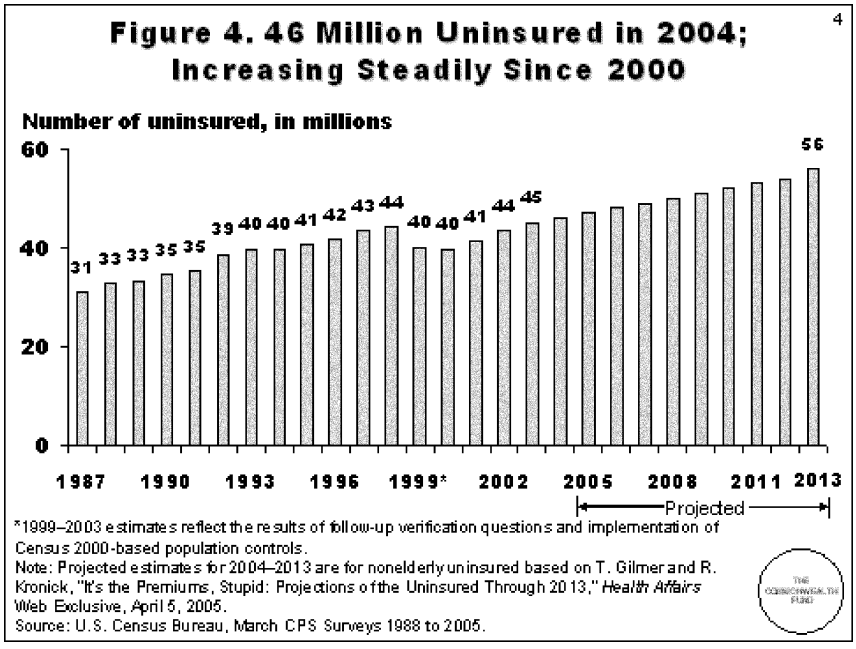
Figure 2. Deductibles Rise Sharply, Especially in Small Firms, Over 2000–2005*

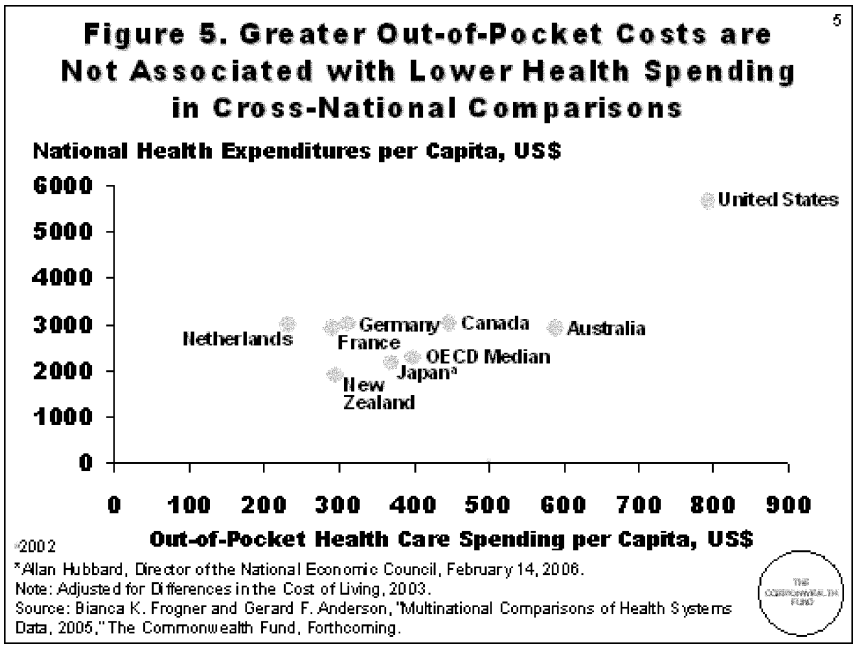
PPO in-network and out-of-network deductibles



*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, April 2004); KFF/HRET Employer Health Benefits 2005 Annual Survey.


3
Figure 3. Percent of Firms Offering Health Benefits Declined Over 2000–2005
Percent of firms offering health benefits
75
50
25
0
69
68
66
66
63
60
2000
2001
2002
2003
2004
2005
Source: KFF/HRET Employer Health Benefits 2005 Annual Survey.


4
Figure 4. 46 Million Uninsured in 2004; Increasing Steadily Since 2000
Number of uninsured, in millions
60
40
20
0
31 33 33 35 35 39 40 40 41 42 43 44 40 40 41 44 45 56
1987
1990
1993
1996
1999*
2002
2005
2008
2011
2013
Projected
*1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.
Note: Projected estimates for 2004–2013 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, April 5, 2005.
Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.


5
Figure 5. Greater Out-of-Pocket Costs are Not Associated with Lower Health Spending in Cross-National Comparisons
National Health Expenditures per Capita, US$
6000
5000
4000
3000
2000
1000
0
United States
Netherlands
Germany
France
Canada
Australia
OECD Median
Japan[a]
New Zealand
0
100
200
300
400
500
600
700
800
900
Out-of-Pocket Health Care Spending per Capita, US$
[a]2002
*Allan Hubbard, Director of the National Economic Council, February 14, 2006.
Note: Adjusted for Differences in the Cost of Living, 2003.
Source: Bianca K. Frogner and Gerard F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Forthcoming.

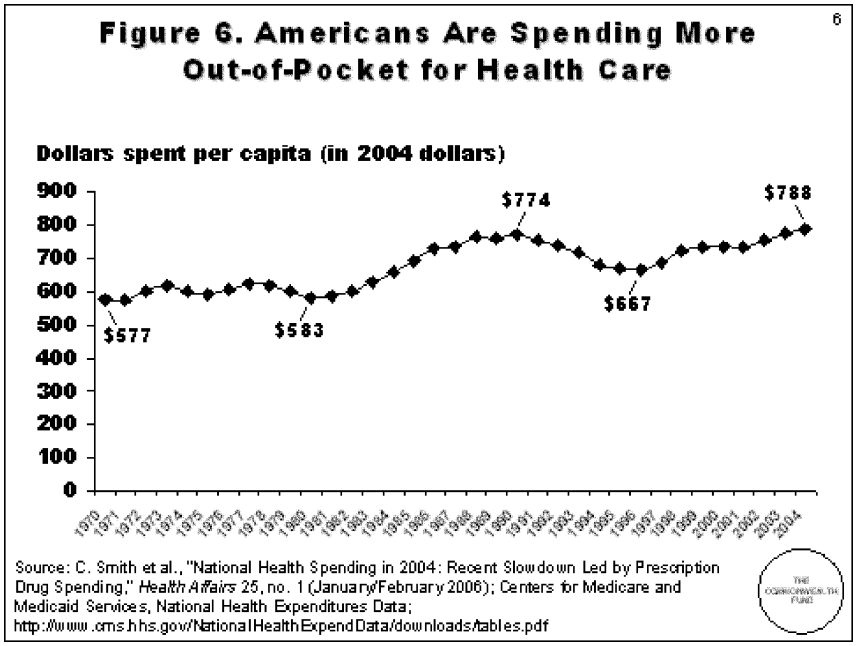
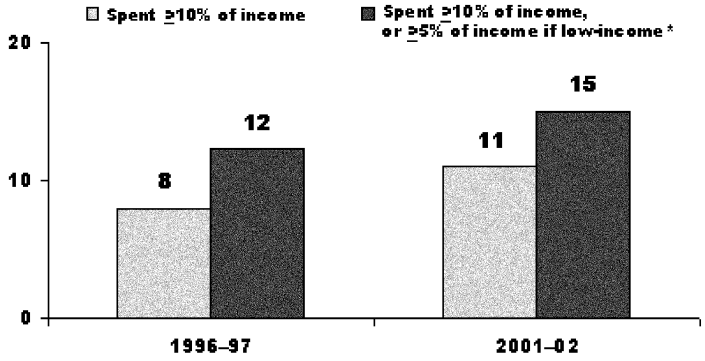
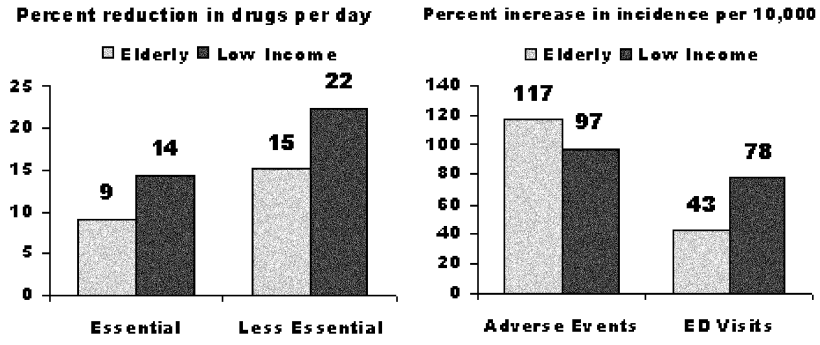

6
Figure 6. Americans Are Spending More Out-of-Pocket for Health Care
Dollars spent per capita (in 2004 dollars)
900
800
700
600
500
400
300
200
100
0
$577
$583
$774
$667
$788
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Source: C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," Health Affairs 25, no. 1 (January/February 2006); Centers for Medicare and Medicaid Services, National Health Expenditures Data; http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

Figure 7. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001–02



*Low-income includes families with incomes <200% of the federal poverty level.
Source: M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.

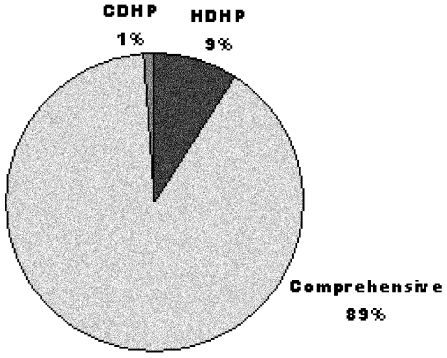
Figure 8. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



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

Figure 9. Few Insured People Are Currently Covered by High Deductible Health Plans (HDHP) or Consumer Directed Health Plans (CDHP) with a Savings Account

9

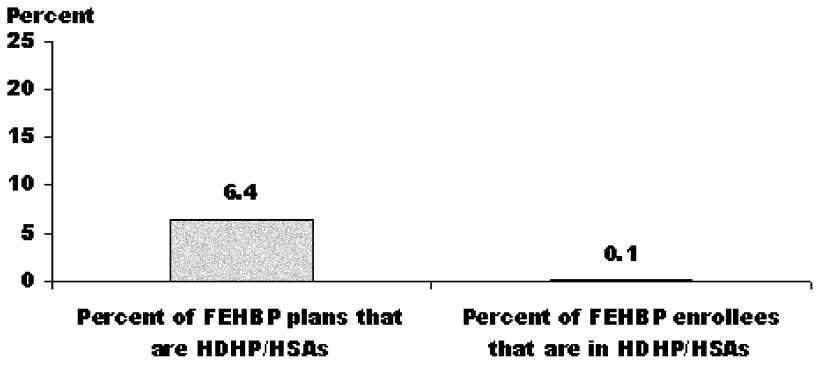


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.

Figure 10. FEHBP HDHP/HSAs Plans Enroll 7,500 out of 9 Million Covered Lives

10

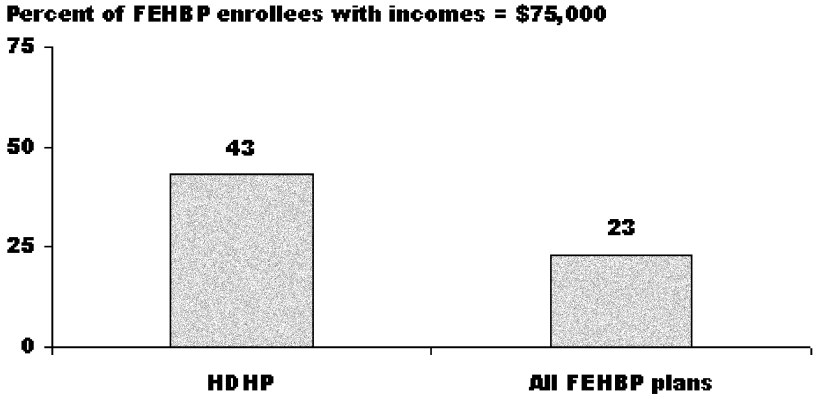


Note: As of March 2005.

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

Figure 11. Enrollees Who Chose HDHPs From the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes

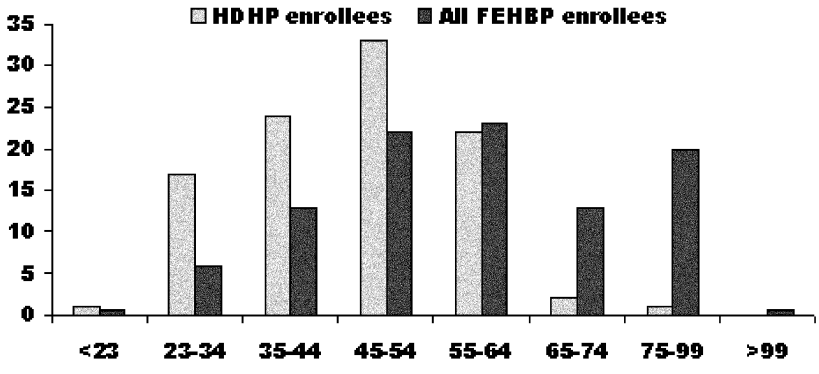
11



Source: Government Accountability Office, *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006.

Figure 12. Age Distribution of HDHP and Other FEHBP Enrollees

12

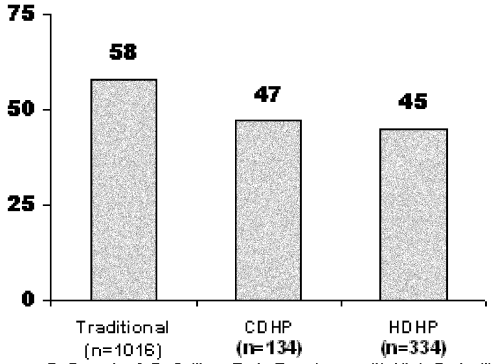


Source: Government Accountability Office, *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006.

Figure 13. Less than Half of Those Enrolled in Employer-Based High Deductible Health Plans Had a Choice

13

Percent of adults with employer-based coverage who were offered a choice of health plans

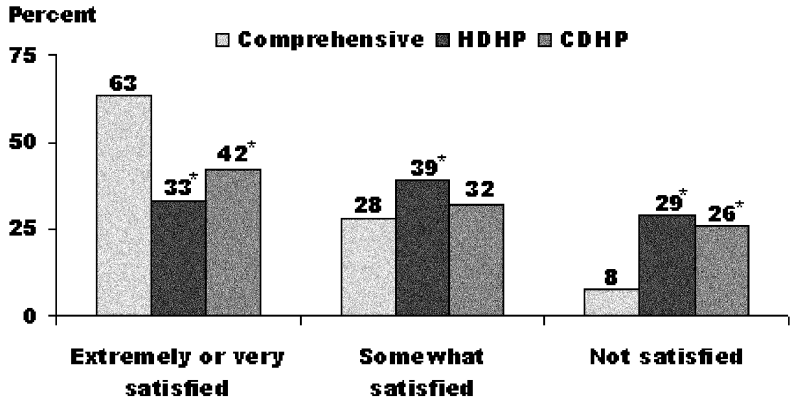


- **CDHP and HDHP owners are less likely to have a choice of plans from their employer**
- **When they have a choice, the savings account is the leading reason for choosing CDHP, while premium cost is the most frequent reason for choosing HDHP. Traditional plans are chosen for low out-of-pocket costs.**

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, December 2005.

Figure 14. Enrollees of HDHP/CDHPs Are Less Satisfied with Their Coverage

14

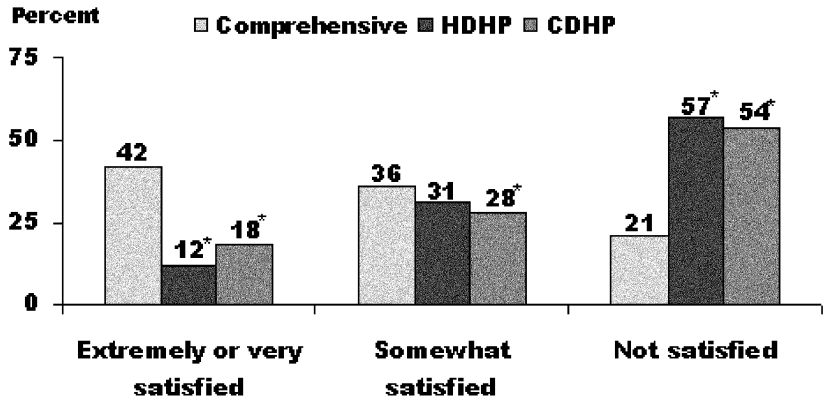


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 15. Enrollees of HDHP/CDHPs Are Less Satisfied with Out-of-Pocket Costs

15

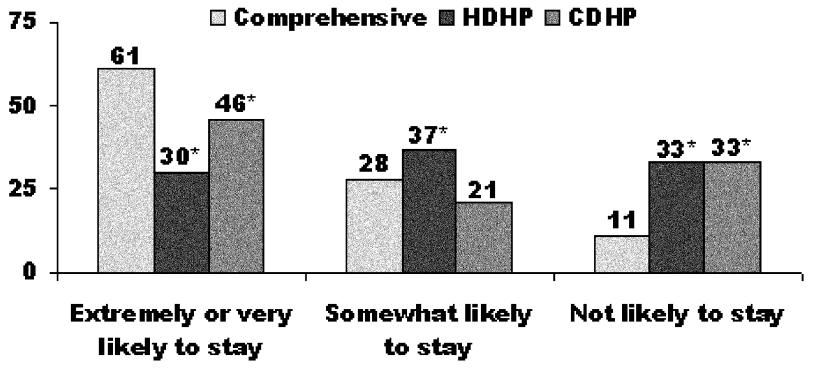


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 16. Enrollees of HDHP/CDHPs Are Less Likely To Stay With Their Current Health Plan If They Had the Opportunity to Change

16

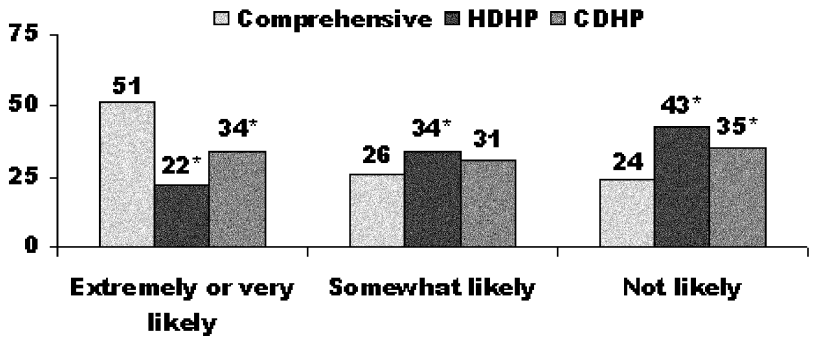


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 17. Enrollees of HDHP/CDHPs Are Less Likely to Recommend their Plan To a Friend or Co-Worker

17

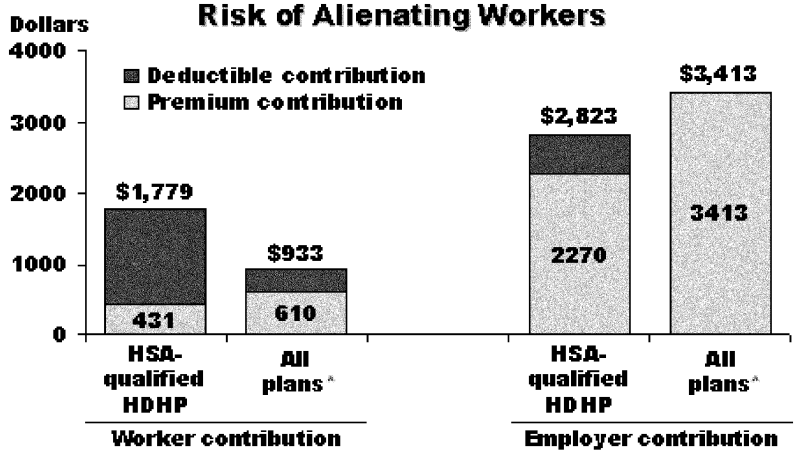


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 18. Workers are Less Satisfied When Their Costs Go Up – Employer Costs Go Down but at the Risk of Alienating Workers

18

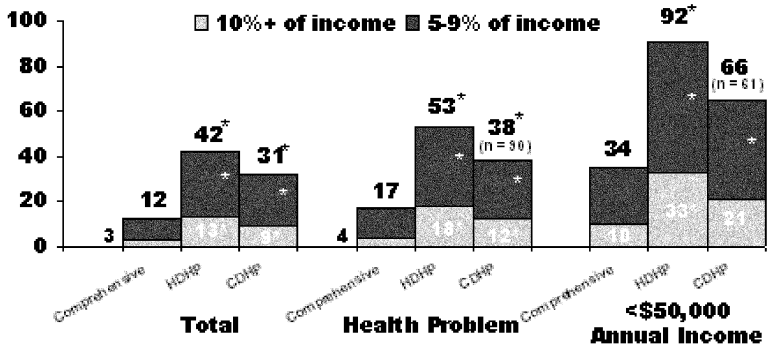


*"All plans" refers to all conventional HMOs, PPOs, and POS plans in the survey, not just HDHP/HRA or HSA-qualified HDHPs. Source: Calculated based on: G. Claxton et al., "What High Deductible Health Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* Web Exclusive, September 14, 2005; J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs*, September/October 2004.

19

Figure 19. Enrollees of HDHP/CDHPs Spend Higher Percent of Income on Out-of-Pocket Medical Expenses and Premiums

Percent of adults 21–64 spending > 5% of income



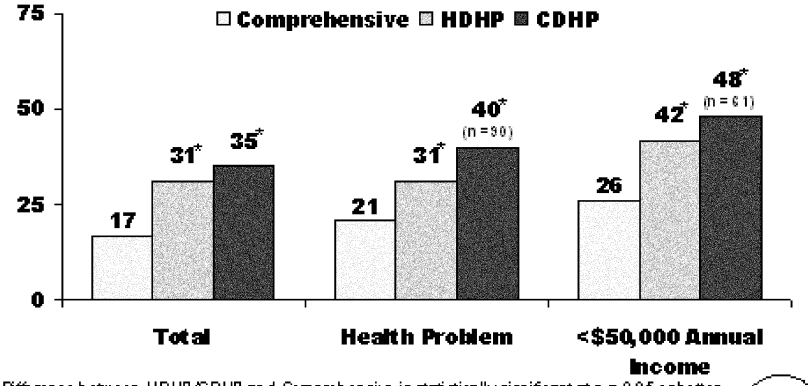
*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

20

Figure 20. Enrollees of HDHP/CDHPs Are More Likely to Delay or Avoid Getting Health Care When Sick Due to Cost

Percent of adults 21–64



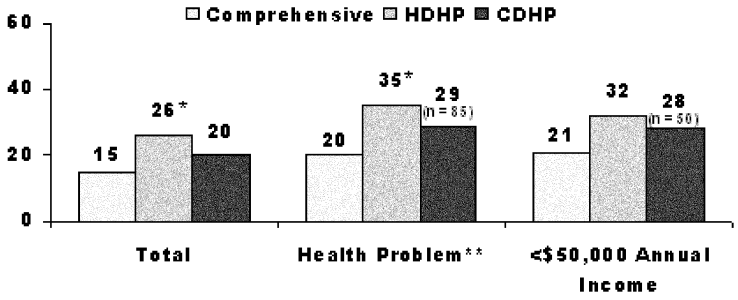
*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 21. Enrollees of HDHP/CDHPs Are More Likely To Skip Doses to Make Medications Last

21

Percent of adults 21–64 with prescriptions in last twelve months



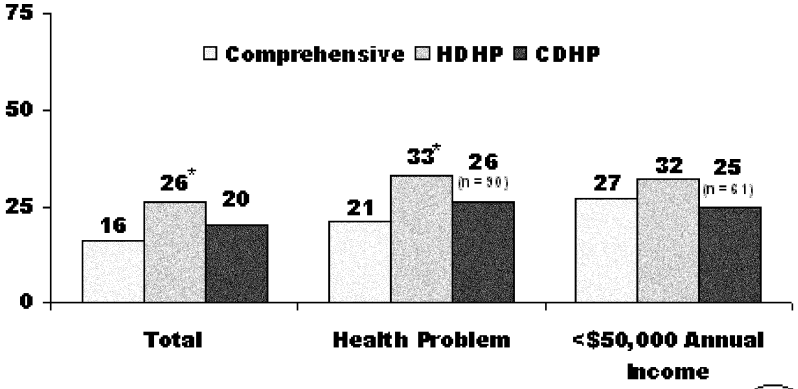
**Health problem defined as fair or poor health or one of eight chronic health conditions.

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, December 2005.

Figure 22. Enrollees of HDHP/CDHPs Are More Likely to Not Fill a Prescription Due to Cost

22

Percent of adults 21–64



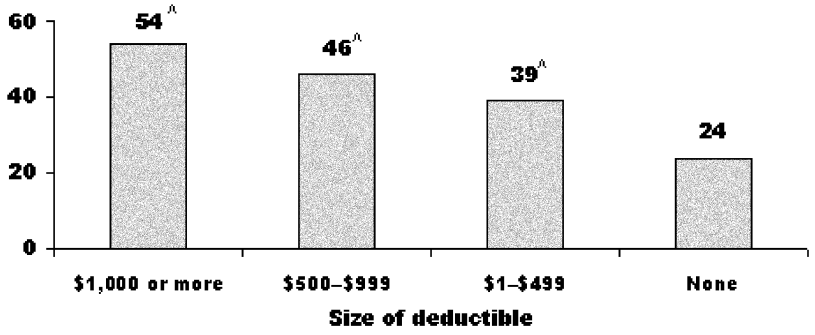
*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

23

Figure 23. People with Higher Deductibles More Likely to Have Medical Debt or Problems Paying Medical Bills in Past Year, by Size of Deductible

Percent of adults ages 19–64 with any medical bill problem or outstanding debt*



Note: Adjusted percentages based on logistic regression models; controlling for health status and income.

*Problems paying,not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

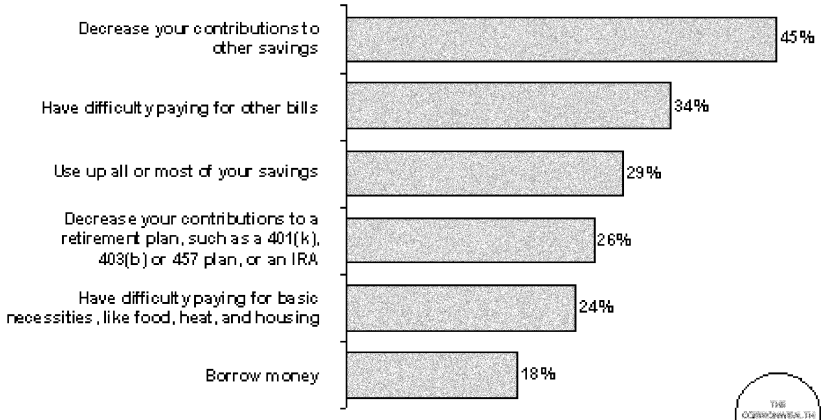
^Significant difference at p < .05 or better; referent category = no deductible.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

24

Figure 24. 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.

25

Figure 25. 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, December 2005.

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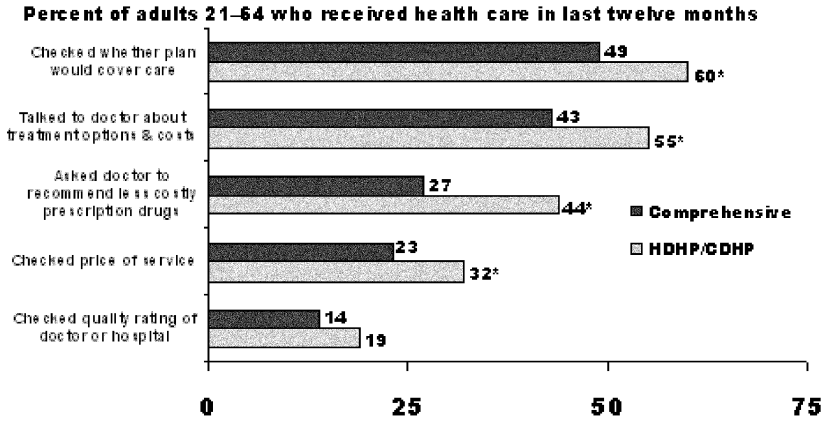
Figure 26. Cost Conscious Decision-Making, by Insurance Source



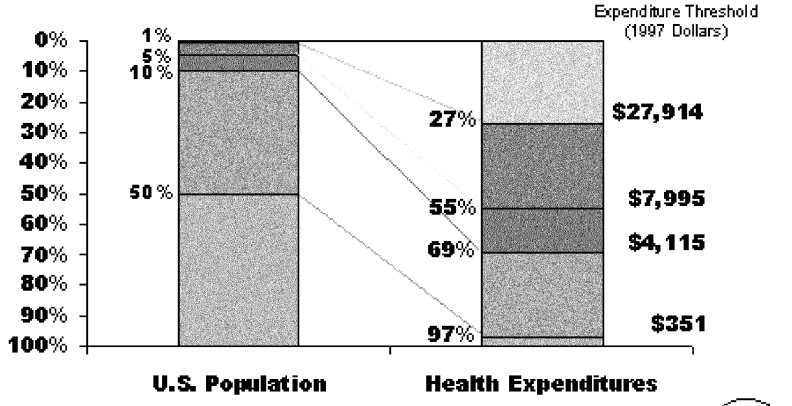
*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 27. HSAs Won't Solve the Cost Problem: Most Costs Are Concentrated in the Very Sick

27

Distribution of Health Expenditures for the U.S. Population, By Magnitude of Expenditure, 1997

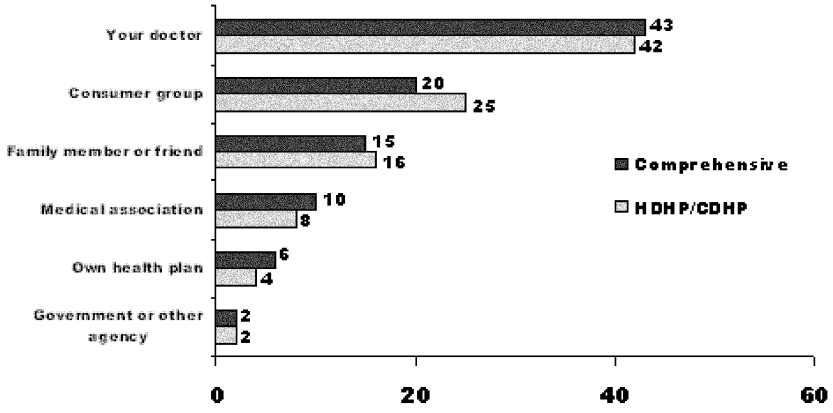


Source: A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

Figure 28. Most Trusted Sources for Information on Health Care Providers, by Insurance Source

28

Percent of adults 21–64

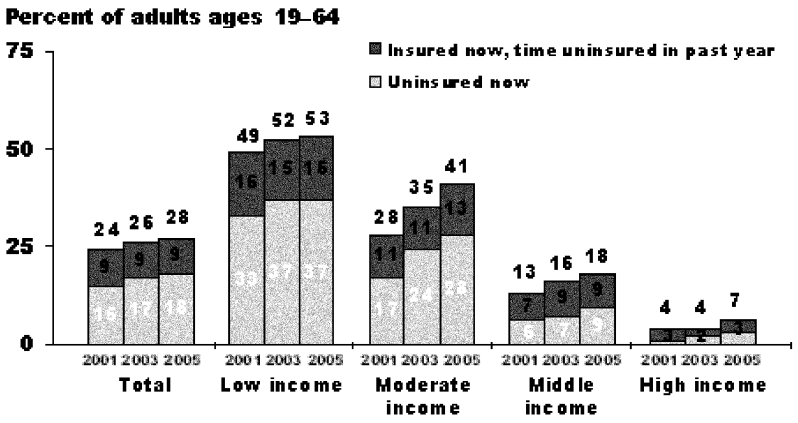


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

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, December 2005.

