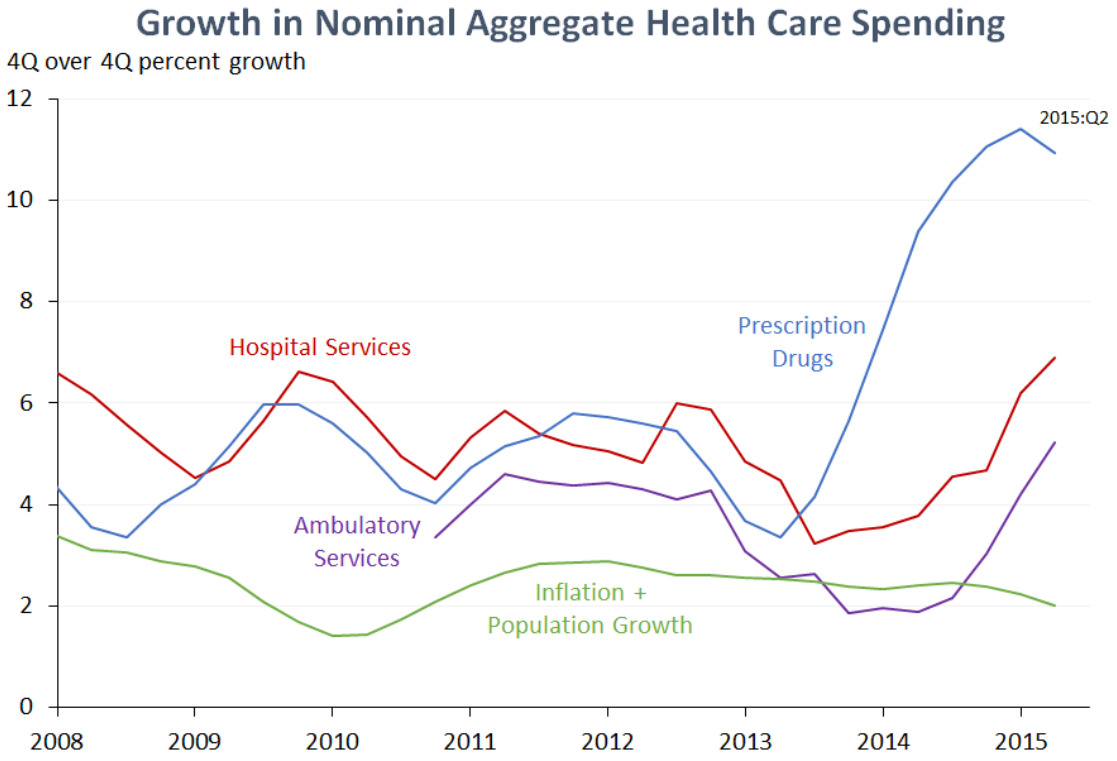
A Hearing of the Joint Economic Committee of the U.S. Congress
"The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve"
June 7, 2018

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

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

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



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

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

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

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

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

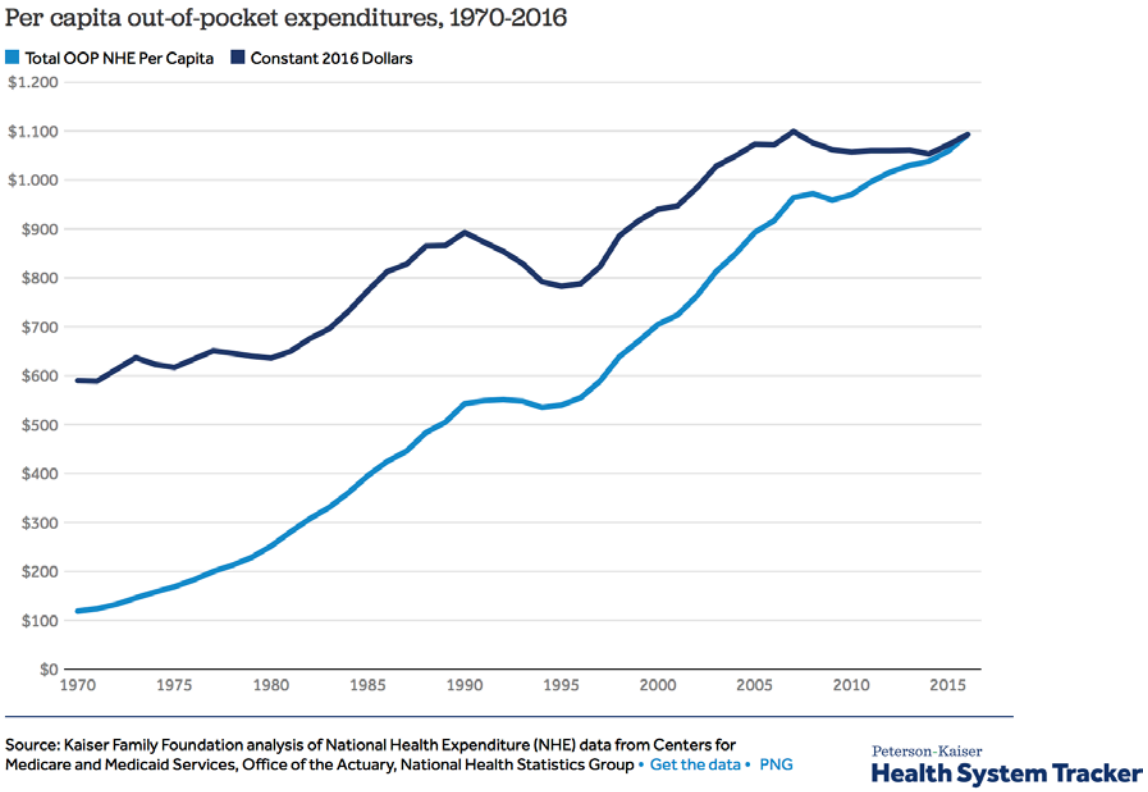
Cost Type	Amount
Inpatient	$19,347
Outpatient	$80
Professional Services	$4,092
Prescription Cost	$718