Figure 29. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005

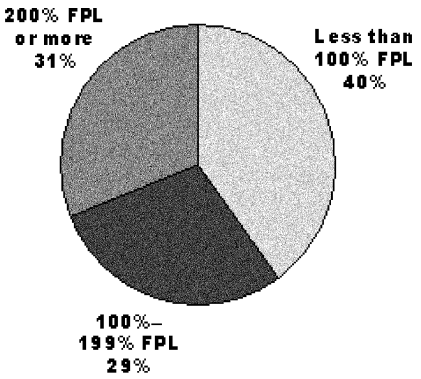
29



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, April 2006.

Figure 30. Distribution of Uninsured Young Adults 19–29 by Poverty Status, 2004

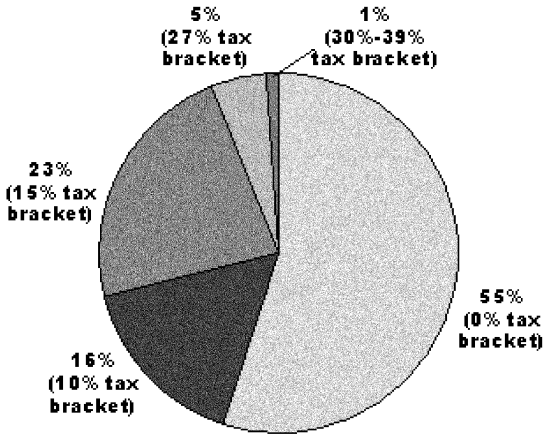
30



Source: S.R. Collins, C. Schoen, J.L. Kriss, M.M. Doty, B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, The Commonwealth Fund, updated May 2006.

Figure 31. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured

31



Source: S.A. Glied, *The Effect of Health Savings Accounts on Health Insurance Coverage*, The Commonwealth Fund, April 2005.

Figure 32. Medicare Physician Group Practice Demonstration

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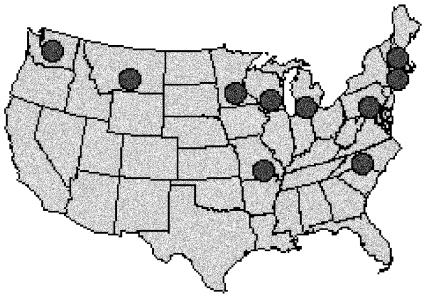

- The Everett Clinic (WA)
- Deaconess Billings Clinic
- Park Nicollet Health Services (MN)
- Marshfield Clinic (WI)
- St. John's Health System (MO)
- Univ. of Michigan Faculty Group Practice
- Geisinger Health System (PA)
- Forsyth Medical (NC)
- Middlesex Health (CN)
- Dartmouth-Hitchcock Clinic

- 10 physician group practices
- 3-year project, began April 2005
- Bonus pool based on savings relative to local area
- Practices expected to save 2%, keep up to 80% of additional savings
- Actual bonuses depend on savings and quality targets

Source: "Medicare Physician Group Practice Demonstration," www.cms.gov, January 31, 2005.

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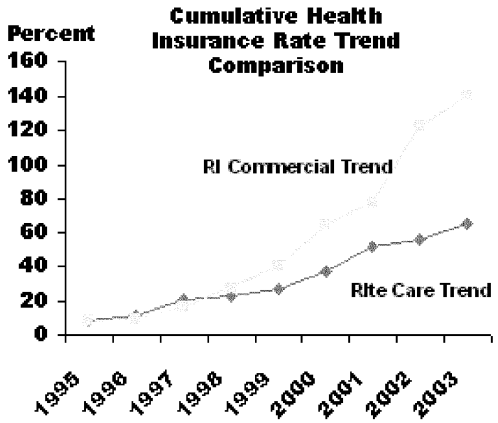
Figure 33. Building Quality Into RIte Care Higher Quality and Improved Cost Trends



- Quality targets and $ incentives
- Improved access, medical home
  - One third reduction in hospital and ER
  - Tripled primary care doctors
  - Doubled clinic visits
- Significant improvements in prenatal care, birth spacing, lead paint, infant mortality, preventive care

Source: Silow-Carroll, *Building Quality into RIte Care*, Commonwealth Fund, 2003. Tricia Leddy, *Outcome Update*, Presentation at Princeton Conference, May 20, 2005.

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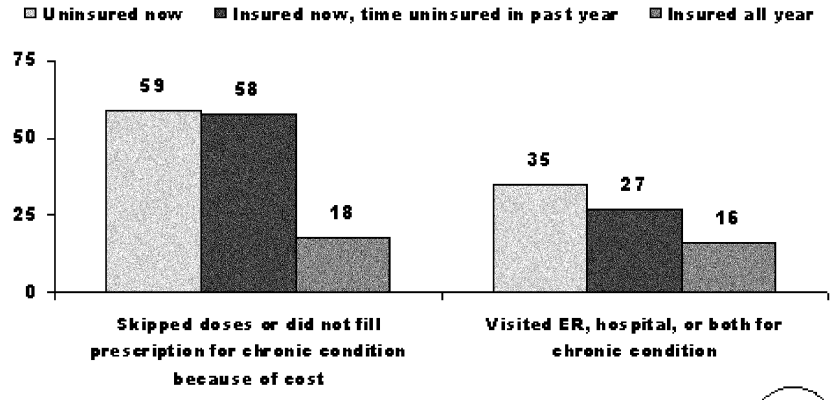
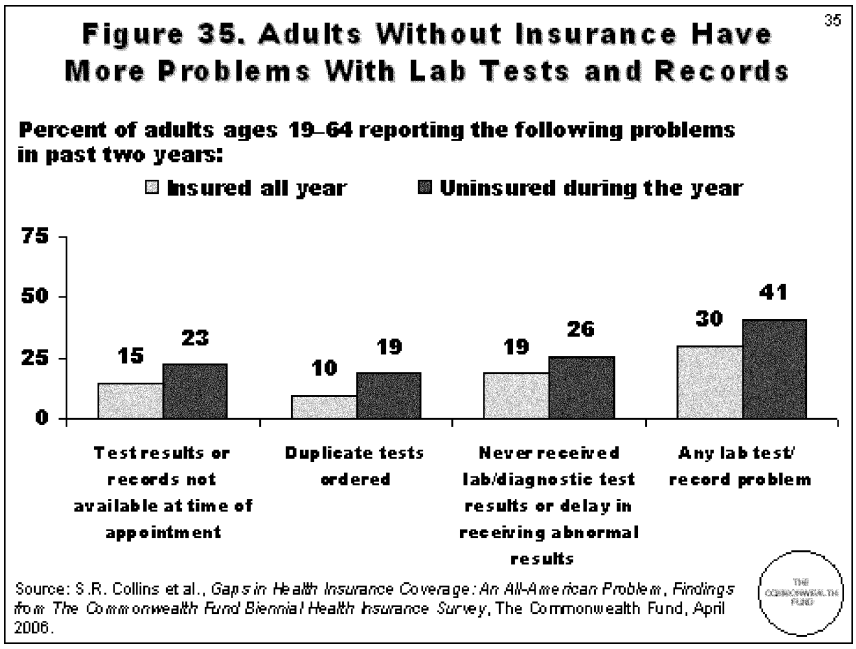
Figure 34. Lacking Health Insurance for Any Period Undermines Quality and Efficiency

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, April 2006.



Chairman THOMAS. Thank you very much. Ms. Therrien.

STATEMENT OF JEAN THERRIEN, EXECUTIVE DIRECTOR, NEIGHBORHOOD FAMILY PRACTICE, CLEVELAND, OHIO

Ms. THERRIEN. Thank you, Mr. Chairman, Ranking Member Rangel, and Members of the Committee. My name is Jean Therrien; I am Executive Director of Neighbor Family Practice, a federally qualified community health center on the west side of Cleveland in a very densely populated urban neighborhood.

I appreciate the opportunity to present this testimony before the Committee today on the topic of HSAs, and especially their impact on low-income Americans and the safety net providers, like Neighborhood Family Practice, that serve these individuals.

As a nurse and public health professional, I am deeply concerned about the growing number of Americans who have high-deductible health plans under the HSA design. These patients have no coverage for primary health care and prescription medication.

I believe one of our goals in health policy should be healthy children and a healthy workforce. Americans who are at low income, like our patients, cannot afford to pay for care up front. Patients in high-deductible plans in my area do not have any savings accounts and are seeking care from safety net providers because this represents their only choice.

I will describe some of the unintended consequences of the policies that promote high-deductible plans.

Cleveland is one of the poorest cities in the country and one that has experienced a longer-than-average economic downturn. Cleve-

land is filled with low-income families, many unhealthy citizens, and struggling small businesses.

High-deductible plans are receiving a lot of discussion and contribution in Cleveland as companies seek ways to control rising health care premiums and stabilize those costs. Many employers are offering high-deductible plans as their only health insurance option for employees, and in most cases they are not able to contribute anything to those employees' HSAs. The plans being marketed locally are also not covering preventive services and they do not provide prescription drug coverage.

Our experience at Neighborhood Family Practice is that we are seeing more and more of these patients each day.

In our 25 years, we have a rich history of providing medical care to families.

We became federally funded in the year 2000, and we want to sincerely thank the Congress for their support, their bipartisan support, of the Federal Health Centers Program. It is the only reason that our organization is currently surviving.

In 2006, we served over 11,000 patients, most below 200 percent of Federal poverty guidelines. A large number of young families and working adults come to us for care; a growing number of these have lost their health insurance and are now uninsured, and a growing number of them are now underinsured and have been switched to these high-deductible plans.

The number of uninsured patients has doubled in the past 2 years from 1,200 to 2,500 in the year 2005. I do not yet have any statistics for 2006, but I imagine it will be even significantly higher and a significantly higher percentage of our population. We do not turn away anyone because they cannot pay for medical care, and that would include insured and uninsured patients.

Every day new patients are seen at our health centers with stories about how their prior provider of care would no longer take them as a patient unless they put the cash up front. Those who seek care at our health center, who are enrolled in high-deductible plans and those who are uninsured have the same coverage when they arrive at our health center; they have no coverage for that primary care visit. That means they don't have any insurance coverage to pay for the office visit, any laboratory testing that may be required, or any prescription drug that they may need. Yet, many of the patients who are enrolled in high-deductible plans are counted as insured in our statistics and are a hidden cost to us.

The ability of Neighborhood Family Practice to provide charity care is because of our Federal grants. The discounts provided to these poorly insured patients are draining needed dollars from the increasing number of completely uninsured patients, and as the numbers of these patients have grown, our funding has remained the same over the past 5 years.

We are also not able to offer the same types of financial assistance to underinsured patients that we would to uninsured patients. The Cleveland Free Clinic is experiencing something similar, with 15 to 20 percent of its adult patient volume being patients from high-deductible plans because they cannot afford medication.

Health insurance models that do not provide preventive care increase health disparities. A bill of even $100 is overwhelming for many low-income families.

Two recent stories at our health center: one, a woman arrived at the window in tears; she had been just switched to a high-deductible plan and could no longer afford the prescription medication for her severely mentally ill son. Another patient was just hospitalized after deferring care for a recurring condition.

I would like to mention quickly a couple of implications for health policy. I would suggest, with respect, that there be thought given to exempting preventive and primary health care services from the high deductible, establishing mechanisms for all low-income individuals to obtain needed medication, especially for chronic illnesses and infections; and requiring employers to fund the HSAs of low-income individuals and also investigate strategies to help provide financial stability for safety net providers like ours that are overwhelmed with under- and uninsured patients.

Thank you, and I would be happy to entertain questions.

[The prepared statement of Ms. Therrien follows:]

Statement of Jean Therrien, Executive Director, Neighborhood Family Practice, Cleveland, Ohio

Mr. Chairman and Members of the Committee:

My name is Jean Therrien. I am Executive Director of Neighborhood Family Practice (NFP), a Federally Qualified Community Health Center in an urban neighborhood on the West Side of Cleveland, Ohio. I appreciate the opportunity to present testimony before the Committee today on the topic of Health Savings Accounts, and especially their impact on low-income Americans and the safety net providers who serve them.

As a nurse and public health professional I am deeply concerned about the growing number of Americans who have high deductible health plans (HSA design). These plans do not provide coverage for primary health care and medications. With the growth in total health care costs, policies that discourage families from seeking care to stay healthy are short sighted. Plans designed only for the financial and tax impact without examination of the impact on the public's health are harmful in the long run. Health policy needs to keep in mind the goals of healthy children and a healthy workforce. Policies also need to consider the long term economic income of increasing health disparities between low and high income Americans. Furthermore, Americans who are low income and cannot afford needed primary care are overwhelming community safety net providers. They seek the ability to take care of themselves and their families and to obtain the medication they need. I will describe for you some of the unintended consequences of the policies that promote high deductible health plans. I will refrain from referring to these plans as Health Savings Account plans, because for the patients in my community there is no savings account, only more health care bills.

The Reality of High Deductible Health Plans in Cleveland

As one of the poorest cities in the country and one that has experienced a longer than average economic downturn, Cleveland is filled with low income families, unhealthy citizens and struggling small businesses. High deductible plans are receiving a lot of discussion and consideration in Cleveland as companies seek ways to control rising premiums and stabilize their costs. COSE, the Council of Smaller Enterprises, a small business coalition that markets health insurance has been "pushing" these types of plans. One small business owner that does work for our health center mentioned that she had reviewed the plans. She considered the plan because of the cost savings. A local insurance broker I spoke with stated that many of his clients are considering these plans. According to him, the average deductible chosen by the firms that have selected this option are $2500 individual and $5000 for a family. However, he has seen plans selected with up to a $10,000 deductible. Many of the employers offer the high deductible plan as their only health insurance option for employees, and—in most cases—do not contribute anything to a savings plan to cover these high deductibles. In fact, the savings account plan does not exist

to cover the high deductibles. While the company benefits by stabilizing their costs, they pass the risk for escalating health costs to their workers. Further, none of the plans being marketed locally covers extensive preventive services. In a few cases, a well women exam and equivalent male checkup are included. However, no plan has well child or maternity care included prior to satisfying the high deductibles. He states, "But the reason many of my clients do not take the plan is that no prescription card is included, even after the deductible is met." Even after the employee meets the deductible they must pay for their prescriptions up front and then submit documentation for reimbursement through their carrier. "Most people don't have the discretionary income to do that, even middle income people."

The health center where I work, Neighborhood Family Practice, has faced the same pressures as many of the small employers referenced above. We have seen double digit percentage increases in our health insurance costs each year. Almost half of our employees make less than $14/hour and support families. Because many of our employees and their families receive care at our health center, we never want to be put in the position of economically rationing care for our co-workers. Therefore, as an organization we have tried to keep deductibles low enough that they would never create a financial catastrophe for an employee's family. However, we have had to shift to higher co-pays for office visits and pass more of the premium cost to the employees to balance our budget the past few years.

Neighborhood Family Practice Background

Established over 25 years ago, Neighborhood Family Practice (NFP) became federally funded in 2000, and has grown rapidly since that time. We sincerely appreciate the strong, bipartisan Congressional support for the Federal Health Centers program. In 2006 we served over 11,000 individuals, the vast majority of who live within Federal poverty guidelines. We serve a large number of young families and working adults, a growing number of whom are uninsured and underinsured. We have a philosophy of access and best practices. We are not just a "clinic," but a medical home. In that spirit we have become actively involved in solving problems presented by our "underinsured" patients and advocating for changes to benefit their health. We do not turn anyone away because they cannot pay for needed care.

Problems for Safety Net Providers with Increasing Use of High Deductible Health Plans

Low income patients who are enrolled in high deductible plans are increasingly turning to safety net providers for assistance. Every day new patients are seen at our health center. Many tell stories about how their prior provider of care began demanding cash up front for the cost of the visit in order for them to obtain needed care. Patients at our health center who have difficulty paying for medical services and are within Federal Poverty guidelines are offered discounts under our sliding scale fee policies. The patients who seek care at our health center who are enrolled in high deductible plans and those that are uninsured are indistinguishable from one another in their inability to pay for needed services. They do not have first dollar coverage for preventive care, office visits, lab testing and prescription drugs. Yet, they are counted as insured in our statistics.

Because our organization has a philosophy of access and services delivered without regard to ability to pay, we work with patients to help them access the care they need. This first includes offering them a discount consistent with our policies. In the past we have considered not offering "insured" patients the sliding scale discount. But then the choice is to deny the care if they do not have the money or bill the patient and have more bad debt. Then the patients who seem to need it most do not come for needed care.

The ability of Neighborhood Family Practice to provide extensive charity care is because of our funding as a Federally Qualified Health Center. Many of the patients enrolled in high deductible plans are below 200% of poverty which is defined as up to $19,600/year for a single person and up to $40,000/year for a family of four. We discount the cost of the office visit from 60–95% per our policies. Most of our patients are below 150% of Federal poverty guidelines. The discounts provided to these underinsured patients drain needed dollars from the growing burden of the completely uninsured patients. The number of our uninsured patients has risen from 1223/year in 2003 to 2548/year in 2005 (doubled!) while our overall volume has grown from 8886 total patients in 2003 to 11,070 patients in 2006 (25% increase). The amount of our Federal grant has not increased anywhere near this amount, from $665,322 to $706,066 in 2006 (6% increase). (For 2006 NFP received the mandated 1% Federal program cut, so our funding actually decreased.) The "base grant adjustments" that we have received have been largely based on increases in the number of uninsured, which does not include the growing number of underinsured.

Other difficulties are presented for the patients because they technically have insurance. If the patient is not aware of the high deductible, the billing staff has to work more closely with them. The patients may need extensive help identifying medications they can afford and where they can obtain specialty and diagnostic care. We are not able to access State funding for the uninsured to cover their visits. We are also not able to provide the same discounted reference lab work. Lastly, these patients are not eligible for prescription drug assistance programs offered by the drug companies in the same way that uninsured patients are. Yet, the organization must devote its time and financial resources to help the patients get their medications and stay healthy.

Neighborhood Family Practice is not the only Federally Qualified Health Center with a growing concern about this trend. Another health center executive states that she sees the number of patients with these types of plans is growing. She believes this represents a shifting of the burden from private sector to government funded organizations. The most notable financial impact is that fact that the "collection" of money is now the risk of the provider. Many companies are encouraging their employees not to pay for services until it is clear that the insurance plan is denying the charge as a part of the deductible. This means cash flow is really delayed and the health center incurs the cost of billing (at least once if not many times) to collect directly from the patient. So, payment from patients is not always forthcoming due to lack of money. They have patients who have high deductible plans that are only funded by the patient, not their employer. So, for these people there is often no money to cover cost. She states, "I understand the concept that these accounts should make healthcare consumers more "involved." The real issue is who gets stuck with the risk. At this juncture, I say we do."

A Cleveland free clinic is overwhelmed by new "underinsured" patients. The Medical Director estimates that between 15 to 20% of the adult medical visits are by people who are "underinsured." This totaled almost 1500 adults last year. He mentioned that this is a growing concern to the Board of the organization and they are beginning to evaluate their policies about these patients. While their organizational mission is to provide health care services to patients that cannot afford them, they see an increased burden of "insured" patients who cannot obtain needed medications. "They may have gone to their regular doctor, who may have given them a discount on the visit," he said, "but then they can't afford their medication and they do not know where to turn."

The majority of safety net providers are reeling financially from the growing number of uninsured Americans. The addition of underinsured families to their patient populations is further weakening the stability of these organizations.

Problems Presented by High Deductible Plans for Our Patients

Health Insurance models that do not cover preventive care increase health disparities and further marginalize the health of low income Americans. It is well demonstrated that patients who seek care early for chronic illness and take care of the health care needs of their children in a timely way are healthier and more productive citizens. Healthy children do better in school. Healthy workers have less absenteeism. This can result in a lower use of the emergency room and lower hospitalization rates. In this way, high deductible plans are a barrier to the health of our patients. These patients are facing difficult choices given that they are in low-income families with limited resources. Similar to uninsured patients they defer care that is needed for chronic illness and do not fill necessary prescriptions. A bill of even $100 is overwhelming for many of our low—income families. Here are some of the examples of health care costs subject to the high deductible under health savings account plans:

- Prenatal care visits for pregnant women
- Office visits for childhood illnesses
- Office visit portion of well child visits that include immunizations
- Annual gynecologic exams including Pap smears
- Medication for chronic illness such as diabetes and high blood pressure
- X-rays for broken bones

Last week one woman appeared at the registration window in tears. Her employer had just switched her health plan to a high deductible plan. Her teenage son, who had a diagnosed serious mental health condition, was on two medications, which cost over $500 per month. She had no way of filling the prescriptions from her low wage job. Another of our patients was just hospitalized with a serious blood clot in his leg. This is a recurrence of a problem from a year ago that almost cost him his life. Because he has a $2000 deductible and no savings, he waited for a week to seek treatment, even though the signs were there that the condition had returned.

The free clinic shared two recent stories. One of a woman who had come directly from a breast biopsy at a large local hospital. "She was literally bleeding through her blouse." She had just received a diagnosis of breast cancer but was told that she could not be scheduled for surgery until she got her blood pressure under control. She had been unable to afford her prescriptions under her new insurance plan. The hospital, as most in Cleveland, did not provide any assistance with obtaining medication. The second story is of a local hot dog vendor, with a high deductible plan, who was discharged from the hospital with a diagnosis of heart failure. He needed additional treatment and studies but was told they were not available to him unless he brought in a cashiers' check for $1000. "It might as well have been a million!," he exclaimed.

Implications for Policy

When the Health Savings Account legislation was considered and adopted, the themes of consumer choice and fiscal responsibility were central. However, the patients seen at Neighborhood Family Practice do not have Health Savings Accounts. They only have bad insurance! They do not have any choice but to seek out safety net providers that will use their time and resources to help them keep themselves and their families healthy. People living in poverty have even fewer choices under these plans because many medical providers will not give them care unless they pay the full charges up front. Why does a rich nation such as ours continue to ask its citizens to choose between needed primary health care and basic necessities of life? Why would we sacrifice the public health of many urban neighborhoods by further promoting a plan that discourages those with the least from learning how to keep themselves and their families healthy? I ask thoughtful consideration of the following:

- Exempt preventive and primary health care services from the high deductible
- Establish mechanisms for all low income individuals to obtain needed medications including those for chronic illness and antibiotics
- Require employers to fund the health savings accounts for low income individuals and their families up to the amount of the deductible
- Investigate strategies to provide financial stability for primary care safety net providers such as Federally Qualified Health Centers who are overwhelmed with uninsured and undersinsured patients

Thank you for your time and attention, Mr. Chairman and Members of the Committee. I would be happy to answer any questions you may have.

Chairman THOMAS. Thank you very much. I want to thank all of you. I apologize; occasionally, the real world creeps into our lives, and I had to deal with it. Were I here at the beginning, I would have complimented all of you.

I think this panel provides us with an opportunity—with the various positions that you bring to the discussion—to allow for, hopefully, some discussion among the panel members. I hope, as some statements were made, some people felt motivated; and as other statements were made, others felt motivated. Sometimes, rather than our just asking the questions, the discussion among yourselves is more enlightening to us in terms of the various arguments.

For example, Ms. Therrien, I appreciate your examples. I was most interested in the local hot dog vendor in terms of your outlining his situation; and the question that immediately came to mind was the hospital that told him he had to have a cashier's check for $1,000, a not-for-profit hospital?

Ms. THERRIEN. Yes, sir, I would imagine that would be the case.

Chairman THOMAS. You need to turn the microphone on.

Ms. THERRIEN. I apologize. That was a story that was related to me by a colleague at the Free Clinic, so I am not aware of the

hospital; but there are no for-profit hospitals in the city of Cleveland.

Chairman THOMAS. That means a not-for-profit hospital said to a low-income person that they had to show up with a cashier's check for $1,000 or they wouldn't get needed treatment.

You are aware that the not-for-profit hospitals don't have to pay income taxes on the basis of their serving low-income and indigent, so I think perhaps as we address hearings on not-for-profit hospitals, that your example will be presented.

In fact, I will find out the hospital, and we will pursue that because those are not the kind of responses you are supposed to get from tax-advantaged hospitals.

Ms. THERRIEN. Thank you, Chairman Thomas. I would be happy to provide you with additional information.

Chairman THOMAS. I appreciate that. Dr. Collins, I always appreciate your testimony. I guess my big problem is, it almost sounded like HSAs were not in law, and people before you testified of the increasing numbers, notwithstanding the difficulty of fitting this new structure in, that your statements were kind of a priori what we heard prior to HSAs becoming law.

Both of you, are you aware of the Treasury Department Notice 2004–23? The purpose of the notice provides a safe harbor for preventive care benefits allowed to be provided by a high-deductible health plan without satisfying the minimum deductible under section 223(C)2 of the Internal Revenue Code.

For those individuals who have the high deductible, that aren't getting the kind of preventive care—perhaps you heard testimony from others in which that is one of the key things they have done is to create a wonderful, preventive care structure; and especially it should be available to the low income.

You might check on the Internet. There may be somebody who has information on the Internet. I believe there was testimony to such effect that these people could be directed to the kind of policies that you say are deficient. They certainly could be provided, because they are being provided, and it is now in statute that you have this safe harbor in terms of preventive care.

Notwithstanding the fact that we have try to move forward, Mr. Lutey, I especially appreciate your testimony. One of the problems I have seen most often is that we aren't—it is not that we aren't spending enough money for health care in this country; it is the maldistribution of who gets the benefits from health care.

We have heard the plea for individuals. We have got the employer benefits. We have tried in the past to at least create a reasonable cap above which decisions are going to have to be made on a hierarchical basis.

If I just went down the line, and mindful of my time and others, if you could give me a rough "yes" or "no." Or if you have to add a word or two qualifier, that is fine:

Would you be supportive of a reasonable cap on the employer deduction, savings from which could be redirected to the low income as a subsidy, so that they could get some of the benefits, notwithstanding their employers aren't able to provide that kind of a deduction? Mr. Cava, yes or no?

Mr. CAVA. I believe so, Mr. Chairman.

Chairman THOMAS. Obviously, the number is critical. Probably somewhere around 10,000 now. We tried at 5,000, years ago. At some point, you don't keep letting folks run it up and others have no opportunity. Ms. Ignagni?

Ms. IGNAGNI. We would be concerned about that, Mr. Chairman.

Chairman THOMAS. I understand why: Cash flow and adding additional benefits which are then paid by a tax-preferred structure are really a sweetheart deal for collectively bargained arrangements.

You heard about individuals trying to make their way, and I think it makes sense if you are going to begin to augment through subsidies or tax credits that you don't leave an open-ended program open-ended. Mr. Jackson?

Mr. JACKSON. I think I would support it, sir.

Chairman THOMAS. Thank you. Mr. Lauer?

Mr. LAUER. Anything we can do to help people who can't afford health insurance is a good thing. My concern, however, would be that we are seeing a trend where there are large employers not offering health benefits because of the rising costs. I think this could actually perpetuate that.

Chairman THOMAS. The key is to control the rising costs, not just to leave it open-ended so nobody has to feel the pain of a decision to create a priority of what you want. If it is open-ended, you don't feel it. Mr. Lutey?

Mr. LUTEY. I believe I would support that, Mr. Chairman.

Chairman THOMAS. Dr. Collins?

Dr. COLLINS. I think we have to be concerned about breaking up the group market. It is the only form of risk pooling that works well.

Chairman THOMAS. That is a good point, but you will be amazed at how creative we are becoming. I lay in front of you the most recent effort by the State of Massachusetts, and I love to repeat that, State of Massachusetts, with a creative market arrangement where they took the fire hose of subsidy to hospitals, turned it toward the individuals in the insurance market and created a pooling, in essence, group arrangement by individuals through a State structure. Portions of that, I think, could be duplicated in a number of other States.

Ms. Therrien, would be you interested in capping the employer deduction so all those folks that line up at your window have, without additional expense to the taxpayers, the ability to get some of those benefits?

Ms. THERRIEN. I can't speak to the tax implications, but anything that would improve access for the patients that we serve, I would support.

Chairman THOMAS. Thank you. I think I won a majority, but obviously it is not going to be unanimous.

Those are the kind of decisions we need to begin to make.

Do you allow one structure, completely open-ended, to continue to move forward and then complain that there are others who don't get benefits? You have to look at creating a balance and a harmonious relationship between one group that gets everything and another group that doesn't get anything.

When you talk about low income, obviously they need help, they need subsidies. Don't talk as though they can't get preventive care and medicines without additional cost, because we have provided that in the law and enlightened providers of these kinds of insurance policies are available to allow that to occur. You heard that in testimony from others. You just have to be a little creative.

The gentleman from California. Do you want the time or do you want me to move on? I can come back to you. Okay. The gentlewoman from Connecticut, the Chairman of the Subcommittee on Health.

Mrs. JOHNSON OF CONNECTICUT. Thanks very much. Certainly, in my mind, a key to the success of the HSAs is some degree of employer contribution, because certainly the low-wage earners are not going to be able to contribute enough to this account to manage basic expenses.

Certainly, the movement of the plans toward coverage of preventive benefits is very, very important and happening rapidly because employers are finding that that cuts the costs.

Two things I would like to ask. First of all, those of you who have these kinds of plans, would you send the Committee the educational materials you use for your employees? This is a complete change of mind-set; it is different from our current health system which treats illness and focuses entirely on treating illness.

Health Savings Accounts can help us focus on prevention, early identification of small symptoms so we can prevent people from getting sicker. It has enormous possibilities for the well-being of participants, but educational materials are key.

Then on this issue of employer contribution, should we be having a requirement that employers who provide a high deductible also provide some contribution to an HSA; maybe not the same contribution every year, maybe starter contributions, but the law is silent on this aspect. I am looking to hear your comments on whether the law should remain silent on preventive benefits or on contribution.

Ms. Ignagni.

Ms. IGNAGNI. Thank you, Madam Chair. I think there are three things. One is that in order of priority we ought to think about a policy where employers can income-relate their contributions. That would do a lot for individuals at the lower end of the income distribution.

Second, we think that it is very important for the Committee to take a very hard look at the issues emanating from chronic care. What more can we do to incentivize the provision of disease management and strategies of that sort?

Third, I think that the Committee will have a discussion that should be a broad discussion, not simply in the HSA context, about individual responsibility, employer responsibility and government responsibility. We have a significant amount of cost-shifting now going on from underfunding, that recent data shows is becoming a much more serious problem.

I think all of those needs should be looked at very broadly.

We also join with many of my colleagues on the panel who have indicated a need for a level playingfield in terms of individual tax treatment as well.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Would anyone else like to comment?

Mr. Jackson.

Mr. JACKSON. In our specific case, in year one of our HSA plan, we funded almost all of the contributions to the savings accounts. Then we switched to our second year of having an HSA at the request of our employees. We are a small company, so we can sit down and talk about these issues, and they preferred to have a lower deductible, better policy where there were no contributions made by the company. Clearly, that should be able to continue to be an option. While we feel that it's important to give affordable insurance, I don't think making mandatory contributions is the answer.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Cava, what kind of contribution do you make to your employees' plans?

Mr. CAVA. Madam Chair, we contribute 60 percent of the deductible of each of the three types of funds that we offer. Even though we do and we feel that this is the appropriate amount at this point, we believe we should have more flexibility in terms of comparability to design plans that deal with chronically ill; and I think to that point, we would warrant the flexibility to offer plans with no employer contribution if, at some point, that is deemed to be the most appropriate mix of plans. That is not our plan at this time. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Lutey?

Mr. LUTEY. I appreciate the question. First of all, I would strongly support some type of requirement for the employers to contribute. I feel that the plan would be in great jeopardy if there was not some sort of contribution by the employer. I would also suggest that the issue raises a number of other issues as well. The amount of money that our organization has put into the plan, is not something that we give to the employee, but is seen as that springboard for partnership. If we can work on the wellness of employees and ultimately reduce premiums, those are dollars that we can share with those employees in their HSAs, and ultimately, it is a win-win. This raises, for me, the issue of prescriptive drugs. If HSAs are truly designed to be preventive in nature, then I, as an employer, would be very happy to pay for some of those preventive drug costs for our employees by including those in the preventive care items rather than having it come out of the HSA account for employees.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Anybody else wish to comment? Oh, my time is expired. I am sorry.

Chairman THOMAS. Anyone who believes they haven't got a chance to respond and you don't want to respond, the record will remain open, and you can provide us written comments. There is no way we can get into the depth that we need to in responses between questions, and the Chair would invite opportunities for cross-fertilization of the testimony. Gentleman from Washington wished to inquire?

Mr. MCDERMOTT. Yes. Thank you, Mr. Chairman. I appreciate your having this panel here today. Since 1993, 1994, when we killed the last attempt to get universal coverage, when we had 35 million people unemployed, we now have 46 million people unem-

ployed, and if Ms. Collins is close to correct, we have another 16 million underinsured. So, we have got somewhere over 50 million people in this country who do not have adequate health insurance.

Now, I would like to ask those of you who are actually purchasers of health care, I think Mr. Cava and Mr. Jackson and probably Mr. Lutey, what percent of payroll do you spend on health care in your operation?

Mr. CAVA. Mr. Chairman, Representative McDermott, I don't have the exact statistic as a percent of payroll but I can say that we spent approximately $40 million of the company's money last year for our employees' health care.

Mr. MCDERMOTT. What is that, $40 million out of what? What is your intake or what is your expenses of the company? Do you have any idea at all?

Mr. CAVA. Our general and administrative expenses?

Mr. MCDERMOTT. Yes.

Mr. CAVA. This would be a rough guess. Approximately less than 10 percent.

Mr. MCDERMOTT. Less than 10 percent.

Mr. CAVA. Yes, sir.

Mr. MCDERMOTT. So, you wouldn't have a problem with 10 percent if everybody was covered and you wouldn't have to deal with this at all, you would be willing to do it for 10 percent, somebody would do it for you?

Mr. CAVA. May I think about that, Representative?

Mr. MCDERMOTT. Okay. How about you, Mr. Jackson? What do you spend?

Mr. JACKSON. Well, as I testified, our current premium is $115,000.

Mr. MCDERMOTT. I want to know against what, what percent of your payroll costs goes to health care.

Chairman THOMAS. Can the gentleman yield briefly? If you will just give us dollar amounts. One is $20 million. Yours is $115,000. We have no ability to relate that to the costs of the company carrying this unless we know what it is, as the gentleman from Washington is asking, a rough percentage. You don't need to be precise. Just kind of ballpark.

Mr. JACKSON. I would guess it is in the 4 or 5 percentage.

Mr. MCDERMOTT. Can I ask you, you have about 20 people. Are all 20 people covered?

Mr. JACKSON. No. There are some employees who opt out because they have spousal coverage.

Mr. MCDERMOTT. So, the President of the company is the professor of the University of Colorado of some sort or another, she covered under the University of Colorado plan?

Mr. JACKSON. That is correct. Not the President, but she is the owner.

Mr. MCDERMOTT. Her husband is also covered on that same plan?

Mr. JACKSON. That is correct.

Mr. MCDERMOTT. So, the top two people are not covered by your plan. Who else isn't covered? Where is their coverage coming from?

Mr. JACKSON. We have a number of employees that some of them, their spouses are employees at Kaiser, and they have no cost insurance through Kaiser, so opt to do that coverage.

Mr. MCDERMOTT. So, this is a plan basically for your low-paid employees who don't have any spousal coverage anywhere else, don't have good insurance anywhere else.

Mr. JACKSON. Well that includes me, and I don't consider myself one of the low-paid employees, but yes, it does primarily affect our lower-paid employees.

Mr. MCDERMOTT. Okay. How about you, Mr. Lutey? What percent of payroll do you spend on health care?

Mr. LUTEY. Depending on the plan, between 9 and 11 percent.

Mr. MCDERMOTT. So, 10 percent wouldn't be too big of a bite for you to handle. So, if we could have universal coverage in this country and have everybody covered for 10 percent of payroll, why would the business community, rather, leave those 51 million out there and try to dance around with the insurance companies and dodge the costs? Why do you want to do that? What is your objection to having universal coverage?

Mr. LUTEY. If I may respond, sir, I believe that for me, the huge win in this is a collaborative nature toward wellness. A universal plan simply is, go to the doctor, get the pill, go home and get well. In the HSA, we have developed a sense of collaboration around doing things that make you well for the long term. There is a knowledge base that our employees have now that they didn't have before about medical conditions and what is going on with them. There is an investment that they have, which has nothing to do, by the way, with dollars. There is an investment about wanting to be well and doing things in the workplace to keep them well.

Mr. MCDERMOTT. So, you've saved money up front? Dr. Collins, tell me what is going to happen long term here. They have saved money up front. You are telling us they are doing better, and they think they have got it all knocked. How's this going to work out?

Dr. COLLINS. Well, there is evidence from the Employee Benefit Research Institute (EBRI) Commonwealth 2005 Survey of Consumerism in Health Care that people do skimp on care, and also I have to say, in terms of the preventive care exclusions and the deductible, the Kaiser Family Foundation and Health Research and Educational Trust (HRET) 2005 Survey of Employer Health Benefits found that only 30 percent of employers who offered HSA-eligible high deductible health plans in 2005 actually did exclude preventive services from the deductible. So, we really do have to be concerned about giving people incentives that are going to cause them not to get preventive care, not to manage their chronic conditions, and perhaps end up with very expensive health conditions down the road. So, it really doesn't address the major cost problems in our system.

Mr. MCDERMOTT. So, it is sort of penny-wise and pound foolish to save money on not paying for preventive care, not the Pap smear and then wind up with the cancer that comes with it.

Dr. COLLINS. That is right.

Mr. MCDERMOTT. Mr. Chairman, I think it is time for us to talk to a real solution that is going to solve this for the American people. We are having more and more companies go into bank-

ruptcy, and what they do is they take off their pension costs and their health care costs, and that is going to be a continuing problem. This is a Band-Aid at best.

Chairman THOMAS. One of the things the Chair may need to do periodically is to make sure that, obviously, I read all the testimony, and statements are being made, and I want to try to go back, and I will try not to take a lot of time, but as I recall, Mr. Cava, in your testimony, given the size and scope of your company, moving in the direction that you have moved, you have actually increased—I believe your statement was you have increased the preventive care aspect. So, when comments are made that somehow HSAs in this structure denied preventive care as though that were a fact, then I have a problem when I read what I read in your testimony. What would you respond to that?

Mr. CAVA. Mr. Chairman, thank you. We provide 100 percent coverage, preventive care, and I did list the specifics in my testimony, and that is part of our commitment. This isn't just a strategy for the more efficient spending of health care moneys. It is about the search for continuous and sustainable improvement in health. We have seen an increase in access to preventive care from 50 percent of our users to 75, 76 percent of our users. They have access to preventive care under our new plan. So, I am not quite sure where the information is coming from, but the information I have is pretty significant and pretty compelling that we are helping to change behavior.

Chairman THOMAS. It may be an attitude as to how you approach this insurance. If you don't think it is any good, you don't look at the options and the various things that are available, and you are dismissing it rather than working with it. Mr. Lutey, I appreciate your comment as well. Now, I will call on Members. I don't want to abuse this, but it seemed to me that what you said was your experience completely contradicted some of the points that were being made about the lack of preventive care under this kind of insurance structure. Gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, Mr. Chairman. Mr. Cava, I just want to follow up. I want to make clear what you just said. I thought I heard you say that since you have gone to the HSA high-deductible plan, that more of your employees are taking advantage of preventive care. Is that what you said?

Mr. CAVA. Mr. Chairman, Representative, yes, that is absolutely the case.

Mr. MCCRERY. So, I assume you mean by that, that more of your employees who are now covered under the HSA high deductible plan are taking advantage of preventive care than those employees who took advantage of preventive care under the previous health care plan that was not high deductible in HSA. Is that correct?

Mr. CAVA. That is correct.

Mr. MCCRERY. Well, that is very curious. You mean, there are some non-HSA, non-high deductible plans that don't cover 100 percent of preventive care?

Mr. CAVA. That is absolutely—that is absolutely correct.

Mr. MCCRERY. My goodness. Do you mean that it is up to the employer to decide how to structure the benefits in his employer-

provided plan? It is up to the employer how to structure those benefits, what to purchase? Of course it is. It is just as easy for an employer to provide preventive care under an HSA high deductible as it is under some low deductible plan, just as easy. It is just amazing to me how we can have testimony from the real world time after time after time after time; not just from people who have an interest in making money off of this. Mr. Lutey is certainly not in that category, and then the last two witnesses have studies that refute all that real-world experience. That is amazing to me.

Mr. MCDERMOTT. Would the gentleman from Louisiana yield?

Mr. MCCRERY. I would be happy to yield.

Mr. MCDERMOTT. If I can put this in perspective, I think the testimony is that you have 7,000 workers covered by this HSA, and you have 43,000 employees that are eligible for it or are not covered by it. Is that correct? Have I got my numbers right?

Mr. MCCRERY. Reclaiming my time. I would be happy to yield for the gentleman to discuss this, but I am not going to give you another 5 minutes to ask questions of the witnesses.

Mr. MCDERMOTT. I am just trying to get the facts.

Mr. MCCRERY. The facts are that have been stated by various witnesses that the number of people opting for this coverage has tripled in the last couple of years. That is a fact. The facts are that about 31 percent of those in the individual market who have high deductible HSAs were previously uninsured. They had no insurance. So, they couldn't get preventive care unless they went to someplace that gave it to them. So, what they now have is some form of insurance. So, I just want to try to bring this back down to the real world here and get people to pay attention to facts that are being testified to by witnesses here today and the experience that people are having in the real world.

Now, one of my colleagues in his opening statement said that some measly percentage of people with high deductible plans actually contributed to an HSA. I don't know where he got those figures. There is some Treasury Department data that could be interpreted that way that is about 2 years old, but the most recent Treasury Department data does not indicate that. So, even if employees are not contributing and there is no data yet to establish that, we know from testimony that employers are contributing to HSAs, and that gives them something to start with, and in the case of Mr. Jackson, he can—how much of the deductible for an individual do you contribute, Mr. Jackson, to his HSA?

Mr. JACKSON. On last year's plan I contributed 100 percent, but this year when we reduced the deductible, they pay it themselves, and every employee opted to pay the full amount.

Mr. MCCRERY. So, last year, you, the employer, contributed 100 percent of the HSA, 100 percent of the deductible to the employees' HSA. So, it wouldn't have been very smart for him to contribute to the HSA.

Mr. JACKSON. No. I don't think he would have been able to last year.

Mr. MCCRERY. It wouldn't have been legal for one thing and for the other thing, why should he? This year, your testimony is, your employees are opting to contribute to their own HSAs. Is that right?

Mr. JACKSON. That is correct. We offered them the option.

Mr. MCCRERY. Another real world example of what is really happening out there and what choices people, intelligent people, whether they are rich or poor, are making in the marketplace, and that, I believe, is what we have got to continue to do is create a real marketplace in the health care industry, not by abdicating costs, not by hiding costs; by making the system more transparent, by making prices more transparent and by making consumers more aware of what they are doing. There is a lot more I would like to say, but I will save it. I yield back.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. Just to help my friend from Louisiana, in 2004, which is the last Treasury Department data available, there were perhaps a million people enrolled in HSAs, and only 90,000 of them had active HSA accounts. Whether there was any money in the accounts or not, we don't know; but it has never been all of the people taking advantage of it. I want to ask Dr. Collins.

Chairman THOMAS. Gentleman yield briefly on my time? It won't detract from yours. I appreciate using Treasury data from 2004, but what we have heard is——

Mr. STARK. We used enrollment data from 2004 too.

Chairman THOMAS. —in 2005 and 2006, we had a virtual tripling. At some point, Treasury's data will catch up with reality. So, I appreciate your citing Treasury, but if they were in the real world, as we know, they would be have been out of business a long while ago if you are looking that far in the past as to what decisions you are going to be making. Thank the gentleman. This will not come off your time.

Mr. STARK. I thank the Chair. In the real world, where people have ever worked in the real world outside of the public trough, they might understand a little bit more about health care costs to employers. In the eHealthInsurance plan—I am puzzled; Dr. Collins, if you could help me. It seems to me that an individual who signs on to an eHealthInsurance plan would be $1,233 more out of pocket, if they had an HSA plan than a non-HSA plan. For a family of three, they would be $2,300 more out of pocket than they would be if they bought the non-HSA plan, and even if you took the high amount that employers contribute of 25 percent, the poor folks who are $2,300 bucks more out of pocket, might have a $600 contribution but no tax savings if they are in the lower income.

I am often puzzled—if you can explain to me whether your studies would shed any light on—except for the fact that you can't trust most insurance salesmen—why anybody would sign onto that kind of a plan. I am going to ask a series of questions, and maybe you can pick up on answering some of them. You mentioned the high administrative costs of purchasing insurance in the individual market. Perhaps you could elaborate to us why it is so important to pool risk and how the HSAs really undermine the pooling aspect and cause a highly adverse selection for people who need insurance most. Then could you just repeat what percentage of plans do provide preventive care. That is optional.

I think Ms. Therrien testified that nobody in the Cleveland area has coverage for preventive care. So, perhaps you could tell us, Dr. Collins, across the country how many offer maternity care, which if you have to pay for that out of pocket eats up—does it count to your deductible and more than increase your out-of-pocket costs? Then Ms. Ignagni, showing the for-profit plans, as she does for high pay, but she won't ever let the plans come to testify, talks about HSAs taking off in the group market, and I wonder if that is something that we shouldn't be alarmed by because it means that as I understand the workers who are at risk of losing more comprehensive coverage and then explain to us what happens to the costs for more expensive group coverage as younger and healthier people move to HSAs. Can you kind of review those things for us as you choose.

Dr. COLLINS. When the employer group market is really our only——

Chairman THOMAS. Dr. Collins, you are obviously not going to have as much time, but he gets another minute and a half. These are important questions. We would hope they would be offered in written response to that, and any of you who want to—because this is a hearing that we are trying to lay a base for. I appreciate the gentleman's questions, and we will leave you some reasonable time to try to respond to some of those, but don't think the universe of response has to be in the minute and a half that the gentleman has left.

Dr. COLLINS. The individual and employer group market is really our only natural form of risk right now that we have for private coverage. The individual market, by contrast, does not pool risk. The administrative costs are 25 to 40 percent of the premium costs. So, it actually buys many fewer benefits, including maternity benefits. If you go to ehealthinsurance.com, and we have actually done this at the Commonwealth Fund, there are very few plans in the individual market that actually offer maternity benefits without a rider. So, that benefit is basically not available to women in the individual or families in the individual insurance market. The other thing that the individual market does is it underwrites each person.

So, this necessarily means that if you have a pre-existing health condition, if you have diabetes, if you have a chronic heart problem, it means that your premium will actually be higher than my premium, a relatively healthy person. So, I guess the question is, can we tolerate this kind of different pricing for people who are our neighbors, who are our family members, who are our friends simply because they have worse health conditions than we do?

So, it is not a particularly good place for us to push everybody without insurance coverage into the market. We do notice that people in the individual market buy high deductible health plans. They have always had the option to buy it. It is nothing new. Thinking in terms of the tax incentives that would bring more people into this market, 31 percent was cited, but it is really not clear whether that 31 percent are long-term chronically uninsured—have they been uninsured for the past 3 months, have they been uninsured for the past 3 years? So, it is really not clear what experience those people have had prior to buying coverage in this market.

Chairman THOMAS. Thank the gentleman. My understanding is—Mr. Lauer, in his testimony, indicated that his definition of uninsured was anyone who didn't have insurance for the last 6 months. Dr. Collins, do you believe there is anything in this new Massachusetts plan that is new or creative in helping to create in essence a group market out of individuals with the central structure that has been provided by the State?

Dr. COLLINS. Well, I think that Massachusetts should be commended for this effort and particularly on the protections of people under 300 percent of poverty. It is a lot less certain—although it has really received most of the bulk of the attention on what will happen to people above 300 percent of poverty—whether those premiums will actually be affordable to people, whether the individual mandate would be able to be applied.

Chairman THOMAS. Well, I was hoping your remarks would focus on the point about the State creating a connector which produces group insurance by collecting individuals through a State-inspired structure, which would solve the problem of the individual market.

Dr. COLLINS. It would help in terms of pooling, but again, it really remains to be seen how much that pooling will actually pull down premiums.

Chairman THOMAS. Oh, exactly remains to be seen, and obviously, this is an ongoing change, and it will be modified as we go forward, and I appreciate the fact that you have indicated that the Massachusetts plan has a possibility of offering some solutions that otherwise were automatically rejected because the individual market couldn't solve problems. Creativity can solve a lot of problems rather than simply repeating the past. Gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman. I do. I want to thank the panelists for very thought-provoking testimony.

Ms. Ignagni, your industry is playing a key role in developing insurance products that speak to the needs of some of those who choose to provide for their medical coverage through HSAs in addition to the traditional employer-based coverage. What we have heard is that those opposing the development of HSAs and consumer-directed health care options are arguing that adverse risk selection will result from younger, healthier consumers using the HSA option, and in turn, creating an adverse reaction in the risk pool. Is this a problem that you have seen developing? Is it a valid concern? Are your member companies seeing any actual evidence of adverse selection?

Ms. IGNAGNI. I am very glad you asked the question. I have a number of pieces of data that I have before me, which I would like to submit for the record.

[The information follows.]

AHIP
Center for Policy and Research

January 2006 Census Shows 3.2 Million People Covered By HSA Plans

Enrollment in Health Savings Account (HSA) Plans Tripled in Ten Months

Summary

A periodic census by America's Health Insurance Plans (AHIP) of its member companies shows that the number of people covered by health savings accounts/high-deductible health plans (HSA/HDHPs) was almost 3.2 million in January 2006, more than triple the HSA/HDHP coverage of about one million reported by AHIP members in March 2005.

Other census findings included:

- HSA/HDHP coverage in the group market rose from 397,000 in March 2005 to 1.4 million in January 2006. Enrollment in the individual market rose from 556,000 in March 2005 to 855,000 in January 2006. (AHIP member companies reported coverage of an additional 878,000 people that could not be classified into either the group or individual market).

- In the individual market, 31 percent of new enrollees in HSA/HDHP plans were previously uninsured. In the small-group market, 33 percent of enrollment in HSA/HDHP plans was in small companies that previously did not offer coverage.

- Twenty-three (23) percent of new purchases of health insurance in the individual market were HSA/HDHP products. HSA/HDHP products accounted for 11 percent of new policies in the small-group market and 7 percent of new policies in the large-group market.

- Half (50 percent) of all people covered by HSA/HDHP plans in the individual market -- including dependents covered under family plans -- are aged 40 or older. In the small group market, 45 percent of people covered under HSA/HDHP plans in the small group market (including dependents) are 40 or older, and in the large group market 44 percent of enrollees are aged 40 or over.

- Over 90 percent of enrollees in HSA/HDHP plans were in PPO (preferred provider organization) products with both in-network and out-of-network coverage. HSA/HDHP enrollees generally have access to negotiated discount arrangements with health care providers through their PPO plans.

AHIP received participation from virtually all of its members in the HSA/HDHP market for this census. This census does not include coverage associated with health reimbursement arrangements (HRAs), which are most commonly offered in the large-group market.

Introduction

Health savings accounts (HSAs) are designed to give consumers financial incentives to manage their own health expenses. An individual's HSA must be coupled with a high-deductible health plan (HDHP). These HDHPs generally cover preventive care services (e.g., exams, tests, immunizations, well-baby visits, etc.) before the deductible is met. HSA funds may be used to cover current and future health care costs.

Health savings accounts (HSAs) were first authorized in late 2003, and regulatory guidance was released in mid-2004. Since then, AHIP has conducted a periodic census of its members to monitor and report on the HSA/HDHP health insurance market. For this census, AHIP received participation from virtually all of its members that sell HSA/HDHP products.

Importantly, the census does not track participation in health reimbursement arrangement (HRA) products, which have features similar to HSAs and are offered by many large employers.

Market Overview

As of January 2006, almost 3.2 million people were covered by HSA/HDHP products. This is more than triple the HSA/HDHP enrollment of approximately one million that was reported by AHIP members in March 2005 (see Figure 1 below, and Table 1 on page 3).

Figure 1. Growth of HSA/HDHP Enrollment from September 2004 to January 2006

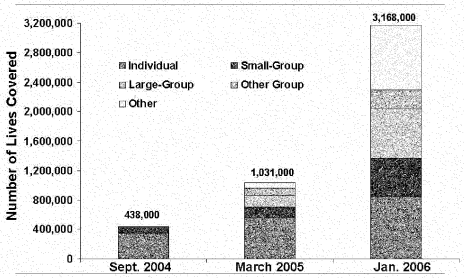


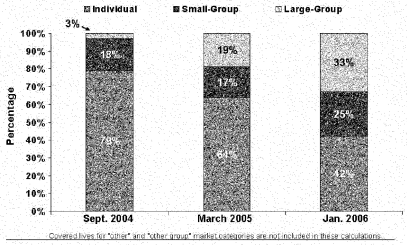
Table 1. HSA/HDHP Enrollment (Covered Lives)			
	September 2004	March 2005	January 2006
Individual Market	346,000	556,000	855,000
Small-Group Market	79,000	147,000	510,000
Large-Group Market	13,000	162,000	679,000
Other Group[1]		88,000	247,000
Other[2]		77,000	878,000
Total	**438,000**	**1,031,000**	**3,168,000**

The January 2006 census included responses from 96 AHIP member companies. Fifty-three companies had enrollment in the individual market, and 87 companies had enrollment in the group market.

The fastest growing market for HSA/HDHP products is group coverage, which has grown from about 20 percent of the market in September 2004 to approximately 60 percent in January 2006.

In particular, the large-group market for HSA/HDHP plans has grown from a very small share of the market in AHIP's September 2004 survey to 33 percent in January 2006 (see Figure 2).

Figure 2. Percentage of Lives Covered by an HSA/HDHP, by Market Type



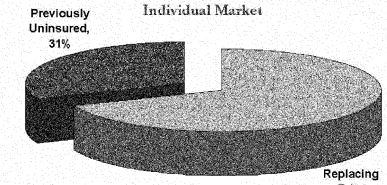
In all three market segments -- individual, small-group, and large-group -- over 90 percent of enrollees in HSA/HDHP plans were in PPO (preferred provider organization) products. PPO plans have in-network and out-of-network benefits, with lower co-payment or coinsurance requirements for in-network services. HSA/HDHP enrollees generally have access to negotiated discount arrangements with health care providers through their PPO plans.

[1] For this census, AHIP members reported their membership in large- and small-group markets according to their internal reporting standards. The "other group" category contains enrollment data for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting.
[2] The "other" category was necessary to accommodate companies that were able to provide information on the number of people covered by HSA/HDHP policies, but were not able to provide a breakdown by market category within the deadline for reporting.

Individual Market

AHIP's member companies reported a total of 855,000 people covered by individually purchased HSA/HDHPs in January 2006. However, this tally for individual coverage almost certainly understates the total, because 878,000 covered lives were not categorized by responding companies into either the group or individual market. According to the census, 23 percent of new policies sold in the individual market were HSA/HDHP plans.

Figure 3. Percentage of HSA/HDHP Policies Purchased by Previously Uninsured

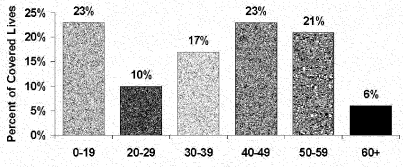


Companies responding to this question reported HSA/HDHP enrollment of 362,336 lives in the individual market.

Data from a subgroup[3] of companies that were able to report on the prior insurance status of their new enrollees in individual HSA/HDHP plans indicate that 31 percent of new policies were purchased by individuals who previously did not have health insurance (see Figure 3).

Half (50 percent) of HSA/HDHP enrollees in the individual market (including dependents covered under family plans) were aged 40 or over; 50 percent were under age 40. Specifically, 23 percent of covered people were younger than 20 years of age; 27 percent were between the ages of 20 and 39; 23 percent were between the ages of 40 and 49; and 27 percent were 50 years of age or older (see Figure 4).

Figure 4. Age Distribution of People Covered by HSA/HDHPs, Individual Market



Data as of January 2006

Table 2 (on page 5) provides information on the average deductible, out-of-pocket limit, and maximum lifetime benefit for the best-selling HSA/HDHP plans sold by companies in the individual market. Table 3 (on page 5) provides the average premium for the best-selling policies in the individual market, by age group.

[3] Companies responding to this question reported HSA/HDHP enrollment of 362,336 lives in the individual market.

Table 2. Description of HSA/HDHP Policies Individual Market – Best-Selling Product		
	Single	Family
Average Annual Deductible*	$2,378	$4,760
Average Annual Out-of-Pocket Limit	$3,371	$6,837
Average Lifetime Maximum Benefit**	$3.8 Million	$4.1 Million
* Policies generally cover preventive care services before the deductible is reached.		
** One company reported an unlimited lifetime maximum benefit, and is not included in this calculation.		

Table 3. Individual Premiums by Age – Best-Selling Product			
	Age 20-29	Age 30-54	Age 55-64
Average Annual Premium, Single Policy	$1,121	$1,914	$3,157
Average Annual Premium, Family Policy	$2,507	$3,951	$5,690

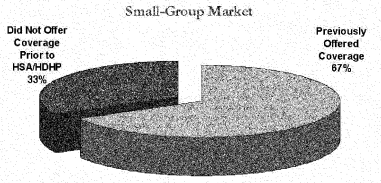
Group Market

Approximately 1.4 million people were covered in the group market under HSA/HDHP plans as of January 2006. This includes 510,000 in the small-group market, and 679,000 in the large-group market. AHIP member companies reported covering an additional 247,000 people in the group market in January 2006 but did not report the breakdown between the small- and large-group markets. These responses were placed into a category called "other group." Finally, these totals for group coverage are understated because 878,000 covered lives in HSA/HDHP plans were not categorized by group or individual market (but were included in the overall totals).

Small-Group Market

AHIP members offering HSA/HDHP products in the small-group market reported enrollment of 510,000 people as of January 2006. In general, small-group coverage was defined as coverage through employers with 50 or fewer employees, although a handful of respondents to the census used a slightly different definition. Among those companies that could provide information, 33 percent of small-group policies were purchased by employers that previously offered

Figure 5. Percentage of HSA/HDHP Policies Purchased by Companies That Previously Did Not Offer Coverage



Companies responding to this question reported HSA/HDHP enrollment of 269,000 lives in the small-group market.

no health care coverage to their workforce (see Figure 5). These policies covered 69,000 employees and dependents.[4]

Average deductibles for the best-selling HSA/HDHPs in the small-group market were lower than those in the individual market, averaging $2,143 for single coverage and $4,311 for family coverage. The average annual out-of-pocket limits for the best-selling HSA/HDHP plans in this market were $3,381 for single coverage and $6,575 for family policies. The average lifetime maximum benefit for small-group policies was roughly $3.5 million (see Table 4).

Table 4. Description of HSA/HDHP Policies
Small-Group Market – Best-Selling Product

	Single	Family
Average Annual Deductible*	$2,143	$4,311
Average Annual Out-of-Pocket Limit	$3,381	$6,575
Average Lifetime Maximum Benefit**	$3.3 Million	$3.8 Million
Average Annual Premium	$2,772	$6,955

*Policies generally cover preventive care services before the deductible is reached.

**Seven companies reported an unlimited lifetime maximum benefit, and are not included in this calculation

Premiums averaged $2,772 for single coverage and $6,955 for family coverage. These premiums are considerably lower than premiums reported from surveys of all employer-based coverage. For example, the average premium was $10,880 in 2005 for employer-sponsored family policies.[5]

Finally, HSA/HDHP plans accounted for approximately 11 percent of new health insurance policies purchased in the small-group market.

Large-Group Policies

As of January 2006, large-group coverage had increased to at least 679,000 lives, up from 162,000 in March 2005. As noted previously, the January 2006 figure is understated by the fact that some responding AHIP member companies did not distinguish among the individual, small-group, and large-group markets (representing 878,000 covered lives), and others did not distinguish between large and small firms within the group market (247,000 covered lives). Seven percent of all new health insurance purchased in the large-group market was attributed to HSA/HDHP plans.

[4] Companies responding to this question reported HSA/HDHP enrollment of 209,000 lives in the small-group market.

[5] Kaiser Family Foundation Employer Health Benefits 2005 Annual Survey.
http://www.kff.org/insurance/chcm091405nr.cfm

Table 5 provides the average annual deductible, out-of-pocket limit, and lifetime maximum benefit for the best-selling single and family HSA/HDHP policies in the large-group market.

Table 5. Description of HSA/HDHP Policies Large-Group Market – Best-Selling Product

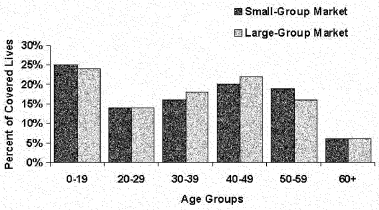
	Single	Family
Average Annual Deductible*	$1,754	$3,494
Average Annual Out-of-Pocket Limit	$3,330	$6,385
Average Lifetime Maximum Benefit**	$2.9 Million	$3.5 Million
Average Annual Premium	$2,745	$6,715

*Policies generally cover preventive care services before the deductible is reached.

**Six companies reported an unlimited lifetime maximum benefit, and are not included in this calculation.

In the large group market, 44 percent of enrollees in HSA/HDHP plans (including dependents) were aged 40 or over. The age distribution of covered lives in HSA/HDHP plans is very similar in the large- and small-group markets (see Figure 6).

Figure 6. Age Distribution of People Covered by an HSA/HDHPs, Employer Markets



Data as of January 2006

Acknowledgements

This census and report were compiled and written by Hannah Yoo and Teresa Chovan.

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Ms. IGNAGNI. We have the most comprehensive survey not only on HSAs, but on the individual market and to the question that was just posed by Congressman Stark about coverage for various benefits, particularly pregnancy, I can tell you that the coverage is very comprehensive. Again, it is the most comprehensive survey. Would be delighted to submit it for the record, number one. Number two, when Dr. Collins—I read her statement last night and had an opportunity to look at the study to which she refers, I did notice that it is a study of Internet users who agreed to participate in the research. So, we are talking about a sample of 185 individuals. We have a sample of 3 million.

I did have an opportunity to talk with—I saw it too late, unfortunately, and I apologize to Dr. Collins. I didn't have a chance to talk to all of our members, but I did talk to the top five members of ours that are the top five in the HSA market today—who are also, by the way, selling HMOs and PPOs, so they offer a range of coverage options. They all report that the preventive care utilization is up, that the prescription drug fill is up and very consistent with what the physicians are requiring, which is so important for disease management.

We also know that health status right now, according to the data, and I can only talk to you about right now what we are seeing in the data, are roughly equivalent, and I think that is explained by the fact that those who are under and over 45 are roughly equivalent.

So, there is a distribution age-wise that I think no one expected 3 years ago when we were talking about these products. On the back end, sir, I think this is also very important, our members are offering comprehensive coverage. This is a high deductible, meaning a roughly $1,000 deductible for the individual, $2,000 for the family. On the back end, there is complete comprehensive coverage, which is very important from the standpoint of protecting risk and providing a safety net, which individuals are interested in.

So, from our perspective, it is not our choice to decide what people purchase. It is our responsibility to offer a range of products, and that is what we are trying to do.

Mr. ENGLISH. Thank you. Dr. Collins, I was interested to read in your survey that the use of consumer-driven health plans appears to have led to greater cost awareness by consumers. You also state that individuals may have delayed or avoided health care due to cost, and yet there was also a finding, I believe, that these individuals are more cost conscious in their decisionmaking. I guess my question is, do markets work? Do you believe that cost-conscious decisionmaking can be a good thing in terms of injecting market discipline into the health care system and generating lower costs through higher competition for many procedures.

Dr. COLLINS. Certainly we did find that consumers in these plans are more cost conscious. I also want to mention that this was a random survey. The EBRI Commonwealth Survey was based on a random national sample pulled from a 4-million member panel of online users who agreed to participate in surveys. So, we did—we did actually find that people are more cost conscious, but that they didn't have the information they needed to make decisions. Certainly giving people more information about quality of care, cost of care will contribute in small ways to improving the health care system and maybe lowering costs a little bit, but it is really unlikely to be transformational. It is not going to dramatically change the way we conduct business. We really need more focus on the provider, paying providers for efficient care, for high-quality care, coming up with quality measures so focusing on how we pay providers is a much more realistic and promising strategy to control costs in the system.

Mr. ENGLISH. I don't think they are mutually exclusive, and I don't think HSAs have ever been offered as a panacea, at least I

have never viewed them that way. My time is up, but Mr. Chairman, I appreciate the opportunity to pose these questions.

Chairman THOMAS. Thank you. The usual answer is all of the above. Gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you. Mr. Cava, let me ask you a few questions. I hope you don't think they are hostile. Our family goes to your establishment. We eat salads as part of our preventive care.

Mr. CAVA. Thank you.

Mr. LEVIN. Just so the record is clear, you say 10,000 in your statement, 10,200 are eligible. How many overall employees are there?

Mr. CAVA. Mr. Chairman, Representative Levin, there are in our company, approximately 45,000 employees in the United States, which would obviously be eligible for U.S.-based benefits.

Mr. LEVIN. So, there is 45,000 and so that means that less than 25 percent are eligible?

Mr. CAVA. Yes, sir.

Mr. LEVIN. Okay. By the way, we have asked the Treasury Department 2 years running for income distribution tables on HSA holders, and they have not given them to us. Mr. Chairman, we would appreciate if you would press the Treasury Department to do that.

Chairman THOMAS. I will. Your phrase was that they have not given them to you. Part of the problem is they probably don't have them. That is one of the difficulties in trying to deal with government collection of information. I am asking all of you, although some of you will contradict yourselves or argue the others' information isn't accurate, whatever you give us is at least contemporary as opposed to the historical viewpoint from Treasury. So, I certainly will send these.

Mr. LEVIN. I think that information is available. It is our understanding.

Chairman THOMAS. I will join you in pressing them.

Mr. LEVIN. Okay. Mr. Cava, in terms of preventive care, by the way, it is our understanding that 70 percent of the insurance plans under HSAs do not cover preventive care. So, if anybody has contrary information, I would like to have that. You are, therefore, in the minority. Quickly because I want to ask some other questions, what kind of preventive care do you cover?

Mr. CAVA. Mr. Chairman——

Mr. LEVIN. People don't have to use their deductible for?

Mr. CAVA. That is correct. Mr. Chairman, Representative Levin, I have listed in my testimony, we cover annual physical, non-age qualified, you don't have to be a particular age. It is just an annual physical, associated preventative tests, Pap smears, prostate exams, different—mammography, vaccinations, childhood vaccinations. This is not a comprehensive list, but it is a good representation of the care that we provide.

Mr. LEVIN. How about child care? Did you say it gets covered?

Mr. CAVA. As it would qualify as an annual physical or as an annual visit, yes.

Mr. LEVIN. Otherwise not?

Mr. CAVA. Childhood vaccinations it does cover, yes.

Mr. LEVIN. That is much more than that.

Mr. CAVA. Yes.

Mr. LEVIN. All right. So, I think before you log the preventive care, the results, you need to look at the whole picture.

Mr. Lauer, our talented legislative expert has calculated for each of the examples what people have to pay before they get health care coverage, insurance coverage, and here is how it comes out.

For Mr. Heloski, he would have to pay $4,040 out of pocket before he gets one dime. For the Ecclestons, they have to pay $6,460 before they get coverage. For Mr. Lomel, he could pay $8,000 without getting any coverage at all. Mr. Botcharnikov would have to spend—he was spending $5,820 in this plan. He could spend $7,262 before getting any help from insurance.

Those are very high health care expenditures. Before anybody tries to applaud HSAs as an answer for the needs of most people, they had better look at this because in essence, what you end up with is high deductibles in so many cases and a tax benefit, and we need to look as to whom this tax benefit accrues.

Mr. LAUER. I would agree with you that those are high numbers and I can't speak for each of them. I don't know whether that is through choice or not. I would assume it may be.

Mr. LEVIN. When you say "choice," meaning what?

Mr. LAUER. Well, they may have chosen that they wanted that higher deductible because they had been paying for health care out of their pocket up to this point anyway, and wanted to fund against catastrophic or financial loss. That is not unusual.

Another point I wanted to make, and I think it is an important one when it comes to businesses and several of the examples we cited in the written testimony, which you have talked about come from that. In the business environment, hopefully, we don't all assume that a business that provides employer-sponsored health coverage that everything is covered, because that is not the case in most cases. For example, in my company where we have pretty robust coverage, I have a wife and three children. We have a deductible for each individual in the family. I make a contribution out of every paycheck for the health insurance. We have copays for physician visits, prescription visits and so on. That is very common. It is not $7,000 or $8,000, by the way, that you just cited.

Mr. LEVIN. How much is it? My time is up.

Mr. LAUER. We are about $400 per individual.

Mr. LEVIN. You are in a high income bracket.

Mr. LAUER. That that is for every employee in my company, Congressman.

Mr. LEVIN. In your case. So, you are talking about $400 per person. You multiply that by five?

Mr. LAUER. Yes, $2,000.

Mr. LEVIN. Okay. Compared to what exists for these people. Twice, three four times that. My time is up.

Chairman THOMAS. Briefly, Mr. Cava, you seem to be the biggest employer around here. So, just to get an idea of why we are holding the hearing now. How many of your employees had HSAs 5 years ago?

Mr. CAVA. None.

Chairman THOMAS. How many had HSAs 3 years ago?

Mr. CAVA. None, Mr. Chairman.

Chairman THOMAS. How many had HSAs 2 years ago?
Mr. CAVA. None, Mr. Chairman.
Chairman THOMAS. How many had them last year?
Mr. CAVA. Over 7,000.
Chairman THOMAS. Okay. When someone cites a number, people need to realize, that is in 1 year and if we bring you back over the next 2 to 3 to 5 years, I think you'll begin to see the roles they are going to play. Thank you very much. Gentleman from Arizona wish to inquire?

Mr. HAYWORTH. Thank you very much, Mr. Chairman, and to the witnesses assembled. Thank you all for taking time to join us today for a hearing that has been both informative and, I guess, Mr. Chairman, extending beyond the realm of the informational, perhaps just given the nature of our institution and perhaps where we are on the calendar, it, at times, becomes adversarial.

The Chairman made mention of the fact that these changes don't occur in a vacuum; that this is a program that has really, for all intents and purposes, in the march of time, just really started. It is interesting with a tip of the rhetorical cap to the adversarial to hear the lament of the cup half full, or perhaps one-quarter full, but I don't believe the process of pouring has yet stopped, nor the process of calibrating or evaluating information. This is an ongoing process.

To that end, let me welcome in particular my neighbor from comparatively nearby Colorado. Mr. Jackson, it is good to have you here and to hear of your real-life examples. Not only do we have a chance to hear the witnesses compare and contrast their different philosophies and their different experiences, but looking ahead, mindful of the fact that very seldom do we pass a new initiative without re-evaluating and attempting to offer some perfections.

Mr. Jackson, let me just put it to you, are there any changes to HSAs that would make it easier for small businesses to participate in HSAs or high deductible health plans, such as a refundable tax rebate for contributions made to their employees' HSA or any other things. If you had to rank things, if you were writing the program again based on what you see and what you know of other small businesses, what would you suggest?

Mr. JACKSON. Well, certainly, any tax advantages to the company to allow them to contribute to the employees' HSAs would be a significant benefit. One of the things—I don't know that it directly relates to HSAs, but the pooling arrangement is significant, and we either need associated health plans, small business health plans, a State-run pooling arrangement, we need some kind of arrangement so that small businesses have an opportunity. Obviously, my company of 20 employees can't compete price-wise on insurance with Wendy's with their number of employees.

I would say that was one of the biggest issues that I see is one, allowing us some mechanism to pool our resources to get lower premiums in general. I would like to comment that writing the—the company last year funded my HSA. For the first time in my life, I was writing a check when I went to the pharmacy to get a prescription. Quite honestly, I was shocked. I just assumed that prescriptions were a little over $20. That is what I always paid. When I take out my checkbook and write a check for $400, it changed my

way of looking. To that effect, in order for the HSAs to become effective, we have to offer them some mechanism to be able to shop. There is a couple of Web sites in Florida that I had mentioned to Mr. Beauprez that allow you to go online and shop for your specific prescription at various drugstores. I can tell you, I asked my drugstore what the price was and they said, "we can't tell you that until we ring it up." If you want to make a purchase, we will tell you the price.

I contacted my doctor's office and asked about the price of a simple procedure, and it was like they had never had that question presented to them before, and no one knew what to say. For HSAs to be effective, there has to be some mass media mechanism to allow—I absolutely believe that people will be good shoppers if we give them the opportunity to be good shoppers, and particularly when they are spending their own money because if they don't spend it, they get to keep it in their account.

Mr. HAYWORTH. The power of the markets. Well, imagine that.

Mr. JACKSON. Absolutely.

Mr. HAYWORTH. I know there are tons of discrepancies between those academics that like to cite the empirical and somehow would like to deny the anecdotal, but I think your firsthand experience as versed as you are in the world of business is very instructional to us in terms of the fact that when it came to health care and the cost of prescription drugs, because you had not had real contact with the reality of pricing, your assumption was something far different from what the market brought to bear. I think that is very instructional to us all, and I think as we have made much of the fact that this is the information age, and as we see the health care of all utilizing the Internet, your suggestions are well taken, especially as a smart shopper. My time has expired, Mr. Chairman. I thank you for the opportunity to inquire.

Chairman THOMAS. Thank the gentleman. Gentleman from California, Mr. Becerra, wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Thank you all for your testimony. Let me see if I can concentrate right now on a couple of questions to Mr. Cava. You are getting lots of questions regarding the establishments because I think so many of us are very familiar with Wendy's. My understanding, from a Securities and Exchange Commission (SEC) filing, is that that there are about 57,000 employees that Wendy's employs. Is that because some of these folks beyond the 45,000 are internationally based?

Mr. CAVA. That is correct.

Mr. BECERRA. In terms of health insurance, do you offer any of the 12,000 of those employees, that are internationally based, HSA accounts?

Mr. CAVA. Mr. Chairman and Representative Becerra, no. We provide U.S.-based benefits according to sovereign law and regulation of the United States and for our non-U.S. employees, we are subject to the laws of those countries.

Mr. BECERRA. Thanks for making sure we compare apples with apples. So, let me make sure I understand this: of the 45,000, 10,200 are eligible for your health insurance coverage now, in the form of HSAs?

Mr. CAVA. That is correct.

Mr. BECERRA. The remaining 35,000 or so are not eligible for any type of health insurance coverage under Wendy's?

Mr. CAVA. Not exactly. We have some specific markets that we do provide more traditional health care to in what we call our midwest and northeast markets, but not the HSA-based, not the high deductible plans.

Mr. BECERRA. Of the 10,200, about 7,000 employees who are eligible for the HSAs have established an HSA account?

Mr. CAVA. That is correct.

Mr. BECERRA. Okay. In terms of the preventive benefits that you offer, are those—I want to make sure I am clear about the answers you gave to Mr. Levin from Michigan. You provide coverage for preventative care before or after the deductible is paid?

Mr. CAVA. That is deductible free, so to speak. It is free care and it is not charged to the deductible.

Mr. BECERRA. Good. Does that preventative care include paternity care?

Mr. CAVA. It does not, in particular. It would only only cover the items which I had mentioned, and I would like to provide more information to you about the plans.

Mr. BECERRA. Appreciate that if you would. Thank you. Of your 45,000 domestically-employed employees, how many are female?

Mr. CAVA. I do not have that information.

Mr. BECERRA. Would you provide that for us? Also, you might as well break it down for the 10,200 eligible for the HSAs and the 7,000 who have established HSAs, what percentage of female. Primary care.

[The written response from Mr. Cava follows:]

Chairman THOMAS. Would the gentleman yield briefly? If we are going to do that, then you want to break out the female group as those who are of child-bearing age versus those who aren't. There are a lot more senior employees.

Mr. BECERRA. Good point. Primary care. Do you provide primary care services such as flu, fever visits that the family may have to make because a child has 103 fever, is suffering from the latest flu that is attacking the country?

Mr. CAVA. The health care plan provides access to physician visits, it provides access for emergency care.

Mr. BECERRA. Does it pay for them?

Mr. CAVA. I am sorry.

Mr. BECERRA. Does it pay for them?

Mr. CAVA. After the deductible. Excuse me, Representative. We also contribute 60 percent of that deductible. So, in essence, it could end up costing the employee nothing.

Mr. BECERRA. Well, after they have paid the deductible?

Mr. CAVA. No, sir. It could end up costing them nothing. Our company provides——

Mr. BECERRA. If I have a child who has the flu——

Mr. CAVA. Yes.

Mr. BECERRA. I go to a physician, physician says, well, this is not a preventive benefit that is offered through your HSA, I charge you $150 for this visit for your child, your deductible is $250, how much of that will you cover?

Mr. CAVA. It could be nothing because the company has paid 60 percent of that deductible, which would have exceeded that $150 into your account.

Mr. BECERRA. Wait, if I have a $250 deductible and you cover 60 percent of a deductible——

Mr. CAVA. No, sir, the HSA deductible is contributed at a rate of 60 percent.

Mr. BECERRA. You are talking about the total deductible which could be—what could a deductible be?

Mr. CAVA. It could be $1,500, $1,200.

Mr. BECERRA. Before I get—if my child gets sick in February and I have not yet reached my deductible of $1,500 you won't cover it, I have to cover out of pocket for that flu visit?

Mr. CAVA. Actually, it probably would have been contributed because we contribute it on a quarterly basis.

Mr. BECERRA. February, the first quarter.

Chairman THOMAS. Will the gentleman yield? It might be better, since we are using usual insurance terms, when you say deductible, the idea of an HSA is that you put money in a bank account and then you draw down that account, but you have to use your own money until the full 100 percent kicks in. The point the gentleman is making that he puts in 60 percent of that money, and he puts it in on a quarterly basis. If your doctor visit costs $150, you would take $150 out of the account and pay the doctor, but it could easily be the money that was put in by the company. Therefore, no money would come out of your pocket to pay for that. That is the concept of the HSA. Thank the gentleman. That doesn't come out of his time.

Mr. CAVA. Thank you, Mr. Chairman. I am sorry. I apologize, I wasn't making that clear.

Mr. BECERRA. No. I thank the Chairman for trying to bring some clarity to that. Let me ask this other question. This is a bit more personal. Mr. Lauer actually got into this. If you are interested in answering it, you don't need to, of course, if you don't wish to. How many of you have established HSAs?

Mr. CAVA. I am sorry. I have one.

Mr. BECERRA. Anyone else? I am just trying to figure out how many folks.

Mr. CAVA. So does our CEO.

Mr. LAUER. We are in transition to it.

Mr. BECERRA. Okay. I have always heard people say, if you work for General Motors (GM), you should buy GM, not Ford. If you work for the manufacturer of Crest toothpaste, you should buy Crest, not Colgate. If you work for the manufacturer of Tide detergent, you should buy Tide, not All. I suspect probably the best source for the American people to know whether or not this HSA product is good is if the inventors and advocates, proponents of it, meaning the Members of Congress here, also have HSAs. I am not sure how many Members of Congress have taken up the opportunity to establish HSAs, but I would be very interested and intrigued to find out how many of my 534 other colleagues in the House and in the Senate have actually established HSAs to see how valuable they really are to the American public. With that, I will yield back the balance of my time.

Chairman THOMAS. Gentleman from Illinois, Mr. Weller.

Mr. WELLER. Thank you, Mr. Chairman. I appreciate the panel being with us here. Mr. Lutey, my Illinois constituent, I am going to direct questions to you.

You are not-for-profit; you are not in the business of making money. You are in the business of providing social services. So, you want to make ends meet, and you had indicated in your testimony you found HSAs to be, frankly, a successful way to reverse a trend that you had stated in your testimony, the trend 2 to 3 years ago was more and more the responsibility of the financial burden for health care coverage was being shifted to the employees.

Mr. LUTEY. Correct.

Mr. WELLER. As a result of using HSAs you reversed that, and you as an employer, as a not-for-profit, were able to increase your share of those costs and provided more as an employee, a benefit. As part of your testimony though, you—as part of our oversight, we are always looking for ways to make things better, and while you had some positive statements, you also had some recommendations about how you feel HSAs can be improved, both from an employer's perspective, but also for the health of the employee.

One of the recommendations was dealing with comparability rules regarding income levels and the amount of contributions that you can make. You suggest contributing more to lower-income employees because higher-income employees could afford to contribute more in their share. Can you further elaborate on that idea and how that would work from your perspective as well as the employees?

Mr. LUTEY. I would be glad to, and I appreciate the question. We are doing this not because of tax advantages and we are not doing this because somehow we are going to be gaining from this process. We are doing it because we believe that this truly is a way that can promote wellness in our organization, and a way to truly affect the employee base and attract new employees to our company.

In my organization, 90 percent of the employees in the plan make less than $50,000, and 47 percent of the employees in the plan make less than $30,000 a year. If I had the opportunity and the ability to put more money into the HSA accounts of those individuals who made less than $30,000, and individuals who had the ability to deposit more pre-taxed contributions out of their own salary, I would be better able to address the adverse impact issue. I would be able to address the issue of employees perceiving that the plan is too expensive when they are standing there at the pharmacy, wondering, how am I going to pay for this?

As I said earlier, for many of my employees, the choice they make is not between high plan and low plan. It is between, "can I afford insurance or will I buy milk for my kids?" So, if there are ways that I can increase the dollars that are available to them and have less out of pocket for them to pay, I believe the plan could truly be successful and impact positively those individuals who are uninsured and who are coming to us to work.

Mr. WELLER. So, these lower-income workers for your not-for-profit would be able to essentially have more take-home pay be-

cause they would be required to put in less because the employer would be putting in more?

Mr. LUTEY. Exactly right. I know some of my colleagues may disagree with me here at the table, and to be quite frank, you may not hear this again from a witness: I am not asking you for more money. I am asking you to allow me to rebalance the dollars I have; to be able to put more money into the HSAs of low-income employees rather than the higher ones so the working poor who can have greater ability to use those dollars for health care needs.

Mr. WELLER. You have also suggested greater flexibility and your point is, in the long term, we can prevent large health claims by encouraging better preventive measures, and one of those suggestions was opening the rules around prescription drugs for preventive care. Can you elaborate on that?

Mr. LUTEY. Yes. One of the questions earlier—I believe Mr. English asked the question—what could happen to improve HSAs for me is, anything you can do to help describe preventive care with a broader definition. Anything you can do to assist employees to make good decisions around their health care would be beneficial. I would far prefer to pay for Lipitor and other preventative medications for my employees who have diabetes and other chronic diseases than to pay for the complications of those diseases when the employees choose not to take the prescribed medications because they don't believe they can afford it.

So, whatever you can do to make preventative prescriptive drugs available for them would be helpful. In addition, if I may refer back to another question asked earlier, one of the key differences for us, that we talk about with our employees, is the reality that there are no lost dollars with an HSA. With HMOs you go in and you also have copays. Well, where do copays go? They just disappear into thin air. In our HSA plan, every dollar that an employee spends counts toward their deductible. Dollars are simply gone out the window. If I can help employees understand that better; if they are willing to make that investment in purchasing their prescription drugs. The plan can move forward.

Mr. WELLER. I thank you for your testimony. I see my time has expired. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Lutey, I really appreciate your ideas. You need to understand though, the fraternity of witnesses may not allow you to join if you continue to repeat that you are not here asking for more money. I just want you to appreciate the consequences of your statement.

[Laughter.]

Chairman THOMAS. Gentleman from North Dakota wish to inquire?

Mr. POMEROY. Yes, I do, Mr. Chairman. I begin with a question of the Chair. Today's Roll Call has an editorial entitled Tax Exempt Corruption, and it includes in its first paragraph, "It is time for the Ways and Means and Senate Finance Committees to follow up with probes of the misuse of tax exempt foundations." It goes on to call for hearings to expose the practice of using foundations as conduits for special interest political money. This gets to the kind of Abramoff schemes that detailed somewhat in the editorial,

but publicized of late and it has been a matter of inquiry for the Senate Committee on Finance.

I know the Chairman has been interested in tax exempt entities. We have had hearings on nonprofit hospitals, we have had a hearing on the credit unions and I have asked the Chairman whether hearings are anticipated on these nontaxed foundations that have been involved in the political corruption allegations.

Chairman THOMAS. Would the gentleman yield?

Mr. POMEROY. I yield.

Chairman THOMAS. The answer's absolutely. We are stating—we have begun as the gentleman noted a systematic study of the not for profits. We thought we would start with those that involve the most billions of dollars of taxpayers' money—that was the hospitals—and the second largest group was the credit unions and we will continue on down the line looking at all of the not for profits and their structures. This is going to be an ongoing investigation. It hasn't been done for a quarter of a century, and we will finish with then having some understanding of where we need to go back and make some changes. Clearly, if something shows up of immediacy, for example, somebody telling someone, go get a cashier's check for $1,000 before you can get services from a not for profit hospital, we will make corrections as we go forward, but the goal is to have a thorough hearing of the nonprofit area and move for changes.

Mr. POMEROY. Reclaiming my—thank you, Mr. Chairman.

Chairman THOMAS. This won't come out of the gentleman's time.

Mr. POMEROY. Thank you. Then I would just add, even though the dollars relative to the class of foundations that Members have an interest in would probably be small relative to the broad array of nontaxed entities, because of the potential of corruption or undo influence related to those nontaxed foundations, I think it needs to play a much higher role than a systematic review of what is taxed and what is not taxed. This really gets to the integrity of the function of Congress. It involves squarely a tax issue and ought to be, as the editorial says, a matter of, in my opinion, immediate Committee on Ways and Means inquiry.

Chairman THOMAS. Gentleman yield?

Mr. POMEROY. Yes.

Chairman THOMAS. That is always a possibility although when you talk about squandering money or corruption and misrepresentation, I invite you to the billions and billions of dollars involved in those entities we have already examined, and it is in the eye of the beholder, to a certain extent. Had we used some other structure, we would have been accused of going after particular groups. We could choose alphabetical. We could choose the dollar amounts involved, but I agree with the gentleman that clearly when something pops up and presented to us, we might be able to move them to the head of the queue. As was indicated by nonprofit hospitals that might have someone come up with $1,000 cashier's check, in a tax preferred mission, we should not allow that to happen. So, clearly the gentleman—reordering based on current events, and I think that will come out of the gentleman's time because of the focus on the current hearing.

Mr. POMEROY. I thank the Chairman. I look forward to the hearing. Question for the panel: where I am very concerned about HSAs is where we are going from here. The Administration has proposed taking the amounts of HSAs up significantly higher, and then allowing those attempts to be used in individual health insurance. What I think we are seeing here is a move to try and move health coverage provided through the employer group format into a defined contribution type of contribution by the employer rather than the present defined benefit. Right now the employer buys a coverage. Whatever copay or deductible is allowed to the employee, the coverage is provided and pays the claims incurred.

What I believe is afoot behind the Administration's proposals is to transition this type of group benefit into a fixed cash amount which would be given to the employee under a benefit structure and the employee is then responsible to go buy their own individually-sold health insurance.

I used to be a State insurance commissioner. I believe this change would significantly short-sell individuals in the workforce. I believe it would ultimately lead to the demise of our private pay health insurance.

I would ask Ms. Ignagni whether or not this transition from a defined benefit to defined contribution, from group coverage to individual coverage, albeit with some employer sponsorship is a trend that they support.

Ms. IGNAGNI. Mr. Pomeroy, I think, as you know, our view is that employers and individuals should decide what products are best for them, point number one. Point number two, we don't think that anything should be done to exacerbate the burden on employers, which is why I answered the Chairman's question the way I did.

At the same time we I think all recognize that the nature of work is changing. There are many individuals who are retiring relatively early who are doing consulting type of work, independent contractor type of work, and enter the insurance arena themselves as opposed to being sponsored by an employer.

So, in that regard we believe in a level playingfield; that we ought to maintain what we have for employers but at the same time offer the same opportunities for individuals purchasing on their own who may very well be in that early retirement category, somewhere between 50 and 65, which is why we have testified to the fact that there should be a level playingfield.

Right now if you are an individual purchasing—if you are in that category and unsponsored by an employer, you can't deduct that, of course, until you hit a certain percent, as you know, of adjusted gross income.

Mr. POMEROY. I have worked long and hard for self-employed deductibility, but the transition of employer group coverage to employer-sponsored, individually purchased coverage by the employee I believe is a serious development and a very adverse one relative to health insurance.

Ms. IGNAGNI. I want to make it very clear in terms of where we are. We are not advocating a product, we are not advocating a type of structure. Our job as insurance plans is to be there to offer

the range of choices that employers and individuals want. We take that very seriously, we have tried to do that.

I might say also to the question that was going back and forth about the numbers of people who have opened up accounts, the GAO has information about that: 50 to 60 percent of individuals in the HSA arena have opened up accounts. We have cited that in our testimony, which I think, Mr. Pomeroy, also bears on your question.

Chairman THOMAS. The gentleman's time has expired but you may respond briefly.

Mr. LAUER. Only an observation, but we are seeing more employees in companies coming into the individual market for various reasons. I think a lot of it is market-driven.

We are finding, more and more, employers don't want to make the decisions for employees about how best to cover them; that they want the employee to make the decision.

We are also seeing, for example, and you saw it this week, some 45,000 people that took the buyout from General Motors. Those people are coming in the way—this point was made, many are older, pre-retiree age, and they are going to need a good option.

Chairman THOMAS. Obviously, if you are interested in preventive care and wellness, we can't have a paternally structured arrangement. You have to get the participation of the individual.

The gentleman from Virginia, Mr. Cantor, wish to inquire?

Mr. CANTOR. Mr. Chairman, thank you. First of all, I want to thank you and your staff for holding this hearing and for doing excellent work to get such a terrific panel. I have enjoyed the discussion. I think it has been tremendously helpful as we deliberate on the issue of health care, specifically HSAs today.

I want to respond to my colleague and friend from North Dakota on the other side of the aisle about his concern of our move away from employer or group coverage. I have to agree with the panel that it really is being dictated by the marketplace.

First we have to consider the cost on employers. Mr. Lauer testified that, frankly, we don't want to do anything to provide disincentives for employers to provide coverage because the fact is they are having a hard enough time trying to keep up with the escalation in health care costs. It is just the reality of the market.

Several have testified as well that more and more individuals in independent contracting positions, retirees, and so forth, move into the market, obviously plans have gravitated in that way too.

So, it really just concerns me as I hear some on the other side attack HSAs as somehow the evil incarnate that awaits us. I would say that, as the gentleman from Pennsylvania suggested earlier, HSAs are not a panacea. They are being utilized as just one more option in the buffet of health care options provided by employers and that hopefully are going to be chosen by individuals.

To me it seems that some of the panelists have indicated opposition to HSAs. Why would you do that? The facts are clearly laid out for the individuals who have had this real world experience and that they are working and the demographics and distribution of population participating in HSAs don't seem that much different than the traditional plans.

Now the purpose I see of expanding and liberalizing HSAs is to really try and change behavior; it is not immediately about saving money, although it will result. If I could quote Mr. Cava: There has to be a sustained change in behavior that leads to a sustained improvement in health. With this change in behavior we will begin to see more health conscious activity, and frankly, more value conscious patients. This will ultimately bring down costs. As we know, wellness participation will lead to less acute care utilization. Bringing down costs will increase access.

Now I want to respond to some of the testimony having to do with emergency room situations or if someone experiences a heart attack and the notion that we are going to expect individuals to be consumers in that instance. Of course we are not. That is clearly not the issue. Health Savings Accounts provide against major medical expenses and they also provide a way for individuals to save tax-free for routine health care, and again, that is the bulk of health care activity, health care attention by individuals.

So, if I could turn for a question to Mr. Cava on the ownership question, the question that we are providing a way for individuals to save and own their account, the notion of portability has been raised here. As an employer, can you share a little bit of insight as to your thinking on—you provide this money, and unlike traditional health care coverage with where the money is provided, the benefit is either used or not and the year is up and we go to the next, that an employee may take the money, take the benefit and leave.

Mr. CAVA. Well, thank you, Mr. Chairman, Representative Cantor. This is a debate, it is an important debate, and I do believe it is about a long-term change in behavior and not just about saving a dollar or two today.

What we have been excited about is that we have created ownership amongst 90 percent of our employees. They have positive balances in their HSAs. That is currently 95 percent in fact.

We are a higher turnover business and it is encouraging to see that of those 90 percent, now 95 percent of the people who do have positive balances in their HSAs, that equals over $4 million, closer, I think the latest, it is $5.6 million as of today, the latest statistics, that we have now transferred to our employees. That money would have gone somewhere else. I am not quite sure where, but I know it wouldn't have gone to our employees.

They are accumulating wealth for the purpose of taking better care of their health. We are seeing changes in attitudes about behavior associated with preventive care, real measurable changes as a result of making people part owners in their health care. We are making it a number one priority like buying health insurance should be.

These are folks in my business, general managers of restaurants, shift supervisors of restaurants who make decisions about renting houses, buying cars, who make decisions about sending their children to school, who make decisions about all the same things that everybody here makes decisions about. Now what they are showing us is they have the capability to make great decisions about themselves and their health care.

It is about ownership, it is about partnership, and it is absolutely directionally where we need to go. Having said that, can we improve? Absolutely. There are some fixes that we can make to the HSA structure that could be helpful to us.

Chairman THOMAS. Thank the gentleman from Virginia. Does the gentlelady from Ohio wish to inquire?

Ms. TUBBS JONES. Thank you, Mr. Chairman. Just for the record I want to be sure that the American people know that as Congresspeople working on health care, it is not about a paternally structured arrangement, it is about access to health care for all people in America, paternal, maternal whatever the heck you want to call it. It is about the people who are not in a position to make real decisions about health care coverage because they have no dollars to save. It ain't about paternal, it is about the need for us to put in a structure that will allow all people in America to have health care; the richest country in the world, where people come from all over the world to get health care and the people right down the street can't access it.

I had to say it for the record because everybody else is talking about paternally structured and wellness participation and all this other stuff. It is about access to health care for all Americans, however we do it.

Let me just quickly ask Mr. Cava, what is the wage you pay a student, or older worker that walks up to Wendy's and says I want a job? No experience. You use up too much of my time saying "Mr. Chairman." Could you just answer the question?

Mr. CAVA. Could you repeat the question, please?

Ms. TUBBS JONES. The question is the person who walks——

Chairman THOMAS. Will the gentlewoman yield? Any courtesies by Mr. Cava will not come out of your time.

Ms. TUBBS JONES. Mr. Cava, someone walking up to Wendy's, getting a full-time job, how much do they make an hour?

Mr. CAVA. It depends upon the position for which they are applying.

Ms. TUBBS JONES. Entry level.

Mr. CAVA. Entry level, crew level, our average wage for the system is somewhere $7.50 an hour.

Ms. TUBBS JONES. $7.50 an hour. Of the 10 percent, 10,000 who have an HSA or participate in HSA, how many of them are workers who make $7 an hour?

Mr. CAVA. Very few.

Ms. TUBBS JONES. Why is that?

Mr. CAVA. Why is that?

Ms. TUBBS JONES. Let me make it plain. Why is that?

Mr. CAVA. That is a very global question, Representative, and let me think and reflect on that.

Ms. TUBBS JONES. I think it is going to take too long to reflect with the minutes I have. Can you give me something back in writing? I guarantee you, Mr. Cava, most people making $7.95 an hour can't access an HSA because they are paying $3 a gallon for gasoline, $3.50 for a loaf of bread, and so forth. It is not to say—all I am suggesting to you is it sounds like a great idea but if you are not making enough money to eat, sleep, saving for health care is a difficult process, even though they want to participate in

wellness, because being well, participation is an expensive proposition and all the studies say that most low income people are not healthy because they can't afford to be healthy. I thank you for your testimony and I want to be as polite to you, Mr. Cava, as I can but I can't allow the stuff that is being said in this hearing to go without being challenged.

I am going to go to my constituent. Please answer why most low income people or people at that level are not participating in HSAs and please respond as to what is the problem with your provision of health care through a practice with HSA. Who are you seeing, why are they coming to you?

Ms. THERRIEN. The primary reason they would come to us is either that they are completely uninsured, which sounds like many of your workforce for whatever reason is uninsured, or if they have an HSA account and if there are no funds, or even if there were funds in the account, they would first need to come to us where we would offer them a discount, then later if they had any money in an account, which they wouldn't, they would be able to get to that money. So, the primary reason that folks are coming to us is simply because they have nowhere to turn. If they are making $8 an hour, they meet Federal poverty standards. Even as a single person they would meet Federal poverty standards. We would offer a discount on the sliding scale based on family size and income. It would be affordable to seek care at our place, and we have a very heavy emphasis on wellness and on prevention.

Ms. TUBBS JONES. The other problem that is presented by creating individual health accounts is you reduce the pool of healthy people available for an employer to have to be able to provide health care for all.

Ms. THERRIEN. I really can't speak to that.

Ms. TUBBS JONES. I am going to go to the health care people. Answer that question for me.

Ms. IGNAGNI. We do not see that happening because we have an equal distribution of people over and under 40, roughly.

Ms. TUBBS JONES. How do you keep that equal distribution in place?

Ms. IGNAGNI. What we do is we make sure that as health insurers—I can't speak to what the employers decide to offer, but I can tell you what we are providing for their consideration. You have a robust system of preventive care, including maternity, and you make sure that you have a structure where there is disease management and there is opportunities to handle——

Ms. TUBBS JONES. Let me ask this question, in most health care programs the reason the employer has the ability to provide the health care is the risk is for the whole pool, not for an individual and that is what makes health care affordable for a pool of people, because you have both the unhealthy and the healthy.

Chairman THOMAS. The gentlewoman's time has expired.

Ms. TUBBS JONES. I guess you can't.

Chairman THOMAS. You certainly can, and all of us are anxious to see the written responses to the various questions. Does the gentleman from Colorado, Mr. Beauprez, wish to inquire?

Mr. BEAUPREZ. I do, and thank you for holding this hearing. It has been an exceptional panel and I think you have provided us

very current information. I appreciate it very much. Mr. Cava, continue on that question. Did I understand right that your company provides a 60–40 match, so 60 percent of the contribution in HSA you are contributing, did I hear right, on a quarterly basis?

Mr. CAVA. That is correct. We did contribute this last year, half of the entire amount on January 3.

Mr. BEAUPREZ. So, that money would be there regardless?

Mr. CAVA. That is correct.

Mr. BEAUPREZ. The $7 an hour employee or somebody making more than that wouldn't have zero money, they in fact would have your contribution?

Mr. CAVA. Mr. Chairman and Representative Beauprez, I wish I had time to respond.

Mr. BEAUPREZ. There wasn't much time.

Mr. CAVA. The hourly employee that works for us may indeed have coverage, and that is hard for people to understand. These are second jobs, they are second wage earners, they are part-time employees who are covered by their parents or others. So, it is very misleading to suggest that they do not have coverage.

Mr. BEAUPREZ. Exactly. Mr. Jackson, I believe you stated that a year or so ago your health care premium cost to Buffalo Supply was $102,000. I am rounding. A 21 percent increase would have gotten you to $123,000. I did just some simple arithmetic, but if that 21 percent continued for 3 more years, in the course of 4 calendar years your health care costs at Buffalo Supply would have way more than doubled.

What is the single biggest reason for the drop in employer-sponsored health plans, either the elimination of, or as I have heard from a number of companies that used to provide 100 percent coverage, I can no longer do that, I am going to provide half coverage, I used to provide dependent coverage, I can no longer do that. So, the reduction or in some cases elimination, what is the single business reason?

Mr. JACKSON. The cost.

Mr. BEAUPREZ. Sooner or later you can't keep up. Now what I understand from my insurance commissioner back in Colorado, and this is very fresh information as of last Saturday morning, is that it is not 31, not 33 percent, but in Colorado, with current information, 41 percent of the people that have opened HSAs were previously uninsured. Now, by any measure, I think it is irrefutable that one of our objectives here in Congress should be to reduce the number of people that are uninsured and by at least my information this has been successful.

I would submit to all of you, in the timeframe we are talking about, since HSAs have been made available, has there ever been anything that we have done, that we have created, that we have incentivized that has had a more immediate or a larger, more significant impact on reducing the ranks of the uninsured?

Mr. JACKSON. No. I wouldn't think so.

Dr. COLLINS. The State Children's Health Insurance Program.

Mr. BEAUPREZ. This is a free market program. I think a point that has been made, and I would submit to you that some of us have a particular bias to incentivizng the marketplace to do what we have seen happen here. I think it was Mr. Lauer, Mr. Jackson,

perhaps Mr. Lutey who spoke to the need of transparency, I think maybe Mr. Lauer spoke most profoundly to it, to empowering the individual to make choice. If I had no idea what this suit would cost, I wouldn't care, especially if somebody else was picking up the tab. I wouldn't care. I would just get another suit, put it on the tab, especially if it was the company tab.

We are all concerned in bending the curve, aren't we? I hope we are, in the rising cost of health care. I think what you have pointed out, Mr. Lauer, is clear indication of one way to do that. Inform and empower the consumer, the end point, the utilizer of health care, whether that is a pharmaceutical drug, whether that is a medical procedure, to make that choice, to make that choice. I think that is one of the most dramatic cultural behavioral shifts we could have incentivized and witnessed, and frankly I am here to celebrate that. Any of you care to respond?

Mr. LAUER. My only comment would be, we find in our membership base that when employees have information and knowledge they make good decisions.

Mr. BEAUPREZ. I particularly thank the panel for the recommendations you have made to improve HSAs. I think it is a very, very good first step. I look forward to seeing them improved and utilized even greater. Thank you all. Mr. Chairman, I yield back.

Chairman THOMAS. Thank the gentleman. The Chair also appreciates the panel. I think one of the things we need to focus on is it needs to be a multi-faceted approach, especially for low income people. We have got to talk about providing their ability to have the wherewithal to participate. The gentlewoman from Ohio is right. One of the things we need to do is double our efforts to make sure those people who are otherwise eligible for the low income programs on the book through Medicaid and others, we maximize the number of people. Now there are a number of people who are not utilizing those services. We have to make sure they are available.

One of the points I hoped would occur in the discussion of this new tool, HSAs, is as someone has said, they are not a panacea. They weren't perfect coming out of the box. What we are trying to do is adjust options for people to make choices. I do believe, however, that as we move to preventive and wellness without full participation by the consumers with the wherewithal to make the choices and with transparency on the part of providers in terms of what the costs are, you will never be able to move forward and educate individuals. I don't expect people to be total experts in this area. We all have people who are experts available for advice. To assume individuals cannot make decisions for themselves, and if they have the information and the knowledge and the wherewithal, they can't make decisions that will improve the overall health care of Americans. This is not a panacea. It is an opportunity to begin to look at incorporating individuals into helping us control the costs rather than being simply consumers of a first dollar, third party program in which neither the consumer nor the provider has any idea of the cost.

I want to thank you very much. We will be back occasionally. We do want to hear from the critics. We do want to make adjustments. We want to make these available, not to try to put this in a stark

position, but to see and reflect how the changing marketplace requires us to respond with changing incentives.

The Massachusetts program I think cannot be copied everywhere. There are some good ideas there, but more importantly, take a look at the government programs that have been out there for some time and somehow sometime, it seems to me, that there is a relishment in how many people are uninsured when in fact if we doubled our efforts to get them into the programs that are already there, you would see a dramatic reduction in the number of uninsured.

So, I want to thank you again. The Committee stands adjourned.

[Whereupon, at 1:03 p.m., the Committee was adjourned.]

[Questions submitted from the Honorable Fortney Pete Stark to Sarah Collins and her responses follow:]

Question: You mentioned the high administrative costs of purchasing insurance in the individual market. Why is it so important to pool risk, and how do HSAs in the individual market undermine this important aspect of an insurance market?

Answer: The administrative costs of individual coverage comprise 25–40 percent of each premium dollar compared to 10 percent of group coverage.[1] This means premium dollars buy fewer benefits in the non-group market than they do in employer group markets. For example, research has shown that few plans in the individual market, even with low deductibles and higher premiums, provide maternity benefits without a special rider.[2]

In addition, to remain competitive and to be responsible to their shareholders, insurers in the non-group market necessarily estimate risk and set premiums sufficiently high to cover risk. This means that 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 all together. 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.[3] But in states that have less regulated individual markets such as Kentucky, Kansas, Washington and Iowa, there is no community rating and carriers can reject applicants based on medical underwriting criteria. In these four states Nancy Turnball and Nancy Kane found that as many as 30–40 percent of applicants in the case of some insurance carriers are rejected for coverage.[4] In Kansas and Kentucky, carriers can impose permanent exclusions for pre-existing conditions. Turnball and Kane found that in Kentucky there is 14–17 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 premium for a $1,800 deductible plan was $10,800 annually.

In its most recent 2007 fiscal year budget, the Administration proposed additional tax incentives for people to purchase HSA-eligible high deductible health plans (HDHPs) in the individual market. The proposals, which aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, would

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[1] 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.

[2] S. R. Collins, S.B.Berkson, D.A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund) December 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.

[3] Nancy Turnball, Nancy 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) February 2005.

[4] Nancy Turnball, Nancy 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) February 2005.

allow a tax deduction for premiums associated with HSA-eligible HDHPs in the non-group market, along with a tax credit of 15.3 percent to offset the premium cost. But based on what we know about the individual market—much higher administrative costs and pricing (and exclusions) based on age and health—it is unclear why we would want to encourage a shift away from natural risk pools like large employer groups to the individual market on either efficiency or fairness grounds. Individuals are covered by employer group coverage by virtue of taking a job, not because they incur, or expect to incur, a health problem. Such a leveling of the tax treatment will lead to higher costs in the health system and more uninsured people as employers, who no longer feel compelled to offer tax-advantaged benefits, drop coverage. Jonathan Gruber estimates that the Administration's proposals would actually increase the number of uninsured Americans by 600,000.[5] While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would respond to the equal tax treatment of some policies in the individual market by dropping coverage. Consequently, Gruber estimates that 8.9 million people would lose their employer-based health insurance. While some people who lose their coverage would buy insurance in the individual market, about 4.4 million would become uninsured.

Moreover, if employer contributions to health benefits were made all or partly taxable, as some policy makers have suggested, this would burden lower-wage workers most as a percent of income. Thus it is regressive, not progressive, to partly or fully reduce the tax exemption for employer provided benefits when the benefit is correctly measured as a percent of income.

Question: Ms. Ignani testified that HSA-compatible high-deductible health plans are taking off in the group market. Isn't this something we should be alarmed by? Doesn't this mean that workers are at risk of losing more comprehensive coverage?

Answer: Yes, this means that people will have less comprehensive coverage depending on what services employers exclude from deductibles, and higher first dollar expenses, depending on the degree to which the employer funds their employees' HSAs. According to the Kaiser Family Foundation/Health Research and Educational Trust 2005 Survey of Employer Sponsored Health Benefits, a national survey of 3,000 employers, 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.[6] The average employee premium contribution in HSA-eligible plans was $431 compared to $610 for all plans. But the average deductible in HSA-eligible HDHPs was $1,901 compared to $323 in PPO plans. Moreover, employers on average contributed $553 to employees' HSAs, just 30 percent of the deductible. This average contribution includes the 37 percent of workers who received $0 contribution from their employers. Thus workers' potential contributions to HSA-eligible HDHPs including deductibles minus the employer HSA contribution was $1,779 compared to $933 for all plans.

Though employers are able under the law to exclude preventive services from the deductible of HSA-eligible plans, the KFF/HRET Survey found that in 2005 just 30 percent of workers covered by an HSA-eligible plan had some preventive services covered within the deductible.[7] Also, the law does not allow for coverage of other important preventive services such as primary care visits or chronic disease management which could help prevent more serious and costly health problems from developing in the future.

Question: Can you explain for us what happens to costs for more comprehensive group coverage as younger healthier people move to HSAs?

Answer: 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 high deductible health plans (HDHPs) of $1,901.[8] When employers offer an HSA/HDHP as a choice among other plans they are most likely to be attractive to healthier, higher income employees. This is because these employees have

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[5] J. Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals,* Center on Budget and Policy Priorities, February 15, 2006.

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

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

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

higher marginal tax rates and thus derive the greatest benefit from the tax benefit. They also have higher saving rates, and will be less likely to draw down their accounts to pay for health services so that they will be able to accumulate balances over time.[9] The General Accountability Office (GAO) found in a study of enrollment in the Federal Employee Health Benefits Program's (FEHBP) HSA/HDHP product 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.[10] Rates of enrollment in the plans were higher among Federal employees under age 54 than among those ages 55 to 64.

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.[11] 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, even if they have been working efficiently prior to the introduction of the HSA/HDHP product.[12]

Many small employers only offer one product—just one-third of insured workers in firms with fewer than 200 employees have a choice of health plan.[13] If small employers fully replace more generous health plans with HSA/HDHPs, this will disadvantage lower income, less healthy employees who benefit less than higher income employees from the tax benefits of HSAs and are less able to contribute to, or accumulate, balances in HSAs.[14] 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.

Question: Is there any indication that savings employers are realizing from switching to HSA plans is being given back to employees in higher salaries?

Answer: There is no evidence to date that I am aware of that this has occurred. National health care spending is climbing by more than 7 percent per year and is expected to continue to outpace growth in the economy by a substantial margin.[15] 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.[16] Employers are coping with rising premiums by passing along more of their costs to employees or eliminating coverage altogether. Many employers have turned to HSA/HDHP products as a way of lowering their health care costs. These plans alleviate the employer's cost-burden by increasing cost-sharing among their employees. It is not as if overall health care costs are declining, such that employers might be willing to capture the windfall in the form of profits, larger annual salary increases for their workers, or lower prices for consumers. Those employers facing rising premium costs have explicitly sought to share those increases with their employees in the form of much higher deductibles, and with low contributions to HSAs on average.

It is an open question whether employers that experience year over year declines in health care costs because their employees are paying more out of pocket for their health care would increase their workers' wages. According to economic theory, employers who do not offer employee benefits compensate their employees through

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

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

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

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

[13] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2005 Annual Survey,* (Washington DC: KFF/HRET) 2005.

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

[15] Stephen. Heffler, et al., "U.S. Health Spending Projections for 2004–2014," *Health Affairs* Web Exclusive 23 Feb 2005; C. Smith, et al., "National Health Spending in 2004," *Health Affairs* (Jan/Feb 2006): 186–196.

[16] Jon Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24 (September/October 2005): 1273—1280.

higher wages.[17] Those companies that do offer health care benefits reduce wages such that the total compensation package is equivalent to that of similar workers employed by firms not offering benefits. In other words, the cost of non-wage compensation is fully borne by employees. Yet there is mixed empirical evidence that workers who do not have health benefits receive higher wages. Indeed, higher wage earners are far more likely to have health benefits through their jobs than lower wage workers.[18]

If health care costs for a firm are increasing, then companies that offer employee health insurance likely will pursue some combination of strategies that will help protect profits and shareholder earnings. Employers may shift costs to employees by limiting the size of salary increases or by scaling back other forms of compensation through benefit reductions or greater employee cost-sharing. Employers may also shift costs to consumers through price increases.

If health care costs are falling, or if companies are offering less comprehensive benefit plans such as HSA-eligible HDHPs, employers might reduce prices to consumers, increase the generosity of other employee benefits, provide higher annual salary increases or increase profits. But we do not know with precision whether those savings will be provided equally to all workers, or just to workers who are younger or less likely to be sick or injured or pregnant, or if they will be diffused through a combination of higher wage growth, price reductions, or higher profits.Information costs about worker health risks, the minimum wage, and anti-discrimination laws likely preclude companies themselves from achieving a precise offset of expected health care costs with changes in compensation.[19]

Question: Insurance industry studies have indicated that around one-third of the people enrolled in HSA-qualified plans were previously uninsured. Isn't this about the same number as the non-HSA individual and small group market generally? Are HSA-eligible plans actually contributing in any particular way to reducing the number of uninsured?

Answer: It has always been true that a high percentage of people buying insurance in the individual market do so because they are uninsured, and a large share of people in the non-group market have high deductible health plans. According to the Commonwealth Fund 2003 Biennial Health Insurance Survey, 30 percent of adults 19–64 with coverage in the individual insurance market had per-person deductibles of $1,000 or more.[20] This was prior to the introduction of HSAs. Because a high percentage of people in the market were previously uninsured it's not surprising that America's Health Insurance Plans (AHIP) says that 31% of those buying individual coverage with high deductibles were uninsured. But the new tax incentives to purchase HSAs have little to do with this. The real way to judge the effect of HSAs on the uninsured is how much higher the percentage of previously uninsured in HDHPs in the individual market is than the historical pattern.

The individual insurance market has always served as a "bridge" or temporary home for individuals and families who could afford the higher premiums during insurance transitions as a result of a change of jobs, college graduates aging off parents' policies, people in waiting periods for job-based benefits, early retirement or other changes. As a result, in any given time period, a substantial share of new entrants to this market were previously uninsured—but they typically are moving through on the way to Medicare or group coverage. Klein, Glied and Ferry find that 53 percent of those in the private non-group market retain their coverage over a 2-year period compared with 86 percent of those with private group insurance.[21] Thus, the AHIP "flow" statistics repeat the historical patterns in this market. Unless we start to see a decrease in the total number of uninsured, and an increase

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[17] J. Gruber "Health Insurance and the Labor Market." NBER Working Paper no. 6762. (Cambridge, Massachusetts: National Bureau of Economic Research) 1998.

[18] 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) April 2006; A. Monheit, M. Hagan, M. Berk, and P. Farley,"The Employed and Uninsured and the Role of Public Policy." *Inquiry* 22(4) 1995: 348–364.

[19] L.H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79(2) (1989): 177–83.

[20] S.R. Collins, M.M. Doty, K.Davis, C. Schoen, A.L. Holmgren, A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund) March 2004.

[21] K.Klein, S. Glied, D. Ferry, *Entrances and Exits: Health Insurance Churning, 1998–2000* (New York: The Commowealth Fund) September 2005.

in the percent of high risk groups insured, the "flow" statistics tell us little about the net effect of HSA-eligible HDHPs on the total number of uninsured.

Question: Prior to 2004, what were the median deductibles in the individual and group markets? How have these levels changed as a result of HSAs?

Answer: Deductibles in employer plans have risen sharply over 2000–2005, as employers have sought to share more of their costs with employees. According to the Kaiser Family Foundation/HRET 2005 Employer Health Benefits Survey, among companies that offer coverage with fewer than 200 employees, the average annual in-network deductible for a PPO plan more than doubled over 2000–2005, climbing from $210 to $469.[22] The average out-of-network deductible for a PPO plan in small companies climbed from $383 to $676. For larger firms with 200 or more employees, average annual in-network deductibles for PPO plans grew somewhat more slowly than in smaller firms climbing from $157 to $254. Average out-of-network deductibles in these larger firms rose from $319 to $510.

In 2005, the average deductible for an individual in an HSA-eligible HDHP across all firm sizes was $1,901. This is relative to an average deductible in 2005 across PPO plans in all firm sizes of $323. This is an increase from an average of $187 in PPO plans in 2000.

With so few workers enrolled in HSA-eligible HDHPs so far it is hard to assess how much of the overall increase in deductibles in employer group plans is attributable to more employees enrolled in these HDHPs. But the trend since 2000 in employer group plans is toward more employee cost sharing through higher deductibles especially in small businesses, with HSA-eligible HDHPs being the extreme form of such cost-sharing.

It is harder to get data on average deductibles of health plans sold in the individual market. The Commonwealth Fund 2003 Biennial Health Insurance Survey found that 30 percent of adults 19–64 with coverage in the individual insurance market had per-person deductibles of $1,000 or more.[23] New preliminary evidence from the Commonwealth Fund 2005 Biennial Health Insurance Survey shows only a slight increase in the share of adults in the individual market with deductibles of $1,000 or more. A large share of people in the individual insurance market have always purchased high deductible health plans in order to lower their premium costs. It is not clear whether the tax benefits of HSAs will increase enrollment in these plans in the individual market.

Question: How much of the reduction in premiums in HSA plans can be attributed to higher deductibles?

Answer: According to the Kaiser Family Foundation/HRET 2005 Employer Health Benefits Survey, the average premium in 2005 for HSA-eligible high deductible health plans for single coverage was $2,700 compared to $4,024 in all plans, or a $1,324 difference.[24] The average deductible was $1,900 compared to $323 in all plans, or a $1,577 difference.

Employers who offered HSA-eligible plans in 2005 reduced their annual contributions to their employees' premiums for single coverage on average from $3,413 in all plans to $2,270.[25] The average contribution to HSA accounts was $553 leaving the total employer contribution to the cost of their workers coverage of $2,823, still a $590 savings over their average contributions to single coverage in all plans. In contrast, the average employee premium contribution in HSA-eligible plans was also reduced to $431 compared to $610 for all plans. But the reduced premium contribution for employees was more than offset by the higher average deductible of $1,901. The average employer contribution to the HSA of $553 was just 30 percent of the deductible, leaving worker's contributions to the cost of their care at $1,779 compared to $933 in all plans, a $846 increase in employee costs.

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[22] J.Gabel, J. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees.* (New York: The Commonwealth Fund) April 2004; Kaiser Family Foundation and Health Research and Educational Trust*, Employer Health Benefits, 2005 Annual Survey,* (Washington DC: KFF/HRET) 2005.

[23] S.R. Collins, M.M. Doty, K.Davis, C. Schoen, A.L. Holmgren, A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund) March 2004.

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

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

[Questions submitted by the Honorable Xavier Becerra to Mr. Cava and his responses follow:]

Question: Thank you for appearing before the Committee on Ways and Means on June 28 to discuss Health Savings Accounts (HSAs). As we discussed, I have some specific questions about the health benefits offered by Wendy's and your employee population. Given that your business is frequently held out by proponents of HSAs as a model for others, it is helpful to have a full understanding of your plan, employees and other relevant data. Therefore, I would appreciate answers to the following questions by July 14, 2006. Unless otherwise specified, references to employees includes franchise employees and others in the total domestic workforce.

1. As a percentage of your total domestic workforce for each year in question, how many employees do you insure this year versus 2005 and 2004?

2. What was/is your insurance plan deductible before and after adopting HSAs? What were/are premiums for self and family coverage before and after HSAs? What was/is the employee contribution toward the cost of premiums for self and family coverage before and after HSAs?

3. During the question period, you said that Wendy's has approximately 45,000 employees in the United States. I would like to get a better sense of coverage among your employee base. Your testimony indicated that your 10,200 employees are eligible for HSAs and 7,000 participate, correct? You mentioned during questioning that some additional U.S. employees have comprehensive coverage. Please tell us how many employees are covered in non-HSA plans, and therefore how many employees in total receive coverage through Wendy's.

4. Of those who are covered, what percentage are self-only policies versus family coverage?

5. How many of your approximately 45,000 employees are ineligible for coverage through Wendy's? Why aren't they eligible (e.g., minimal level of hours worked per week, salary v. hourly, waiting period or minimum required period of working prior to eligibility, and so forth.)? What are the eligibility requirements at Wendy's?

6. Of those who are not covered, please provide, if you are able, the number who have coverage elsewhere through (1) a spouse, (2) individual coverage, (3) public programs such as Medicaid or Medicare, or (4) other.

7. What is the average wage or income across all Wendy's employees? What is the average wage or income for those who are eligible for the HSA option? What is the average wage or income for employees who participate in the HSA? What about for those who contribute to their HSA?

8. What is the average age across all Wendy's employees? What is the average age for those who are eligible for health coverage?

9. On page two of your testimony, you cite some statistics about the number of your employees who have received a physical. Please clarify the claim—e.g., do you mean the percentage of all employees, those who are insured through Wendy's, or just among the 7,000 who participate in the HSA?

10. What is the coverage or cost-sharing on your plan after the deductible (e.g., 80 percent, 100 percent, and so forth.)? Are enrollees required to use a network of providers designated by your insurer?

11. During our discussions, you clarified that maternity benefits are not covered until the deductible is met, which prompted a discussion about the age and gender mix of your workforce. Please provide us with the percentage of women, differentiated by age, in your workforce versus those who participate in the HSA versus those who participate in the non-HSA coverage.

Answer: Within the Quick Service Restaurant segment and in retail generally, hourly crew level employees are not typically eligible for health insurance although there are variances among industries and between markets. These are most often entry-level, part time jobs with high turnover and very low participation in employer provided health plans.

Wendy's full time eligible workforce is approximately 10,200 employees. Critics predicted large numbers of workers would decline coverage and enrollment would decrease dramatically when fully replacing traditional plans with Health Savings Accounts (HSAs). However, our participation rate varied only slightly and is currently 96% of what it was before changing plans in 2005 (68%—2006, 71%—2005, 70%—2004).

It's not possible to fairly compare deductibles between plans. Before 2005, we offered a traditional Preferred Provider Organization (PPO) with lower deductibles and higher premiums like those currently offered by many employers. HSAs are required to be linked to a High Deductible Health Plan (HDHP) with minimum deductibles of $1,050 for single and $2,100 for family coverage.

Each year, Wendy's gives about 60% of the deductible to our workers regardless of their plan choice or level of coverage (Le. single or family). We deposit these funds directly into the employee HSA bank account on a prorated basis at the beginning of the quarter. Wendy's makes these grants to employees on a pre-tax basis to their own account whether or not they contribute personally. Worker exposure to the deductible is relieved both by employer contributions and the tax free treatment of all contributions.

When planning our benefit structure for 2005 we were experiencing our fifth straight year of double digit increase in health care costs. Offering the same plan would require us to continue imposing higher and higher deductibles, employee contributions and co-insurance rates so we took appropriate steps to break the cycle.

Our current HSA plan has been a very good decision for our employees and our company. Never before have we had 3 years in a row where we've improved the benefit we offer employees at no additional cost to them. Each year since changing to a Consumer Driven Health Plan (CDHP) we've increased the amount the company gives employees for their HSAs, expanded no-cost preventive care options and hope to continue making more enhancements going forward.

From 2000 through 2004 Wendy's had a traditional PPO. Every year employee deductibles increased 20–25% while worker contributions went up 5–10%. There was no probability the trend would change. To offer the same PPO type plan, employee contributions would have had to increase at least 15–20%, employee coinsurance up 10% and deductibles up 15–20% each year according to estimates.

Contributions per pay period (14 davs/2 weeks) under the old PPO

		Estimated	
Management & Administrative	**2004**	**2006**	**2006**
Single	$36.00	$42.00	$50.00
Family	87.00	101.00	120.00
Shift			
Single	19.00	22.00	26.00
Family	46.00	54.00	64.00

The contribution schedule below is for the new HSA. Rates are for 2005, 2006 and estimated for 2007 and have not changed for 3 years.

2005—2006 and Estimated 2007

	Management & Administrative			Shift	
	Plan A	**Plan S**	**Plan C**	**Plan O**	**Plan E**
Single	$ 43.00	$31.00	$21.00	$24.00	$15.00
EE + CH	95.00	71.00	45.00	56.00	36.00
EE + SP	98.00	74.00	48.00	59.00	39.00
Family	123.00	95.00	54.00	70.00	45.00

Currently 68% of Wendy's 10,200 eligible workers are enrolled in the HSA plan.

It's important to note that Wendy's does offer a traditional PPO to eligible crew level employees in two markets. Routinely, only 5–7% of newly eligible crew each quarter in these markets accept coverage. Of those who accept coverage, 75% elect single, not family coverage. Single coverage in this PPO plan costs the employee $8.00 per week which on average is nearly equal to the pay for 1 hour of labor.

It is safe to assume that a portion of the employees who reject health coverage from Wendy's may already be insured through their spouse or family. When a worker declines our coverage, we respect their decision and especially their privacy and therefore do not require a reason. Comprehensive information about plan details is available from field management teams and the Human Resources Department. The company also gives employees, at no cost to them, the services of a national benefits administration vendor who has staff dedicated exclusively to Wendy's. They provide professional support through a toll-free call center. We want workers to make a well-informed decision in a confidential and private environment and the call center provides that option.

On the whole we provide health coverage for 20,000 lives which is the total of our participating workers and their dependents.

The average wage of HSA eligible workers didn't change after the introduction of the HSA program. It was implemented as a full replacement meaning everyone eligible for the previous PPO plan was eligible for the HSA plan. Eligibility for participation in our plan isn't based upon income.

One of the most gratifying results from our CDHP strategy is the positive changes our employees are making to improve their own health. We surveyed HSA participants, from a statistically valid sample, on topics including previous preventive care practices. Just 50% had routine physicals in 2004 (the last year of the PPO). Following the introduction of the CDHP and HSA, 75% of the same respondents received a physical in 2005. A 25% increase is remarkable and an example of a preventive benefit that is free for workers in our plan. One which we believe will help them take steps to improve their own health.

Employees are not required to use network providers and may go to any physician or facility they choose. In-network, they receive coverage at 85–90%. Non-network coverage is 60–70%.

Health Savings Accounts and Consumer Driven Models can help more people make the best health care decisions about short and long term needs. We encourage Congress to consider these improvements to HSAs and to also enact Association Health Plans:

- Change or eliminate comparability rules so we can design better plans for the chronically ill
- Allow preventive medications to be carved out of HSA deductibles so co-insurance can apply immediately
- Permit moneys in FSAs to roll into established HSA accounts instead of being forfeited at the end of the year
- Allow Medicare eligible workers to opt for HSAs
- Permit veterans and their families to participate in HSAs
- Allow association health plans thereby facilitating effective creation of multi employer welfare associations across state borders
- Pursue the aggregation and access to reports on both the quality performance of health care providers and facilities and the cost of service including medications and prescriptions

[Submissions for the record follow:]

Statement of Grover Norquist, Americans for Tax Reform

Chairman Thomas and Ranking Member Rangel, thank you for extending the opportunity for me to submit a statement for the official committee record.

Americans for Tax Reform is a grassroots advocacy organization that supports lower taxes, less government, and more freedom.

The most exciting and innovative product in health care today is undoubtedly the health savings account (HSA). In the just over three years since Congress created HSAs, over 3 million accounts have been opened, and another 3 million health insurance policies are HSA-eligible, according to the Government Accountability Office. Human resources firms like Hewitt Associates and most employer groups have consistently said that HSAs are the direction that companies are moving in. The overwhelming majority of individual market policies are HSA-compatible products.

Testimony before this committee is likely to flesh out these and other extremely-beneficial details of HSAs with great skill and accuracy, so I won't be repeating them here. Instead, I wanted to share a cautionary note from history, by looking at another successful tax-advantaged savings product, the Individual Retirement Arrangement (IRA). This product had a very popular early start, only to be crippled by excessive legislative interference and complexity.

The IRA was created by Congress as part of ERISA in 1974, largely as a way for workers to roll vested pension benefits into a personal account if they terminated

employment. A special provision was put in place to allow workers not covered by a workplace retirement plan to contribute the lesser of 15% of earned income or $1500.

In 1981, the Economic Recovery Tax Act was signed into law by President Reagan. It increased the contribution limit to IRAs to the lesser of 100% of earned income or $2000, allowed a spousal contribution, and removed the requirement that a worker not have pension coverage.

This led to an explosion of Americans contributing to IRAs. In 1980, a little more than 2 million households contributed to an IRA. By 1986 when this law was fully put in place and understood by the public, this number shot up to over 16 million households—an eight-fold increase in just six years.

IRAs of the post-ERTA period were simple, easy products. If you had a job and made at least $2000, you could contribute to one. If you were self-employed, you could contribute even more (15% of net income from self-employment). Everyone got an immediate tax deduction which, given the marginal rates at the time, could have amounted to a tax subsidy of $0.50 on the dollar. If you touched the money before retirement (age 59 and ‡), you had to pay taxes on it plus a 10% tax penalty. If you left a job, you could roll vested workplace retirement plan amounts into it. At age 70 and ‡, you had to start taking the money out. If you died with money in there, your spouse or heir would pay taxes on it.

Importantly, the IRAs were not limited by income. There were not several kinds of them for several kinds of savings. Contribution limits did not go up and down with age. They were not related to workplace retirement plan coverage. As a result, banks and brokerage firms could take these simple products and market them easily. The fact that they could be contributed for a prior year at tax time was another benefit.

Then, the world changed for IRAs. In 1986, Congress passed the Tax Reform Act, which severely curtailed IRAs. Americans not covered by a workplace retirement plan were unaffected. However, pension-covered Americans found themselves unable to make deductible IRA contributions if their income exceeded modest amounts. This resulted in having to keep a confusing record of "basis" in "non-deductible IRA contributions."

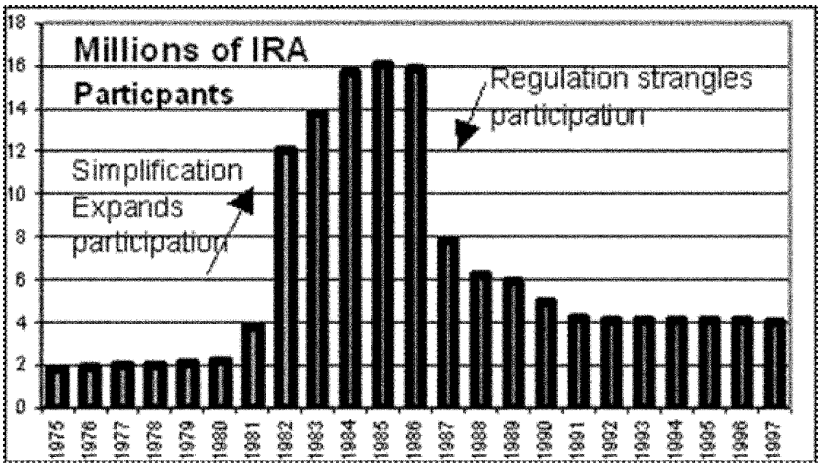
In later years, policymakers took this once-simple product and made it even more confusing. Spousal IRA contributions were allowed, but contingent upon the income and pension coverage of each spouse. Education IRAs (later renamed Coverdell ESAs) were created, with their own set of contribution limits, withdrawal rules, and eligibility requirements. Roth IRAs (no deduction, but no retirement or death tax) were created in 1997, contingent on income. 529 College Savings Plans joined the mix, too. SIMPLE IRAs were created as replacements for the largely-failed SARSEP experiment of 1986. Medical Savings Accounts, the precursors to HSAs, were created with confusing eligibility rules, limits on the overall amount of the accounts, and other poison pills that doomed this worthy effort to failure.

In recent years, catch-up contributions and changed limits on income led the entire tax-advantaged savings world to throw up their hands in confusion. Responses to these criticisms led to the Treasury Department's 2003 three-fold savings account model, and the somewhat more generous models of the President's Commission on Fundamental Tax Reform—both of which have been stalled.

We fear that by putting these type of tax-increasing and confusing provisions into HSAs, we'll be doing to HSAs in 2006 what we did to IRAs in 1986. The chart below shows that IRA contributions shot up in 1982 when they were made universal and simple. After 1986, when income thresholds limited deductibility, IRA contributions fell off the map and never recovered. In fact, contributions to IRAs declined by 40% from 1986 to 1987 even for families that were still eligible to contribute. For Americans making less than $25,000, the reduction in contributions was 30%.

These facts of history demonstrate that when most Americans and the financial services industry see a complex tax-advantaged savings vehicle, they turn the other way and run. 1986 killed the golden goose of retirement savings that was the post-ERTA IRA. Imagine where our precarious Baby Boomer retirement savings situation would be today if the trend-line of IRA contributions had continued unabated until the present day.

Does anyone doubt that HSAs, which are already a leap for many people to take from traditional health insurance, would be endangered if we raised taxes and/or imposed confusing new rules on them? Many, many people would use this as their excuse not to make the leap from traditional to consumer-driven health care—and all in the name of a payroll tax credit and recapture scheme that is considered by some in Congress and the Administration.



Source: Internal Revenue Service Statistics of Income data

For a better approach to this, the committee should look at S. 3488, the "Tax Free Healthcare Savings, Access, and Portability Act" introduced by Senator Tom Coburn (R–OK).

If Congress is looking to expand HSAs in a way that will increase health insurance enrollment, encourage patients to act as consumers, and encourage Americans to save for their health care needs in retirement, it should limit itself to the following initiatives:

1. Raise HSA contribution limits to at least the level of the out-of-pocket maximum annually. Ideally, there should be no limit to HSA contributions at all. It's good public policy to encourage people to save money for their health care and retirement needs.
2. Allow HSAs to be made portable from job to job and funded by employers.
3. Allow rollovers from health reimbursement arrangements (HRAs) and flexible spending accounts (FSAs) to HSAs.
4. Allow HSA funds to be used to pay high-deductible health insurance premiums.
5. Expand the definition of "qualified medical expenses" to include such items as gym memberships, exercise equipment, nutritional supplements, cosmetic surgery, non-prescription drugs, and other clearly-medical purchases by Americans.

In conclusion, Congress needs to keep one overarching concern in mind when altering HSA policy—keep it simple. Complexity is what killed one of the most successful tax initiatives of the last century, the Traditional IRA contribution. Don't let complexity kill the most important tax initiative of this century, the health savings account.

Statement of Robert W. Lane, Deere & Company, on behalf of Business Roundtable

Today, I am providing written testimony on behalf of my company, Deere & Company and on behalf of Business Roundtable. Business Roundtable is an association of 160 chief executive officers of leading U.S. corporations with $4.5 trillion in annual revenues. This testimony is presented on behalf of the Roundtable's Health and Retirement Task Force.

Some 10 million people work for Roundtable member corporations—with John Deere accounting for more than 47,000 employees. Counting employees and their families, Roundtable companies provide health coverage for about 25 million Americans. Business Roundtable's public policy priorities are to ensure a vibrant economy and a competitive workforce. These priorities go hand-in-hand with our goals of pro-

moting a healthier workforce, strengthening the health care marketplace, and improving the value of our health care spending.

I would like to first congratulate Congress for creating health savings accounts (HSAs)—a tool that has the potential to truly impact the rising cost of health care in America. Health Savings Accounts provide a way for our employees to gain considerably more value from their own health care dollars.

However, I am here today to point out that we believe the use of health savings accounts will not become as widespread as Congress intended without some small, but important, enhancements. Health Savings Accounts have the potential to dramatically impact how employees spend their health care dollars. However, they need to deliver the same value to the employees of large and small businesses alike in order to have a positive impact on our health care system.

This testimony provides background information and suggestions on four recommendations that would position health savings accounts to become a powerful tool for individuals as they continue to seek the most prudent way to spend their health care dollars.

Health Care Value

Soaring health care costs are harmful to our nation's economic health and our ability to be globally competitive. At Deere, the annual salaried family premium for our most popular 100% HMO plan is $12,300. This represents a significant benefit cost as well as value to all of our employees, and especially for lower paid employees. Deere has been innovative in managing health care costs through the use of self-insured plans, managed care networks, and disease management programs in order to provide this level of benefits to our employees.

In a December 2005 Business Roundtable survey, CEOs cited health care costs as corporate America's number one cost pressure (42%) for the third year in a row. This topped energy costs (27%) and litigation costs (9%). Likewise, families across the country are looking for ways to deal with rising medical bills.

Improving health care value does not rest with any single stakeholder. To the contrary, everyone involved in our health care system—employers, insurers, doctors, consumers and the government—must find and help institute reforms that improve the value of health care expenditures. The key strategy for achieving this is to embrace policies that will make the health care system more efficient while keeping patients safe and healthy.

The success we had in the 1990s using managed care plan designs was due to the efforts of insurers, doctors, and employers. Largely overlooked in the managed care plan designs were the preferences and decisions of patients. During the last two decades the managed care plan designs insulated the patients from the cost of health care services largely due to the very modest co-payments and nearly 100 percent coinsurance plans.

As a result, we have seen greater patient demand for more services, prescriptions and higher levels of technology with little understanding of cost, benefit or value of these services. Roundtable CEOs, for example, believe we can improve the value of health care and improve the system by empowering consumers with price and quality data; helping our employees take more control of their and their families' health care decisions; improving patient safety; and transforming the system through the use of technology. Business Roundtable companies provide health benefits because it is cost effective to deliver a portion of the employee's compensation in this manner, creating an employee value proposition that encourages health insurance enrollment and leads to a healthier, productive workforce.

Of these objectives, I want to emphasize that one of the most important steps toward transforming our health care system is harnessing the power of our employees as consumers of the system. At Deere, we have some very simple guiding principles:

1. To create affordable, sustainable health benefit plans that encourage all employees to participate actively in their health and health benefits;
2. To reform the health purchasing process by changing the health care value equation at the point at which most health care consumption decisions are made—the point of care by the patient;
3. To support a benefit design that encourages and rewards employees for adopting healthy lifestyles and behaviors to have a greater impact on the future of health care benefits; and
4. To provide insurance protection.

Consumer-Centric Health Plans

These plans—FSAs, HRAs and HSAs—have promoted greater engagement and understanding by our employees in purchasing health care services. The newest,

Health Savings Accounts, is an example of health care reform guided by principle and good public policy. HSA plans seem to combine the best of managed care (networks, credentialed providers, outcomes reporting) with the aligned interests of the indemnity plan designs, while providing the much needed insurance protections. Business Roundtable believes that HSA plans are a powerful tool to improve the value and quality of care that Americans have come to expect out of our health care system.

Philosophically, we need to agree on the role of the employee and in terms of deciding on their health and health care. Why? Because HSAs put health care consumers back in the driver's seat to select the health care benefits that they want and need, and therefore, have the potential to be transformational for the American health care system. At Deere, we speak of a shared responsibility with employees to manage their health and health benefits. The words "potential to be transformational" because we cannot transform our health care system without the active participation of Americans. As Americans, we are not likely to support a system of the government or health insurance companies deciding what is best for our own families. While the initial take-up rate for these types of consumer directed products is somewhat small, **more needs to be done to make these plans more attractive to large employers and their employees if we are going to have a meaningful impact on provider reporting, outcomes and patient engagement.**

To that end, Business Roundtable seeks your support for the following four changes to reduce the tension between rising health care costs and our current competitive business environment.

If we fail to bring about an improvement in health care value, then the impact may be felt in a variety of ways—from the limiting of covered services, loss of employer provided health care that will have the greatest impact on the lower paid employees, and even a loss of American jobs, both in the manufacturing and service sectors.

As I stated earlier, health savings accounts are a powerful tool and Business Roundtable seeks these changes to increase the use of these accounts to the benefit of employees across the country.

First—Coordination with Existing Plans

A significant disincentive is the inability of our employees to use widely available flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) in conjunction with their health savings accounts (HSAs). Employees often have concerns about how to pay for their out-of-pocket health care expenses if insufficient amounts are available under the HSA, especially early in the year when they are responsible for the deductible. The FSA may solve the budgetable concerns of our lower paid employees since they can have access to the entire FSA amount—while budgeting the expense over the entire calendar year. Without coordination of these accounts, employees may have to scramble for the payment of a maintenance prescription or the delivery of their child in January without the ability to pay under an HSA alone.

In addition, employees have a familiarity with the rules and requirements and use of a FSA and HRA. As we all seek to encourage employees to become better consumers, consumers need flexibility to use FSAs and HRAs in conjunction with the HSA. Some employees today have FSA and HRA accounts—they have experience with them. Business Roundtable strongly encourages the Ways and Means Committee to support the changes that are included in H.R. 4511, the "Flex HSAs Act" and H.R. 5262, "the Tax Free Health Savings Act of 2006," both introduced by Representative Cantor (R–VA). These bills would address the two most important obstacles to widespread adoption by our employees of these new plans: 1) the ability to budget the deductible expense over the entire year; and 2) ability to save dollars beyond the deductible to prepare for future unpredictable medical expenses.

Second—Contribution Limits

We support lifting the current contribution limits to an HSA so that individuals and employers could budget up to their out-of-pocket expense into their health savings account. This is a critically important change if we expect Americans to be able to succeed at managing unexpected health care expenses and not merely drain their accounts with their expected health care costs from year to year. After all, the policy is intended to encourage employee engagement and planning.

Third—Contribution Amounts

Business Roundtable supports regulatory efforts to permit employers to vary contributions to employees' HSAs when an employee is a low-wage worker or has a chronic illness. The Department of Treasury is reviewing comments on a proposed

rule to permit such flexibility—we believe this is a necessary change to ensure that these plans can better address the special needs of these workers.

Fourth—FSA Rollover

Business Roundtable also supports legislative changes to permit a limited carry forward of up to $500 in a flexible spending account (FSA) or a rollover into a health savings account (HSA). Today, the current FSA "use-it-or-lose-it" rule causes many individuals not to participate in FSAs or to incur unnecessary care at year end to avoid forfeiting their money. Allowing employees to carry forward these amounts aligns with the principle of consumerism. We thank the House of Representatives for consistently support a rollover provision like that contained in the House-passed version of the Pension Protection Act of 2005 (H.R. 2830).

Other Health Care Priorities

Business Roundtable Health and Retirement Task Force strongly supports other efforts to encourage workers to become better consumers—including greater access to information on cost and quality data, more efforts aimed at disease prevention and disease management, and arming the health care system with 21st century information technology.

Business Roundtable believes that the disclosure of information is an important tool to help American consumers transform our health care system. We want to give our workers access to information about the cost and quality of health care services and the institutions, providers, and suppliers who deliver that care. While private sector disclosure of price and quality data is occurring, we believe that the Centers for Medicare and Medicaid Services (CMS) should release 100% of the Medicare claims database. This is essential to measuring cost efficiency and compliance coupled with nationally-endorsed clinical guidelines by providers and suppliers.

We also support legislation to create a health information technology system with uniform interoperability standards. We must improve and deploy the health care system's information technology sooner rather than later. This is one change that can save administrative costs and greatly improve the delivery of health care services.

Conclusion

As a representative of Business Roundtable and John Deere, we believe health savings accounts are valuable—they will increase consumers' access to quality health care services. Expansion of consumer-centric accounts is critically important in moving toward a system where we combine the best features of managed care with the positive aspects of individual control over health spending choices, enabling our workers businesses and our nation to remain competitive.

Statement of Coalition to Promote Choice for Seniors

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 HSAs. 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. HSA withdrawals used to pay premiums for Medicare Advantage plans or employer-sponsored plans are 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 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.

We stand ready to assist in this important endeavor.

Statement of Greg Scandlen, Consumers for Health Care Choices

Thank you for the opportunity to share the experiences some real people have had in dealing with Health Savings Accounts (HSAs) and other forms of Consumer-Driven Health Care.

Before doing that, let me take a moment to thank you personally, Mr. Chairman, for the leadership you have shown in this area. You have made a real difference in the lives of millions of Americans. You have made it possible for them to acquire health insurance when they could not before. You have given them the opportunity to be active participants, rather than passive recipients, in the health care system. You have allowed them to choose the health plan that works best for themselves and their families.

I believe the enactment of HSAs has spawned a revolution in American health care. One that will lead to better quality, lower costs, improved efficiency, more accountability, and greater convenience for all Americans. It will also restore the patient-physician relationship that is the essential moment in any health care encounter.

But those system-wide effects are all in the future. Only time and experience will tell how profound the changes will be.

Meanwhile, HSAs have already helped millions of people. The effects are often hidden from Washington-based policy experts and researchers who rely on population-wide surveys and national data.

For instance, HSAs are an enormous help to people with surges of income—commissioned salespeople, seasonal workers, farmers, consultants, entrepreneurs, and the like. Washington rarely thinks about these people, assuming instead that everyone is on a bi-weekly payroll like federal employees are. But people who do not get a steady paycheck are the risk-takers and innovators of our economy. They find it very difficult to pay huge insurance premiums, month after month, year in and year out.

HSAs enable them to minimize their monthly premium obligation and fund their HSA when the money is available. Instead of paying $600 a month, every month, they may be able to lower that to $300 or $400 a month, and then fund their HSA when they receive their commission checks—anytime from January of one year to April 15 of the following year.

This kind of flexibility is essential to a dynamic economy. And it was you and this Committee who made it possible, Mr. Chairman.

Here are some examples of people who have benefited from HSAs. These and more are available at our web site at—http://www.chcchoices.org/testimonials.php

Chris Krupinski of Fairfax, Virginia, is a self-employed graphic designer. She owns CK Art and Design. She writes:

"I am a widow with three children and have had my own business for about 10 years. Although I have kept insurance during that time, I could only stay with a company for about a year and a half before the policy would get too expensive and I would have to look again for another company. Before finding out about HSAs, I was paying $900 a month for a family plan that had a $2,000 deductible for every

health event. That meant when I had two knee surgeries in one year—I owed $2,000 for each of them before my insurance kicked in.

"Then I heard about Health Savings Accounts. I now pay $350 per month for my family, with a yearly deductible of $3,500. Each month, I put aside another $350 into my HSA account. That HSA account is my money, and yet, I am still paying less per month than I was under the old policy.

"The beauty of the HSA is that if I have anything left over at the end of the year, that money is mine. It gives me options, and it is much better financially. Before, when I wrote those premium checks out each month, that money was just gone."

Lawrence Kneisley, MD, is a physician in Torrance, Califonia. He writes:

"My son Andrew, then age 16, broke his arm (distal radius and ulna) snowboarding in December, 2003. He was hospitalized for urgent surgery at Torrance Memorial Hospital. He was admitted in the afternoon, spent about 2 hours in the OR under the care of the orthopedic surgeon who performed an open reduction under general anesthesia using a C–Arm X-ray for alignment. He was hospitalized overnight on the pediatric ward and discharged at noon the following day. Total time in the hospital-about 20 hours. The hospital charge was $18,834.03! This did not include the orthopedic surgeon's fee. Our HSA (at the time an MSA from Medical Savings Insurance) determined that Torrance Memorial Hospital Medical Center's reasonable and customary charge to be $4961.64. This was based on the Medicare diagnostic related group (DRG) according to the diagnosis and procedure codes provided on the hospital bill.

"Medical Savings Insurance paid the hospital $2,019.36. I paid the remainder, $2,942.28. I felt this was fair and reasonable. After some investigation and discussion, the hospital accepted this amount as payment in full.

"The lesson I learned was that if Medical Savings Insurance had not investigated and challenged the claim amount that the hospital wanted to charge, I would have been forced to pay most of the inflated bill. I got educated to the fact that hospitals accept lower but still profitable rates from big insurers such as Blue Cross and various HMO's such as Health Care Partners and still make money. They then charge smaller insurers, and patients with MSA's (now HSA's) *huge markups,* some 350% in my son's case when compared to Medicare and the HMO contracted rate. Certainly if the Medicare payment rate and HMO payment rate are acceptable to a hospital then the self-paying patient deserves the same deal."

Ian Duncan, an actuary in Hartford, Connecticut writes:

"Susan and Clark Furlong own a small organic farm outside Phoenix. They supply local markets with fresh produce and sell their products on the Internet. They have three children: Tucker, 6, Will, 4, and Tess, 2. Susan has a background in diabetes and lactation education, and works part time for Lotter Actuarial Partners. As a part-timer, she's not eligible for benefits, so she and Clark shopped around for a high-deductible policy, eventually buying one from Fortis. Their policy covers 100 percent of medical costs after a $4,800 family deductible. The quarterly premium is $753, before contributions to the optional medical spending account. The Furlongs decided to forgo the optional drug rider, self-insuring their drug benefits because they're not on any maintenance medications.

"As parents of young children, the Furlongs have their share of emergency room visits. Recently, Will fell while playing a recorder, which scraped the back of his throat, resulting in a fair amount of blood and discomfort. The Furlongs wanted to have Will examined by a doctor. The first decision they faced was: hospital emergency room or walk-in medical center? The walk-in medical center was closer and likely to be cheaper, so that's where they went. Because the Furlongs didn't have comprehensive first-dollar insurance, the medical center wanted payment in advance before the doctor would see Will, so they paid the $200 fee. But the doctor decided that he couldn't help, and told the Furlongs they should go to the emergency room. Before they left the walk-in center, Susan negotiated her advance payment back.

"Two things immediately differentiate the Furlongs' response under the high deductible plan, compared with a typical insured's response: first, a cost-benefit evaluation of the clinic vs. emergency room setting, and second, getting their money back from the clinic.

"In the emergency room, the Furlongs faced a decision about having an X-ray, which they decided to do after discussing cost and benefits with the physician. Will was checked out and given a clean bill of health, although he was uncomfortable and couldn't swallow. His physician prescribed Augmentin (a name-brand antibiotic) and Lortab elixir (a brandname painkiller). Susan checked both of these carefully, particularly the antibiotic, which cost $94.99 per prescription. The painkiller cost $27.39. In the end, she chose a generic antibiotic (Amoxicillin) at $69.69 and a ge-

neric painkiller ($14.79). There wasn't much the Furlongs could do about the emergency room costs, but every other expense associated with the accident was checked carefully and evaluated. They made each decision before incurring the expense. How carefully would an indemnity plan member evaluate similar expenses?

Jeffrey Dunham runs a trust and investment company in San Diego, California. He writes:

"We looked at (no . . . put through the ringer) the pros/cons of HSA's for at least a year perhaps two for the 45-ish employees of our trust and investment company. We looked at its effect on single folks, on married folks, on those with families, on older employees, on younger ones. . . . You get the picture. We heard every potential heart ache we could think of. Yet, in the end . . . I did it because it allowed (forced) the employees to have a vested interest in the health care choices they made. It touched everything from what they ate . . . to how much they exercised . . . to whether they needed to see the doctor . . . or not . . . and whether they needed the 2nd, 3rd opinion . . . or not. They got to have the care they wanted when they needed it . . . and benefit from the savings they created by good decisions. It was fair for them . . . fair for us. We all now had "skin in the game" . . . for what these costs would look like in the years ahead.

"At first there were many nay-sayers. What if this . . . what if that . . . yet, by the time enrollment came around the word began to spread that the company was doing something good for them . . . giving them more options—more choices. Far more than we thought signed up for the HSA option. I expect more to follow each open enrollment period. In short—it worked better than we had expected.

"It took some pushing to get it done. It was worth the effort."

Evelyn Preston recently purchased a non-group HSA in Michigan. She writes:

"I only have one prescription and knowing I will now pay for it with my HSA dollars, I checked on the prices. Before, this was not much of a concern to me as I would have paid my $15 copay for a prescription regardless of where I bought it. It turns out that Walgreens, where I had been having it filled, charges $18 more than Meijer. Of course, now I've switched my prescription to Meijer.

"I was talking to my son, married with 2 children. They pay $5 co-pay so it doesn't matter to them where they get their prescriptions filled . . . again totally convenience. Now that the dollars are coming out of my medical savings I will look at price."

Kirby Nielsen is a broker in Worthington, Ohio. He writes:

"The critics of HRAs and HSAs have it about 180 degrees wrong in their assessment of chronic health problems and High Deductible Health Plans.

I have "Paraneoplastic Syndrome" that involves the failure of my immune system. It is a rare disease that few physicians remember hearing about in Med School. In short, my immune system makes antibodies to fight cancer that (for me), has not yet appeared. In fact my antibodies are actually bad guys that are destroying my peripheral nervous system. My deterioration is progressing slowly due to my willingness to push immune suppression therapy to the limit.

"My annual medical bills run over $30,000 per year for the two years I have lived with this diagnosis (the amount approved by the insurance company). This year I have a high deductible health plan and it is so much better than my old traditional plan with a $250 Deductible 80/20 to $10,000 with a physician's co-pay and an Rx card.

"The first thing with a chronic condition is not so much the advantage of choice (which would be an advantage to a healthy person) as to whether or not to have tests and other medical services; it is that all these expenses go directly to my deductible early in each plan year. Another way to put it is I get to fulfill my $4,000 deductible quicker.

"Secondly, when I reach my deductible, I have 100% coverage. Believe me; having met my deductible and having 100% coverage does not encourage more health care spending. A person who is chronically ill is tired of tests and medical services and would rather not get more health care. Our motive is only to find the underlying cause, treat symptoms, and relieve pain. I met my deductible 6 weeks into the plan year and now I have no more co-pays, no Rx card, and no hassles at all other than the disease itself.

"With the HDHP, I pay the same out of pocket as I used to pay, but I hope I have shown some of the reasons why a HDHP is really a good deal for a person with a complicated and expensive chronic health problem.

Ben Cutler is President and CEO of USHealth Group in Fort Worth, Texas. He writes:

"USHEALTH Group is a small (under 200 employees) insurance company headquartered in Fort Worth, Texas. In March of 2005, we received a renewal notice from our group insurance carrier, UnitedHealthcare. The plan was costing $5,600 per employee prior to any rate increase. As expected, the renewal notice from United was hefty—a 19% increase which translated to a new cost per employee of $6,600!

"Fortunately, we had requested a quote from United for an alternative high deductible HSA qualified plan. Neither our broker or United recommended that we do a complete conversion, feeling it was far too radical a move. Against their advice, we decided to install an HSA programs featuring $2,000 individual, and $4,000 family deductibles. The premium savings were compelling; instead of a 19% increase, the high deductible premium was 28% less than we had been paying. That lowered our cost per employee from $6,660 to just under $4,000. These savings, combined with a small increase in the employee cost sharing of the premium allowed the company to contribute $1,750 for individual and $3,500 for family into the HSA account and match additional employee contributions up to the full deductible.

"We thought we were prepared for a sizable employee backlash, but we underestimated the level of employee objection. People were not at all happy with this change. Working with our broker and United, we prepared a comprehensive education and communication campaign that included several evening sessions where spouses were invited. Armed with a more comprehensive understanding of how the plan would likely impact them financially, employees grudgingly accepted the change.

"One big concern was the financial consequences of a sizable medical expense before sufficient funds were accumulated in the employees HSA. We agreed to provide an interest free loan up to the full HSA contribution if that occurred, with repayment coming from future employer contributions into the employees account. As it turned out, several employees took advantage of that financial bridge.

"As an additional employee incentive, First HSA, our HSA plan administrator, was able to provide 6.15% interest on employee account balances. The behavioral change occurred almost instantaneously. Now employees were spending their own money for healthcare services. Within a few weeks, the stories of what happened when employees became "shoppers" and not just consumers of healthcare services began to emerge:

- Kim is a 42-year-old divorced mother of two. Her eldest son was diagnosed with ADHD. Neither Kim nor her daughter had health issues. Kim was quite concerned about how she was going to afford the expensive medications for her son on her $27,000 a year salary. She came to see USHEALTH Group's human resource officer Jan Fogg to find out how the new HDHP was going to work for her. Jan and Kim researched the costs of the required medications and applied them to a financial outlay model demonstrating how the plan could be used in situations like this. The answer to her particular problem was first and foremost a timing issue. She was able to get her son's first prescriptions filled on the previous plan and by the time she needed refills, she would have enough to pay for them out of her HSA. It was also important that she use the 90-day mail-in prescription method rather than monthly trips to the pharmacy which saved her quite a bit of money overall.
- Mary Jane is a 47-year-old employee who has bronchitis and asthma. She was quite skeptical about having the necessary funds in her HSA to pay for her monthly medications. When we implemented the new HDHP, Mary Jane immediately went to her doctor and explained how the plan worked and that she would not have enough money in the account to pay full price for her medications. Her doctor was able to supply her with enough samples that would last until her account had a sufficient balance to start paying for regular prescriptions on her own. Mary Jane's doctor further understands that not only medications, but office visit costs must be paid in full by the HDHP patient. It is her practice to not require any payment at the time of visit, but to allow the billing process to run its course through the insurance company for repricing and then issue a bill once the EOB has been created. The entire process can last nearly two months, allowing the patient to have delayed billing. For Mary Jane, the HSA plan works and she even has accumulated enough at the end of the calendar year to have money in her account for the next deductible year.
- Jerald is a 56-year-old employee and one of a handful of employees who has a chronic condition (diabetes) which requires several doctor office and lab visits per year in addition to maintenance medications. He has elected to pay for the costs from his personal checking account, leaving his HSA intact. By doing a cost comparison on the best method of purchasing his medications, he is able

to manage his purchases through either the mail-order method or a monthly purchase at his local pharmacy. His HSA continues to grow and earn interest at 6.15%. At 56, Jerald is hoping his HSA account will accumulate a sufficient sum to cover excess medical expenses when he retires.

- Jack, a 36-year-old employee with a family, did some research on his own during the weeks of education prior to the implementation of the HDHP and HSA and found that his doctor understood the issues Jack's family might have with the HSA and supported the idea of ordering maintenance medications at twice the strength to allow for pill-splitting and thus, a cost savings of almost 50% on his family's medications. Jack was ahead of his time. Several months into the plan year, the carrier issued a notice to covered employees that recommended pill-splitting. Several employees have been diligent about "comparison shopping" for healthcare services, such as x-rays or colonoscopy fees, and have shared that information with other employees who have also been able to realize a cost savings.

"The final piece of good news recently arrived in the form of UnitedHealthcare's 2006 renewal notice. The Company's broker was all smiles as he communicated that based on United's projection of a 67% loss ratio under the new plan, United was offering a mid single digit renewal increase!!! As USHEALTH Group's management had hoped, the new HSA plan was a huge success for all concerned!!!"

Joint Statement of Gail Shearer and William Vaughan, Consumers Union

Mr. Chairman, Members of the Committee:

Consumers Union, the independent non-profit publisher of *Consumer Reports,* opposes more public expenditure of limited tax dollars on health savings accounts (HSAs).

We believe that HSAs are harmful from a societal point of view and to those who most need help with health care expenses. While some healthier and wealthier individuals may benefit from HSAs, when Federal debt is increasing roughly $1,000,000,000 a day, this is not where additional health care dollars should be spent.

The evidence is quickly mounting that HSAs are primarily attractive to upper income people and people who tend to be healthier.

The tax shelter nature of HSAs is revealed by a GAO report [1] that some people actually pay for medical expenses out-of-pocket rather than draw down their tax sheltered HSA accounts. This may or may not be good savings and tax policy for upper income people, but it has little to do with good health policy.

Polling by the Employee Benefit Research Institute and the Commonwealth Fund[2] show that people with HSAs are

- less satisfied than those with traditional insurance coverage,
- often forgo needed care,
- may actually spend more on health care and have higher out-of-pocket costs, and
- generally have a difficult time shopping for health care (finding hospital and doctor quality and cost data).

In attachments #1 and #2, we discuss these issues in greater detail.

To throw more money at this scheme when we are facing serious cuts in successful programs like the State Children's Health Insurance Program (S–CHIP) makes no sense. We urge this Committee to resist further tax expenditures on HSAs and instead save the revenues for the kind of health care programs that Americans really want. (We note that in picking Medicare Prescription Drug Plans, a great deal has been made of the fact that seniors have preferred the plans with the lower deductibles. The Part D experience should be a lesson about how consumers clearly favor low-deductible coverage; high deductible health insurance policies are being imposed on consumers in many cases.)

So called "Consumer-Driven Health Care" is an Orwellian slogan designed to hide the fact that costs are being shifted onto the backs of consumers. And in the realm of health care, increased cost sharing means that the lower income in our society will go without—and their health and the health of their children will suffer. In-

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[1] GAO, "Consumer-Directed Health Plans," April, 2006. GAO–06–514.

[2] EBRI Issue Brief No. 288, December, 2005.

stead of shifting costs to consumers when they are sick or as they age, Congress should help address the underlying causes of run-away health costs.

HSA advocates forget the core fact that governs the world of health insurance: 50% of the healthiest people use 3% of the health care dollar; 10% of the sickest people use 70% of the health care dollar. To take money out of the health care insurance system (i.e., spend less on high deductible catastrophic insurance policies) and give that cash to the healthy half of the population to put into savings accounts means that the money will not be there for the very sick who need intensive, expensive care.

For all these reasons, we urge the Committee to stop diverting money in an ill-advised experiement and return to the consideration of meaningful health care reforms and true cost containment strategies that the American public need and want.

Attachment 1, from *Consumer Reports, May 2006*

False promises: 'Consumer driven' health plans

A promotional pamphlet for a health savings account (HSA) boasts, "If you plan correctly, you may find that you spend far less for health care than ever before." True, if you could plan to avoid cancer, being hit by a car, or growing older. But you can't.

Three million Americans have signed up for high-deductible health plans, which are often paired with tax-advantaged HSAs designed to give them the funds they need to pay those deductibles. Proponents call this "consumer driven health care." They claim that patients who have to take on more of the costs themselves—annual deductibles range from $1,050 to a total deductible and costs of $10,500—will avoid unnecessary care and look for medical providers who deliver high-quality care at the lowest price, thus driving down costs. The plans are touted by some, including President Bush, as a solution for the U.S. health-care crisis, with its 46 million uninsured.

The reality is that these schemes shift increased financial risk to consumers and will surely weaken our already fragile health-insurance system. HSAs provide little assurance of affordable, quality health care to those with chronic illnesses, families with children, those of moderate incomes, or older Americans with more health-care needs. HSAs do nothing to address the factors that really drive up health costs: care for those with chronic diseases; overuse of technology; hospital care; prescription drugs; and end-of-life care.

Who benefits, who doesn't?

HSAs may benefit young, healthy workers without dependents, who don't spend much on medical care. They're especially advantageous for the wealthy of all ages, since the higher the tax bracket, the more valuable the tax break. Contributions to HSAs are tax-deductible, the account grows tax-free, and money pulled out for medical expenses is not taxed. After age 65, money saved in the account can be used for any purpose, without a tax penalty. But the income level of the vast majority of uninsured Americans prevents them from reaping those tax benefits.

A recent national survey by the Employee Benefit Research Institute, a nonprofit organization, found those currently in HSA-type plans were significantly more likely to spend a large share of their income on out-of-pocket health-care expenses than those in comprehensive plans. They were also more likely to skip or delay health care because of costs. And though HSAs work on the premise that consumers have access to reliable cost estimates and comparative information about providers, that information all too often does not exist. No surprise that the survey found those enrolled in HSAs far less satisfied than those with traditional, comprehensive coverage.

So, who, besides the wealthy, benefits from HSAs? Employers do, since they are shifting health-care costs to their employees and are more able to predict health-care expenses. And financial institutions offering HSAs are poised to reap billions in profits from the fees they can charge in setting up those accounts.

A health-insurance system can function only if costs and risks are spread among healthy and sick participants. But healthy employees who don't expect to need much medical care are the ones most likely to abandon traditional plans in favor of low-premium, high-deductible ones. Those left in traditional plans will be sicker and more risky to insure. That means a greater likelihood of steep premium increases, pricing coverage out of the reach of more workers and adding to the ranks of the uninsured.

"Consumer driven" health plans, including HSAs, abandon the premise that the community has a responsibility to care for all members. The health-care system needs fixing, but HSAs are a sham substitute for comprehensive reform.

For more on health savings accounts, go to www.consumersunion.org/HSA.

Attachment #2,: *Health Services Research* 39:4, Part II (August 2004)

Commentary—Defined Contribution Health Plans: Attracting the Healthy and Well-Off[3]

by Gail Shearer

Driven by a philosophy that favors unbridled faith in the free marketplace, the year 2003 may well go down in health care history as the year that the health care system officially abandoned the premise that the community has a responsibility to care for each member, replacing it with the philosophy that individuals should each look after themselves. The most visible change that nudges the system toward self-insurance is the provision in the Medicare bill that expands and makes permanent "health savings accounts" (HSAs) (formerly known as "medical savings accounts" or MSAs). This provision allows most Americans to set up tax-advantaged savings accounts (no tax is paid when money is paid in or when paid out, an unprecedented new tax loophole), when they also have a high-deductible health insurance policy. These new accounts are likely to favor the healthy (who stand to benefit financially from a new tax shelter since their accounts need not be depleted on health care expenses) and the wealthy (the higher tax brackets mean higher tax benefits). 1 In his State of the Union address, President George W. Bush's proposal for a new tax deduction for premiums for high-deductible policies introduced the possibility that health savings accounts' penetration of the marketplace—and the demise of the employer based health care system—will be accelerated. 2 The second development is the encroachment of so-called consumer driven health care plans (CDHC) into the employer-based health insurance marketplace. This new approach is dressed up with a consumer-friendly name, but in reality, as noted in Christianson, Parente, and Feldman (2004, this issue), this new approach is characterized by higher deductibles for employees. A more apt label, and one that seems to have been overtaken by CDHC, is "defined contribution health care." As a gentle reminder to health researchers and policymakers that a consumer-friendly name should not be used to mask a marketplace change that may be harmful to consumers, I will use the "defined contribution health plan" (DCHP) label to refer to these new plans. "Defined contribution" accurately connotes limited employer liability for health care costs. "Consumer-driven" implies that the consumer exerts considerable control—hardly an accurate portrayal of high-risk consumers' likely experience with a high-deductible plan. The two studies raise red flags about the potential for these new plans to appeal disproportionately to the healthy and those with high income. They contribute to the dangerous distraction of policymakers from the goal of working toward a health care system that provides affordable, quality health care to all by spreading costs broadly and fairly across the community.

COMMENTS ON STUDY 1 (UNIVERSITY OF MINNESOTA)

Study 1 (Christianson, Parente, and Feldman 2004, this issue) considers the experience at the University of Minnesota, when 16,000 employees were offered several health insurance choices, including policies that combine relatively high-deductible health insurance coverage, a personal care/health care savings account check, and a gap between the amount contributed to the account and the deductible, assuring that employees would face some out-of-pocket costs before their health insurance policy provided coverage. This study does nothing to make DCHP appear to be consumer-friendly and confirms concerns about what a shift toward DCHP will mean for the health care system. This section summarizes and considers some of the key findings. DCHP Appeals Disproportionately to People with Relatively High Income The average income for employees who enrolled in DCHP (and responded to the survey) was 48 percent higher than the income for employees who did not enroll in DCHP ($71,406 versus $48,148) (Christianson, Parente, and Feldman 2004, Table 1, this issue). This wide disparity lends strong support to the notion that higher-income individuals are more likely to enroll in a high deductible health insurance plan in which they could be at risk of large out-of-pocket costs before meeting a deductible.

DCHP Appeals Disproportionately to a Relatively Sophisticated Population of Faculty Members and Does Not Appeal to Union Members

Thirty-six percent of DCHP enrollees were faculty members; only 14 percent of non-DCHP enrollees were faculty members. Participants in the civil service/bargaining unit were more likely to favor non-DCHPs: 50 percent of enrollees in non-DCHPs were civil service/bargaining unit members, while only 23 percent of DCHP

[3] "Consumer-Driven Health Care: Beyond Rhetoric with Research and Experience," Health Services Research (vol 39, no. 4) August 2004, Part II, pp. 1159–1166.

participants were. The DCHPs appeal disproportionately to relatively sophisticated participants (Table 1).

An Overwhelming Majority (96 percent) of Employees Favor Low-Deductible Coverage to DCHP, Based on Their Choices in the Marketplace

The low participation rate in DCHPs indicates that there is no groundswell of consumer demand favoring a health care system centered on high-deductible health insurance: 4.3 percent of the eligible population participated in the DCHP program. (This assumes that families do not have more than one employee eligible for this coverage. A total of 695 employees—349 individuals and 346 families—enrolled, out of a total population of 16,000 employees.)

The Study Design Is Inadequate to Allow Conclusions about Risk Segmentation by DCHPs

The study uses a self-reported measure of chronic illness to study the potential for risk fragmentation, and finds no significant difference among DCHP and non-DCHP enrollees. This measure is insufficient to draw a conclusion on risk fragmentation. A more in-depth measure of health care costs, possibly a time series, for all covered individuals in each family is needed. The measure used does not take into account whether employees might anticipate certain health care costs in the future (e.g., a planned pregnancy, elective surgery), which would discourage enrollment in a DCHP for fear of high out-of-pocket costs. Some health conditions might have regular costs associated with them, but respondents might not consider them to be a chronic illness (e.g., back pain) but more of a chronic condition. This is an area where further expansion of the underlying health status of respondents is critical.

The Satisfaction Level with DCHPs Is Not Impressive

While respondents in DCHPs were somewhat less satisfied than respondents in other plans (7.46 versus 7.55, on a scale of 0 to 10, 10 is best), the difference can be considered trivial even if technically statistically significant. *Internet Support Tools, a Key Selling Point of DCHPs, Were Used Only Moderately.* While 30 percent of respondents in DCHPs used provider directories, only 8 percent used disease management information, and only 12 percent used pharmacy-pricing tools. These numbers do not support the premise that DCHPs mobilize employees to comparison shop and access Internet resources to manage their care and control costs. Overall, the first study paints a picture of highly educated and high income faculty members gaming the health care system by selecting into the high-deductible plan if they believe that they will come out ahead financially. The limited measure of health status precludes drawing conclusions about the segmentation of the health risk pool, but overall there is nothing in this study to dispel the concern about risk fragmentation. Perhaps the strongest conclusion from this study is that DCHPs appeal disproportionately to highly educated, high-income members of an employee group. They appeal to a tiny portion of employees. The small fraction of employees who enroll do not make full use of the tools that they offer, and are not particularly satisfied with the plans' performance.

COMMENTS ON STUDY 2: HUMANA EMPLOYEES

Study 2 (Fowles et al. 2004, this issue) reports the results of a survey of 4,680 employees of Humana Inc., 7 percent of whom selected a new "consumer defined health plan option" (referred to as DCHC below). This is the epitome of a "defined contribution health plan": the employer would pay a fixed amount, 79 percent of the reference plan, for each employee. This study provides troubling confirmation of the potential of DCHPs to fragment the health risk pool to the detriment of the less healthy.

Those Selecting DCHP Are More Likely to Be Healthy

The study found that enrollees in DCHP were "significantly healthier on every dimension measured." This study used a more comprehensive measure of health status, including measures such as reported health status, likelihood of a covered member receiving regular medical treatment, likelihood of having a personal physician, and existence of a chronic health problem. Those who selected the DCHP were less likely to have a chronic health problem (54 percent) and more likely to have had no recent doctor visits (3.07). Enrollees in DCHPs were more likely to be in excellent health (31 percent versus 18 percent) (Table 1). The study found that employees reporting that a family member had a chronic health problem were half as likely as others to select the DCHP.

Enrollment in the New Plans Was Modest

Like the University of Minnesota employees, the Humana employees did not flock to the high-deductible coverage (despite the annual premium savings of $400 per year for an individual and $1,200 per year for a family): only 7 percent enrolled in the new plan. Individuals were more likely to enroll in a DCHP than families.

Sociodemographic Findings

Those enrolling in DCHPs were more likely to be college-educated, white, male, and in positions exempt (from a union) than those who enrolled in other plans. The finding that blacks are about half as likely to enroll in DCHPs is troubling, and suggests that just as policymakers are waking up to the magnitude of disparities in our health care system, yet another policy that separates blacks (and presumably other minorities) from whites is created. Income is not listed as an independent variable, ruling out the ability to estimate the relative importance of race and income.

This study clearly demonstrates that widespread expansion of DCHPs within the employer marketplace will fragment the risk pools in the employer based health insurance marketplace, one by one. Employer-based health insurance coverage has been held up as the one place in which risk pools tended to be unified, with costs spread among employees (albeit paid directly in large part by employers). DCHP's have the potential to unravel this important risk-spreading role. This study clearly demonstrates that risk segmentation, to the advantage of the healthy and the disadvantage of the less healthy, will be a reality should the role of DCHPs expand in the health insurance marketplace.

IMPLICATIONS OF THE STUDIES FOR PUBLIC POLICY

Members of the public and policymakers should view these two studies as the proverbial canary in a coal mine. They raise red flags about the potential that DCHPs (like their cousins Medical Savings Accounts) appeal disproportionately to the wealthy and healthy. The first study shows that the income level of employees selecting DCHPs is 48 percent higher than those not selecting them. The second study finds that those selecting DCHPs are healthier "on every dimension" than those not selecting them. The concern that this new model of health care will appeal more to the sophisticated who can "game the system" and shift costs to the sick becomes greater after reviewing these studies. They should set off alarm bells about the potential long-term threat to our health care system.

The scope and design of these studies did not allow consideration of some of the most important issues that will affect the long-term impact of this new type of plan. Some important areas for future research include: To what extent will DCHPs merely shift cost to sicker employees, instead of truly lowering health care spending?

Over time, will sophisticated employees "game the system," opting out of DCHPs when they anticipate high health care expenses related, for example, to pregnancy or elective surgery? To what extent will employer's health care premium dollars be diverted from paying for health care expenses to paying to build health reimbursement accounts? To what extent do these new health plans create new financial barriers to health care for low-wage workers? Do consumers have the necessary information about quality of providers on which to make informed decisions?

What are true consumer/employee preferences regarding deductible levels? To what extent will the gap between the health reimbursement account and the deductible pose a financial barrier to getting needed health care? Will anticipated cost savings occur, or will they fail to materialize since so much health spending is concentrated among those with catastrophic expenditures?

Will the new high deductibles and sense of spending one's own money deter preventive care and early treatment for illness, ultimately leading to worse health outcomes and higher costs? The findings from these two studies are troubling for another reason: because of the nature of adverse selection, over time, DCHPs may drive lower-deductible health insurance options out of the marketplace (Zabinski et al. 1999). Bolstered in the health care market with the enactment of the health savings account provision in the Medicare bill, in a few short years, it is very possible that unpopular high-deductible health insurance coverage will be the only choice that many employees may face for their coverage in the employer-based market. Those with high health care expenses will face higher out-of-pocket costs than they would in the absence of DCHPs. It is troubling that this type of change in the health care marketplace will take place in the absence of a public debate. Advocates of medical savings acccounts, for example, maintain that there should be a choice of plans. The reality is that over time, as adverse selection pushes the next "relatively healthy" group toward high-deductible plans, an insurance marketplace death spiral will result and ultimately will remove the very choice (a low-deductible plan) that employees want.

Both studies contribute to the body of knowledge about DCHPs, "as a first, limited attempt to shed light on the important issues" (Christianson, Parente, and Feldman 2004, this issue). In considering the health policy expertise and money devoted to these studies, it is important for health researchers and policymakers to ask fundamental questions about priorities for future health research. The buzz about DCHPs in health policy circles creates a sense that valuable dollars are being spent in an effort to rearrange the deck chairs on the Titanic. More resources should be devoted to charting the course to guarantee all U.S. consumers have guaranteed, quality, affordable health care. We should be moving full-steam toward this vision, not spending countless hours and resources analyzing new models that promise to split the healthy from the sick, shift costs to the sick, favor the highly educated and high-incomed, and grow the inequities on our system. The two studies confirm that DCHPs are a dangerous distraction from this mission; they undermine the important value of a communitywide approach to looking after one's neighbor in a health care system that would spread costs broadly in an effort to achieve affordable, quality health care for all.

NOTES

1. In addition to benefiting from a higher tax bracket (and higher tax benefit from HSAs), the wealthy are more likely than the non-wealthy to be able to risk the out-of-pocket costs of a high-deductible policy.

2. Because healthy individuals may be able to get a lower premium for a catastrophic policy in the individual market, the new tax deduction available to individuals, when combined with the possibility that employers will increasingly "cash-out" health benefits when the healthy opt-out of coverage, could lead to rapid erosion of the employer-based health insurance market.

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Statement of Council of Insurance Agents and Brokers

On behalf of the Council of Insurance Agents and Brokers (The Council), thank you Chairman Thomas, Ranking Member Rangel, and members of the Committee 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

[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

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]

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 prescription drug coverage to be offered without a high deductible.

The current law for HSAs requires that prescription drug expenses be subject to the high deductible before coverage begins. Many employers, however, do not apply prescription drugs expenses toward their health plan deductibles, but instead require cost-sharing by an employee on each prescription they fill. Exempting prescription drugs from the high deductible is likely to encourage more employers to offer HSAs and more employees to enroll.

3. Permit individual family members to satisfy the individual deductible for HSAs ($1,050) rather than the family deductible (@$,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 Health Reimbursement Arrangements (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 health reimbursement arrangements (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. Encourage employees to save for retiree health expenses. HSAs were designed to be both a spending *and* a savings vehicle.

Current contribution limits, which may not exceed the health plan deductible, are unlikely to create the level of asset accumulation during an employee's working career that will be needed for heath expenses in retirement. Allowing an individual or employer to make contributions above the amount of the health plan deductible would help many individuals save for their future health care needs in retirement.

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[2] *Id.*
[3] *Id.*

7. 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.

8. 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 or contact The Council directly, Alycia Kiley (202–783–4400).

Statement of Dawn J. Lipthrott, Ethical Health Partnerships, Winter Park, Florida

Health Savings Accounts are being proposed as an answer to help reduce the number of uninsured, reduce healthcare costs, and give patients more cost information and choice that will lead to lower spending. I have an HSA and have found that they fall far short of the claims used to promote them, especially in the area of affordability.

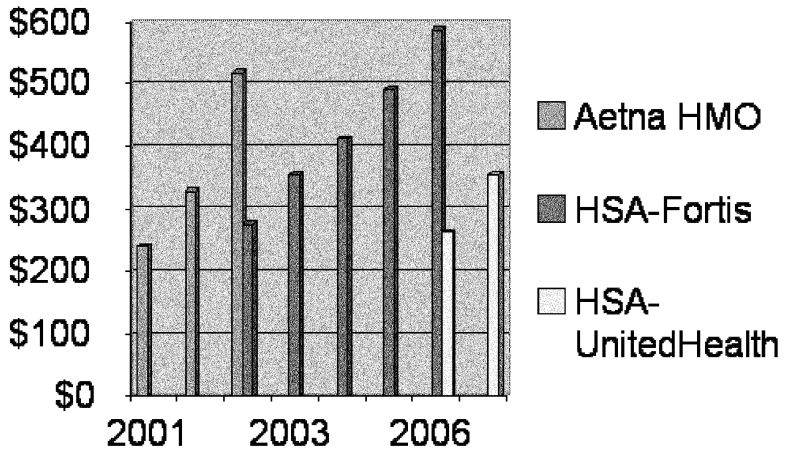
In this statement, I will address, both from personal experience as a self-emplyed person with individual insurance through an HSA, and from published sources, the proposed benefits of Health Savings Accounts and health cost factors.

1. They will give many people the ability to obtain and afford insurance coverage.

a. Premium costs of Health Savings Accounts increase at the same rate, and sometimes more quickly, than standard plans. So the insured ends up paying high premiums with a high deductible.

Personal experience:

As a self-employed professional, here is what happened to my insurance premiums, both with a traditional HMO (blue), my first HSA (red) that quickly become just as unaffordable, and my current HSA (yellow) obtained this year.



I obtained a small group policy from Aetna, which I qualified for as an individual business owner. I have no employees. From 2001 to 2003, my Aetna small group insurance premium more than doubled from $240 to $520 although I never used it except for a routine mammogram and no history of illness. My insurance agent told me that health insurance companies simply don't want to insure individuals and price them out. I decided to switch to an HSA since it was my only viable option.

HSA #1:

In September of 2003, after giving all my medical information, I was quoted a price of $276 per month by Fortis insurance and in answer to my questions, was told that premiums in my county of residence increase an average of 10–12% per year. By the time I got my policy, they had raised the initial premium to $355 because I am above current weight standards, although they knew that when they gave me the quote.

The monthly premiums for individual coverage with an HSA increased as follows:

$355 initial premium. October 2003
$413 1st year renewal date. October 2004
$493 6 months after the first increase. May 2005
$587 announced at the end of the second year, effective on the new renewal date of March 31st, 2006.

The insurance company said it was due to regional increases. My premiums did not go up 10–12% annually as stated, but rather 20% and 37%.

HSA #2:

In February, 2006 the second insurance company quoted a premium rate of $264 after obtaining height weight and health status and so I enrolled. When I received the policy, the premium was actually $355 because I am still overweight, which they knew at the time of the original quote. They also report that average annual increases will increase approximately 8–10% per year in my area. Time will tell how quickly these premiums increase.

Cost of Premiums vs. Health Cost Spending Increase:

Health Affairs reports that national growth in healthcare spending was projected to slow nationally from a high of 9.1% in 2002 to an 7.4% in 2005 and future increase is predicted to be fairly stable for the next decade. (Source: *Health Spending Projections Through 2015,* Health Affairs W 62, February 2005) However, my premiums increased more than 20% per year, sometimes more than 35%.

HSA's do not provide affordable coverage.

2. Proponents repeatedly claim that HSAs will reduce rising health care costs.

What the studies show:

The leading professional journal on health policy, *Health Affairs,* published an article in December 2005, "*The Rise in Health Care Spending and What to Do About It,"* by Kenneth E. Thorpe, PhD, Chair of Emory University's Department of Health Policy and Management. His report added to the growing literature about the real drivers of health costs. And those factors reveal that Health Savings Accounts will be no more than a bandaid that will have little impact.

Thorpe's article sums up the two main areas that contribute to 2/3 of the rise in spending:

a) the rise in treated disease prevalence, much of which is preventable (63% of rise in real per capita spending)

b) changes in thresholds for treatment (lower standards for cholesterol levels, blood pressure, etc.)

c) innovations in treatment, some of which are positive, and some of which are not cost-effective for the level of benefit they provide.

He states that "health behaviors like overconsumption of food, lack of exercise, smoking and stress accounts for approximately 40–50% of morbidity and mortality." "80% of health care spending is traced to patients with largely predictable health care needs and expenses, the chronically ill."

Obesity—an increasingly significant factor in rising health costs:

Thorpe is one of many investigators who are documenting the effects of the rising incidence of obesity on healthcare spending.

The rapidly rising prevalence of obesity puts people at greater risk for numerous serious illnesses such as certain forms of cancer (including breast, colorectal, and kidney among others), diabetes, high blood pressure, arthritis, cardiovascular disease and more. The combined prevalence of both overweight and obesity averages 53.6% across all categories and is largest for those enrolled in Medicare (56.1%). Obesity-attributable expenditures totalled $75,051,000,000 from 1998–2000. (Sources*: Estimated Adult Obesity-attributable Percentages and Expenditures by State* (BRFSS 1998 to 2000). http://www.naaso.org/statistics/obesity_exp_state.asp. Also: *National Medical Spending Attributable to Overweight and Obesit* y. Finkelstein, EA et al, *Health Affairs.* May 14, 2003.)

Patient non-compliance with treatment for chronic conditions such as diabetes, high blood pressure and others:

In 1992, the cost of medication noncompliance alone was $100 billion ($45 billion in direct medical costs). $31.3 billion was spent on nursing home admission due to noncompliance, $15 billion was spent on hospital admissions due to noncompliance, and $1000 was spent per year per non-compliant patients versus $250 dollars spent per compliant patient. No doubt these costs have gone up considerably in 10 years since little has been done to address them. (Source: *Compliance in Elderly Patients,* University of Arkansas College of Pharmacy http://www.uams.edu/compliance/; Also, *Schering Report IX: The Forgetful Patient: The High Cost of Improper Patient Compliance.* Also Standberg, LR, *Drugs as a Reason for Nursing Home Admissions,* American Healthcare Association Journal 10, 20, 1984))

5 Conditions contribute to 31% of healthcare spending:

Of the top five diseases or conditions that make up one third of health costs, hypertension and other cardiovascular disease can be reduced by more focus on prevention and lifestyle change. It would make sense to focus energy and resources into reducing health costs instead of simply cost shifting.

Defensive medicine and inconsistency in awards

A 2003 Department of Health and Human Services report states that finding ways to fix unreasonable jury awards could save $70–$126 billion in health care costs per year. This does not have to mean caps, although that is one way. (*Source:* U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis,* March 3, 2004)

It can mean setting a schedule of recommended awards for avoidable injuries as is done in several other countries. Just 2 months ago, in Seminole County, Florida where I live, a jury awarded a woman $28 million because she has to catheterize herself twice a day after having surgery for an incontinence problem. She has no ongoing medical expenses, continues to work, and has normal life expectancy. That $28 million is not only inappropriate, it costs every one of us who obtain healthcare.

It would make sense to explore meaningful alternatives to the current tort system for handling complaints and patient injury to reduce cost, improve patient safety, and avoid unnecessary tests and procedures.

"Our health costs are rising sharply. In the past 5 years, private health insurance premiums have risen 73%." President Bush

President Bush is absolutely on target. The statement about health cost drivers that I presented in #2 is part of what contributes to the rise in premiums. In addition to preventing and treating the health conditions mentioned, insurance companies themselves contribute significantly to the rising costs of insurance that make it more and more unaffordable for patients.

a. Insurance Profits Consistently Increase in Double-Digit Percentages:

The nation's HMOs reported a $6.98 billion profit for the first six months of 2005, representing a $1.2 billion, or 21.2 percent, increase over the $5.76 billion earned during the same period in 2004, according to Weiss Ratings, Inc., the nation's leading independent provider of ratings and analyses of financial services companies, mutual funds, and stocks. (Source: Weiss Ratings, HMOs Earn $7 Billion in First Half of 2005, http://www.weissratings.com/News/Ins_HMO/20060130hmo.htm)

Here are the other headlines from Weiss Ratings about the profitablity of HMOs. (Weiss was named by the Government Accounting Office Report GAO/GGD–94–204BR as the most accurate rater of insurance companies,)

1/30/2006—HMOs Earn $7 Billion in First Half of 2005
10/24/2005—HMO Profits Jump 21% in First Quarter 2005
8/8/2005—Nation's HMO Profits Increase 10.7% in 2004
5/24/2005—Profitability Continues to Surge for the Nation's HMOs
2/7/2005—50% of HMOs Financially Strong as Profitability Continues
12/8/2004—HMO Profits Increase 33% in First Quarter 2004
8/30/2004—HMOs Earn $10.2 Billion in 2003, Nearly Doubling Profits
5/3/2004—HMO Profits Skyrocket to $6.7 Billion in First Nine Months of 2003

Source: http://www.weissratings.com/News/Ins_HMO/

b. Insurance Executives Earnings:

While patients and employers struggle with rapidly rising insurance premiums and physicians receive cuts in reimbursement, health plan administrators are rewarded with excessive amounts of compensation. Earning profits is the American way, but not in a manner that places undue burden on patients and their physicians while requiring government to scramble for solutions to the rising costs.

2005 Earnings	Total Compensation including stock option grants	Cashed out stock option exercises from previous grants	Unexercised stock options remaining from previous years
UNITEDHEALTH William W. McGuire, CEO	$36,988,014	$114,552,832	$1,142,202,769
AETNA Ronald A. Williams, Chariman	$6,108,475	$18,208,281	$164,722,382
WELLPOINT Larry C. Glasscock, CEO	$11,725,513	$	$22,61,000
HUMANA Michael B. McCallister, CEO	$3,849,338	$	$24,133,460

Source: SEC Filings

c. Merger bonuses and golden parachutes for insurance executives:

In November, 2005, UnitedHealth acquired PacifiCare for $9.2 billion in cash, stock and assumed debt. **The agreement also would include $230 million in accelerated stock options and payments to PacifiCare executives and an additional $85 million in signing bonuses to executives who remain employed with the company after the acquisition** (*Kaiser Daily Health Policy Report, 10/18 and 11/05*). The California Public Employees' Retirement System, which holds shares of PacifiCare and opposes the proposed payments to executives, voted against the acquisition. PacifiCare would not allow shareholders to vote separately on the proposed payments to executives.

In addition to large bonuses for facilitating, and sometimes from preventing, mergers, health plan executives who retire often do so with "golden parachutes". An

article by Robert Kazel in AMNews in August, 2004 states the following example, among others: In 1996 Aetna bought out US Healthcare. US Healthcare Chair, Leonard Abramson, was paid $2 million per year plus benefits as an advisor, $1 million dollars per year for a noncompete agreement, $10 million as a merger bonus, and an IOU for $10 million when he left the company completely. He also received a $25 million airplane as a gift and $ 2 million per year to operate it.

d. Administrative Costs Per Insured Person:

A report on Trends and Indicators in the Changing Health Care Marketplace.by the Kaiser Foundation shows a graph in Section 6 that administrative costs per insured person rose from $216 in 1998 to $421 in 2003, an increase of 95%.

Within the past 2 years, courts have found many of the largest health insurance companies responsible for unethical payment practices to physicians, and have ordered them to pay multimillion dollar penalties and payments, as well as change their practices. Insurance companies should also be held accountable for managing administrative costs, scrutinized for excessive premium increases, and held accountable for excessive pay that is passed on to the public burden. This is another important area of reducing health care spending.

4. Physician or hospital fee transparency does not influence decision-making or affect health costs, except for the uninsured or for patients going out-of-network.

"Patients need to know in advance what their options are, the quality and expertise of the doctors and hospitals and how much their procedure will cost." President Bush

Physician fee transparency does not help patients make informed decisions, nor does it do anything to control costs because insurers pay flat fees based on the current Medicare rate, no matter what the physician's stated fee is. The agreement with the insurance company is that the physician cannot bill for more than what is allowed by the insurance. That is the agreed upon rate that the physician will accept. What he or she charges does not factor into the payment by insurer or patient.

Moreover, even if it did make a difference, I doubt patients would choose their surgeon or cardiologist because he or she is the cheapest in town.

5. People are increasingly choosing to purchase HSA plans because they see the benefits.

Personal experience:

Although I care deeply about healthcare and am very committed to getting information to make good decisions, I did not get an HSA for that purpose. I bought in HSA because I could no longer afford anything else. I bought a second HSA after only 14 months because I could no longer afford the increased premiums of the first one. When people like me are forced to frequently switch plans because of unaffordable premiums, larger gaps in coverage are created. A non-cancerous lesion, that only minimally increase the chance of breast cancer, leads to complete exclusion of any breast-related disease for a lifetime. I can only imagine the out of pocket expense I will have if that were to ever come to pass.

Many people have 'bought' HSA plans because more and more employers are shifting the cost to the employee because they can no longer afford to provide health insurance. Perhaps the premiums do not rise as quickly when obtained through an employer, but as in other plans, individual purchasers are priced out of the market. When you can't afford anything else, and you don't qualify for Medicaid or Medicare, it's the only option to being uninsured. It is not really about choice, informed or otherwise.

Saving for future medical costs:

The Ways & Means Committee statement announcing this hearing states that almost half of the HSA plan purchasers have annual incomes of less than $50,000. To think that families with that level of income will, or can, put money into savings for healthcare, is not realistic. During the first two years I had my first HSA, I could not put any into the account because of what I had to pay out-of-pocket when I actually had to obtain care.

Conclusion and Recommendations:

Kenneth Thorpe, writing in the journal, *Health Affairs,* reports that based on the studies of health costs, even if every adult had an HSA or similar plan, HSAs would most likely have only a limited impact on the level and growth of health care spending.

I therefore recommend the following as starting points for more impactful areas of reform:

- Focus on prevention of obesity and lifestyle related disease that contributes to over one third of healthcare spending. These could include school and employer based programs, insurance sponsored educational and incentive programs for plan members, use of motivational programs for patients, and other initiatives.
- Improve chronic disease management and patient compliance with ongoing treatment.
- Create initiatives through professional associations to improve patient safety, including medication safety.
- Focus on meaningful insurance reform to reduce administrative and other non-care costs that would include:

a) Creating more stringent review and oversight of premium increases at the state level, particularly in the individual market. Create Public Service Boards or the equivalent that would also participate in review of premium increase proposals.

b) Reducing administrative costs for insurance. Simplifying codes and procedures would also reduce administrative time and costs for physicians and facilities.

c) Create methods of accountability for excessive rewards and executive compensation, all of which is passed on to consumers.

d) Explore alternatives to the tort system for resolution and compensation of avoidable patient injury. Health courts, no-fault approaches, apology laws, mediation with early offer, offer alternatives used by others.

e) Create standardized guidelines and award schedules for non-medical expense compensation for juries and judges to create consistency and fairness in any awards ordered.

With increased utilization by a growing aging population and by others, health costs will be difficult to control. It is a complex system with numerous factors that impact cost. However, it seems essential to me, that we address one or two areas that have the potential for the biggest impact.

Food Marketing Institute
June 28, 2006

The Honorable William M. Thomas
Chairman
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20510

Dear Chairman Thomas:

On behalf of the Food Marketing Institute (FMI)[1] and its 1,500 member companies, I would like to thank you for holding this very important hearing on the role of health savings accounts (HSAs) in transforming health care in the United States.

When President Bush signed the "Medicare Prescription Drug, Improvement and Modernization Act of 2003," it was clear that the traditional model of employer-provided insurance through an HMO or PPO was pricing people out of the market and dramatically impacting both a company's bottom line and its employees' quality of care. The creation of health savings accounts in this legislation offered businesses—particularly small businesses—a flexible and affordable new way to provide employees with health insurance.

Since their introduction, HSAs have become an important option that companies—including a number in the supermarket and grocery store industry—have employed to try and control costs without sacrificing quality of care. And with insurance premiums continuing to rise,[2] they are likely to be utilized even more often in the future.

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[1] The Food Marketing Institute (FMI) conducts programs in research, education, industry relations and public affairs on behalf of its 1,500 member companies—food retailers and wholesalers—in the United States and around the world. FMI's U.S. members operate approximately 26,000 retail food stores with a combined annual sales volume of $340 billion—three-quarters of retail food store sales in the United States. FMI's retail membership is composed of large multi-store chains, regional firms, and independent supermarkets.

[2] The Kaiser Family Foundation estimates that in 2005, the annual insurance premium for a family of four was $10,880, with the employer paying $8, 167 of this and the worker paying

Continued

While HSAs can help consumers to take control of their health care decisions by bringing to bear market forces, the regulations governing their use have not kept pace with the changing nature of the health care market.

Recommendations for HSA Reform

As part of his 2007 Budget Proposal, President Bush offered a number of reforms that would loosen current restrictions on HSAs and expand their use. Among the recommendations are:

- Increasing the limit on contributions to HSAs—President Bush would increase the contribution to a high-deductible health plan's[3] out-of-pocket maximum;
- Allowing HSAs to be portable—among other things this would allow consistent coverage while freeing plans from an arduous web of state regulations;
- Allowing participants to retroactively pay for qualified expenses incurred during a calendar year, provided that an HSA is established by the tax filing deadline—under current law, funds can only pay for expenses incurred after the health savings account is set-up.

These proposed reforms are a positive step towards making health savings accounts more attractive to consumers and more practical for businesses to offer. FMI encourages the Committee to enact legislation to put them in place. A number of these reforms are already included in H.R. 5262, legislation proposed by Rep. Eric Cantor, which we feel would be an excellent vehicle for HSA reform.

There are two additional changes that the supermarket industry believes are of such importance that we would like to draw your attention specifically to them:

1. **HDHPs should be permitted to cover the cost of prescription drugs without requiring consumers to first meet the cost of the plan's deductible.** The cost of prescription drugs accounts for a disproportionate share of many consumers' health dollar, and the fear that they will have to meet this cost out-of-pocket is one of the biggest impediments to our industry's expanding use of HSAs. While we acknowledge that adding prescription drug coverage may increase costs in the short-term, it is our belief that it will lead to cost savings and improved care in the long-run, if for no other reason than that it will encourage consumers to take the maintenance medications that can help prevent long-term complications and conditions. It is absolutely essential that this reform is implemented if we are to encourage aging and unionized workers to take advantage of consumer-driven, market-based health care.
2. **Employers should be permitted to contribute more to the HSAs of workers with chronic conditions than to the accounts of healthy employees, even over and above the current maximums.** Consumers with chronic conditions or at risk for them express a tremendous amount of anxiety when faced with a shift to HSAs. Many of them worry that they will be faced with a significant increase in out-of-pocket expenses. Allowing their employers to contribute additional amounts to their health savings account helps to ease these concerns and encourages consumers with chronic conditions to seek the help they need. The long-term costs of obesity, high blood pressure, diabetes, and a number of other chronic conditions can largely be mitigated by quality preventive care and ongoing maintenance programs. Allowing employers to contribute more to HSAs to cover the costs of these treatments, therefore, is not only sound public policy but offers the promise of long-term savings.

These two reforms—prescription drug coverage and additional HSA funding for chronic care—are absolutely essential if health savings accounts are going to gain widespread acceptance and use in our industry.

Beyond HSAs—Providing for Maximum Flexibility

Health savings accounts are clearly an important reform and a significant opportunity to empower consumers. But they are not a panacea. FMI strongly encourages the Committee to promote market-based solutions to health care reform that provide the maximum amount of flexibility to both employers and consumers. This includes

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the remaining $2, 713. This is an increase of 9.2 percent from 2004. Information available at http://www.kff.org/insurance/7315/summary/ehbs05-summary-b.cfm.

[3] Under current law, in order to open an HSA, an individual must also purchase a high-deductible health plan to accompany it. These "catastrophic plans," as their name implies, have a high deductible that must be met before coverage begins. HSAs can be used to cover this deductible, but current law limits HSA contributions to either the HDHP deductible or $2,700 for self-coverage ($5,450 for a family), whichever is less.

not only HSA reform but also promoting and expanding the use of health reimbursement accounts (HRAs) and flexible spending arrangements (FSAs).

Both HRAs and FSAs currently face regulatory restrictions that sharply limit their use, not the least of which are recordkeeping and paperwork requirements that force families to save shoeboxes of receipts and fill-out an endless series of forms. The IRS should pursue web-based technology solutions that can streamline the process and ease paperwork requirements.

FSAs are also limited by their "use it or lose it" structure. Human resource managers within our industry repeatedly cite this as the biggest impediment to greater employment of FSAs. Employees are simply too concerned with the risk of losing unused contributions at year's end to enroll in these important programs, costing them savings from using pre-tax dollars to cover medical expenses. FMI strongly supports the $500 FSA rollover included in "the Pension Protection Act" (H.R. 2830) and encourages Committee conferees to fight to keep this provision in a final conference report. We would also encourage the expansion of the $500 limit. Expanding the limit would increase savings to American families and encourage greater use of these health care vehicles.

Looking at the supermarket and grocery store industry, it is clear that one size does not fit all in terms of health care. A number of companies have shifted their employees into HSAs and have seen resulting cost savings. Many will continue to offer health plans through an HMO or PPO, if for no other reason than that union contracts lock them into this for the foreseeable future.

But changes to our current health care system need to be made that harness the forces of the free market and provide businesses and employees with as many options as possible. As indicated in this letter, there are a number of legislative vehicles and proposals that advance these reforms. We encourage the Committee to consider these bills and other proposals that have been put forward and to pass a bill that promotes genuine change.

Thank you for your consideration of FMI's comments. If you have any additional questions or concerns, please do not hesitate to contact me.

Sincerely,

John J. Motley III
Senior Vice President

Statement of Ronald Bachman, Healthcare Visions, Inc., Duluth, Georgia

Laws and regulations matter. Insurers, employers, and other health service vendors can only operate businesses within the allowed parameters set in Washington, D.C. Millions, if not billions, of dollars are poised to create products and services to address the health care cost, quality, and access problems we face as a nation.

Real change requires real change. Tinkering and tweaking the current system will not do. Transformation to a new approach is the only solution. Healthcare consumerism is the developing basis of a 21st Century Intelligent Health System. We are in the 3rd to 4th year of a dramatic transformation that began June 26, 2002 when Health Reimbursement Accounts (HRAs) were created by new Treasury guidelines. Health Savings Accounts (HSAs), part of the 2003 Medicare Modernization Act, are the fastest growing new health product designs. They offer affordable coverage by engaging employees in their own health and healthcare purchasing. Both HRAs and HSAs are a part of a broader movement to Healthcare Consumerism.

It is difficult to see the forest for the trees. Who knew when the Renaissance was starting or when Communism began to fail? It is only in retrospect that we can see major transformations. I believe the future of Healthcare Consumerism has four developing generations. Current HSA laws support the foundational 1st generation that impacts mainly discretionary expenses of office visits, emergency room use, prescription drugs and some diagnostic tests. While these costs are generated by 80% of the covered members, they represent only 20% of the costs of healthcare. If we stop at this point the transformation will stall. We must develop a system that works for and address the sickest population with chronic and persistent conditions—the 20% of the population that generate 80% of the cost.

True healthcare consumerism is about empowering the individual and creating ownership through an emphasis on personal responsibility. To allow the creative entrepreneurial market to develop the products and services behind an effective consumerism transformation, the market needs and has been crying out for the next generation of HSAs.

Many saw the initial 2003 HSA legislation as a vehicle to move away from employer-based healthcare and support a transformation to individually owned portable health insurance. That was, and is, a laudable goal. Most sales of HSAs have been to individuals and small groups. Many also now see the real value of HSAs as creating ownership that empowers employees to control their demand for services. Ownership can occur in both individually-based and employer-based policies. If a viable individual market of insurance was developed, employers could more easily move to a defined contribution funding of healthcare.

Employers have been asking for changes to expand the take-up rate of HSAs.

1. Increase HSAs to the out-of-pocket maximum of the associated High Deductible Health Plan.
2. Allow rewards and incentives for "comparable employees" for wellness and disease management program participants.
3. Allow HSA on a voluntary basis to be used only for healthcare expenses while employed.
4. Allow HSAs to be used to purchase health insurance, so that HSA accumulations can be used by early retirees and others to purchase insurance coverage.

Insurance should consist of three parts—budgeting, risk sharing, and savings. For the first time in history, healthcare has a savings element. With proper HSA flexibility, plans can use both the carrot and the stick to change behaviors. At the end of the day, behavior change is what consumerism is supporting. Without behavior change that benefits the health of the individual, the use of high deductible plan designs will only create more cost shifting.

Finally, if healthcare consumerism is truly transformational it must address our country's most difficult health problems. It must work for the sickest among us, there must be a consumer-centric Medicaid, a Consumer-centric Medicare, and a form of healthcare consumerism that addresses the uninsureds.

Two current bills in the House of Representatives are critical to the development of the next generation of HSAs and healthcare consumerism. The Cantor Bill (HR 5262) and the Shadegg Bill are the next steps needed for creating the 21st Century Intelligent Health System. These bills will support healthcare ownership and the expansion of HSAs to a wider population.

Every system is perfectly designed for the outcomes achieved. If you want a market-based solution to healthcare, and not a national universal insurance system, it is imperative that Congress continue what it started with the initial HSA legislation. It would be a shame to get this close to real change and be too timid to take the next step. For those who may want to wait for more evidence of success of HSAs, someone once said, "It is never too early to do the right thing."

In conclusion, Congress can not control the budget deficits without addressing healthcare. HSAs have proven themselves to lower trends and the cost of healthcare. By lower just the increases in healthcare by 2 percent, the federal government would increase revenue and lower health related expenditures by 10's of billions of dollars each year. The time for action is now. This is why we elect members of Congress—to make REAL CHANGE.

Ronald E. Bachman FSA, MAAA is a Senior Fellow at the Center for Health Transformation, an organization founded by former U.S. House Speaker Newt Gingrich. Nothing written here is to be construed as necessarily reflecting the views of the Center for Health Transformation or as an attempt to aid or hinder the passage of any bill before the U.S. Congress.

International Health, Racquet & Sportsclub Association
Boston, Massachusetts 02210
July 10, 2006

The Honorable Bill Thomas, Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The International Health, Racquet & Sportsclub Association (IHRSA) would like to thank you for the opportunity to submit this written testimony as part of the Committee's hearing on Health Savings Accounts (HSAs). IHRSA is the leading trade association representing the private health and fitness industry, with over 7,000 members in 74 countries. Our members are committed to policy initiatives

aimed at promoting exercise, preventing disease and improving the health of all Americans, hence our interest in HSAs.

HSAs are becoming an increasingly important part of the American healthcare landscape and consumers who have access to these accounts can currently pay for prescription drugs, doctors' visits and other medical treatments with pre-tax dollars. This tax benefit helps ease the financial burden when Americans pay for medical treatment once they are sick. However, current law offers no tax benefit to help individuals and families take steps to prevent illness in the first place.

IHRSA strongly believes that the current HSA system should be expanded to provide for more disease prevention by allowing expenses for exercise programs and related equipment to be payable out of HSA monies. Fortunately, legislation (H.R. 5479) is currently under consideration in the House which would do just that.

Introduced by Ways and Means Committee member Jerry Weller (R–IL), the so-called Personal Health Investment Today (PHIT) initiative will allow fitness center dues, payments for some exercise equipment and other fees associated with programs of physical activity to be paid out of HSAs and other pre-tax medical savings vehicles.

If enacted, PHIT would give parents the opportunity to pay for their children's soccer league fees out of their HSAs. They could join a fitness center and pay for the membership fees with pretax dollars or they could purchase a home gym to help them fight the onset of obesity, a primary risk factor for developing any one of several chronic diseases which are currently fueling the frightening increase in our national healthcare expenditure.

Depending upon a consumer's individual income tax bracket, the PHIT initiative could help Americans save 25–30 percent on their exercise costs. Health experts agree that regular physical activity substantially reduces the risk and symptoms of numerous diseases and medical conditions and is associated with fewer hospitalizations, physicians' visits, and medications, resulting in lower healthcare costs. The PHIT tax incentive represents an important step to induce more people to get the levels of exercise they need to improve their level of fitness and help lower healthcare costs for all Americans.

The Department of Health and Human Services predicts that spending on healthcare will consume 20 percent of the nation's gross domestic product by 2015 if current trends hold true. At this rate of growth, America is on track to spend roughly $4 trillion on healthcare within the next ten years. This level of spending for medical treatment is unsustainable and can only be curbed through efforts to prevent disease before treatment is necessary.

During the hearing on June 26, some concern was expressed that many of the existing HSA arrangements offer little in the way of disease prevention due to varying levels of coverage offered by the high deductible health insurance plans tied to the accounts. By enacting PHIT, the Congress has the opportunity to address this issue independent of the insurance plans associated with the respective HSAs—a win-win for all concerned.

Given the healthcare crisis we are facing in this country today, IHRSA and its members strongly believe that creative solutions are necessary to improve the nation's fitness levels. As the Ways and Means Committee considers future adjustments to the HSA system, we urge you to support legislation like the PHIT initiative, which would make expenses for exercise payable with pretax dollars.

IHRSA and its members stand ready to help advance these kinds of initiatives aimed at improving the health of all Americans. Please let us know how we can work together to achieve this critical objective.

Sincerely,

Helen Durkin
Director of Public Policy

Statement of National Association of Chain Drug Stores, Alexandria, Virginia

Chairman Thomas and Members of the House Ways and Means Committee:

The National Association of Chain Drug Stores and its members support legislation which incorporates elements of the Bush Administration's Comprehensive Agenda for Affordable and Accessible Health Care designed to expand the use of health savings accounts (HSAs). We agree with President Bush that HSAs help to make health care coverage more affordable, while providing greater choices and flexibility for workers and their employers. We believe it is crucial to the health of

this country's workers that the expansion of HSA use be strongly encouraged by the government.

However, we urge that any HSA legislation enacted include a provision requiring that all prescription and non-prescription drugs be covered under the safe harbor for qualifying HSA-linked high-deductible health insurance policies. Currently, the IRS allows a safe harbor for prescription drugs covered during the policy deductible only if those drugs are used to *prevent* illness. This permits—for example—coverage of statins such as Lipitor, prescribed to treat high cholesterol and prevent heart disease. However, medications prescribed for an existing illness, injury, or condition that could be aggravated by non-treatment and neglect are not covered under the safe harbor. This is a short-sighted policy that should be corrected. Policies should be permitted to cover all drugs—prescribed and over-the-counter—during the deductible, without disqualification.

Otherwise, we particularly endorse the elements of President Bush's proposal that would expand the advantageous tax treatment of employer and employee contributions to HSAs, to cover all of an employee's out-of-pocket expenses, up to the maximum out-of-pocket spending limit specified under the HSA-linked high deductible health policy.[1] We also support provisions that would: (1) allow individual taxpayers a tax deduction for high deductible health plan premiums, a tax credit for employment taxes related to the payment of premiums, and a refundable tax credit for coverage costs under a high deductible policy: (2) permit payment of high deductible health plan premiums from HSAs; and (3) permit employers to make greater contributions to HSAs for employees with greater medical expenses.

Thank you for your time and your consideration of our concerns.

Statement of John C. Goodman, National Center for Policy Analysis

Making HSAs Better

Mr. Chairman and members of the Committee, even though Health Savings Accounts (HSAs) are having an enormously beneficial effect on the design of health insurance in this country by allowing more than one million people to manage some of their own health care dollars and partly self-insure through these account, they can be made even better. On behalf of the National Center for Policy Analysis, a leader in promoting private alternatives to government regulation and control, I offer several proposals to improve HSAs.

Making Incentives Better. Not all medical services are the same. Patients *can* exercise discretion for many of their health care needs, and it is *appropriate* for them to do so. Take arthritic pain relief. The annual cost of brand-name drugs is typically $800 more than over-the-counter substitutes and they are riskier. (Vioxx and Betra, 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 people differently, none of us can determine for another individual whether the tradeoff between cost and pain relief is worthwhile. So it is appropriate and desirable for people to make these decisions themselves, and reap the benefits and bear the costs of their decisions.

By contrast, a semiconscious patient on a gurney is not in a position to make choices about alternative treatments. Even if he could, discretion in this setting is typically *inappropriate*. Or consider the case of a diagnosed schizophrenic. He may choose to stop taking his prescribed medication, but it's in our self-interest to make sure he is not encouraged to do so.

Unfortunately, the HSA law treats all these cases the same. It requires a high, across-the-board deductible and requires the patient to bear the costs of purchases below the deductible amount. A better approach would allow insurers to design their plans so that different deductibles (and copayments) apply to different medical services. Where patient discretion is possible and appropriate, the deductible should be high. Where patient discretion is more difficult, and in any event inappropriate, the deductible should be low or nonexistent.

Creating Opportunities for the Chronically Ill. 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,

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[1] Under current law, the favorable tax treatment for annual contributions is limited to the lesser of the amount of the policy deductible or $2,700 for an individual or $5,450 for a family. This proposed change would increase the limit on favorable treatment of contributions to $5,250 for individual coverage and $10,500 for family coverage.

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 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.

Letting Markets Work. The current HSA law's primary problem is that decisions the market should make have been made by the tax-writing committees of the U.S. Congress instead.

What is the appropriate deductible for which service? How much should be deposited in the HSAs of different employees? How can we use these accounts to meet the needs of the chronically ill? In finding answers, markets are smarter than any one of us because they benefit from the best thinking of everyone. Further, as medical science and technology advance, the best answer today may not be the best answer tomorrow.

Case Study: South Africa. HSAs (called Medical Savings Accounts) emerged in the 1990s in Nelson Mandela's South Africa and have now captured more than half the market for private health insurance there. Since the South African government never passed a law dictating an HSA design, their plans developed in a relatively free market. The South African "free market HSAs" are different, and in some ways more attractive, than what we have in this country. For example, one of the most popular plans there offers first-dollar insurance coverage for most hospital procedures—on the theory that hospitalized patients have little opportunity to make choices, and discretion is not appropriate in that setting in any event. A high deductible applies to "discretionary" expenses, however, including most services delivered in doctors' offices.

South Africa's more flexible approach also allows more sensible drug coverage. While a high deductible applies to most drugs, a typical plan pays from the first dollar for drugs that treat diabetes, asthma and other chronic conditions. The reason is obvious: It would be counter-productive to encourage patients to skimp on drugs that prevent more expensive-to-treat conditions from developing.

Conclusion

Ideal reform in this country would allow unlimited contributions to HSAs and permit such accounts to wrap around third-party insurance—paying for any expense the insurance plan does not pay. Barring that, we should at least allow flexible deductibles and risk-rated deposits to HSAs.

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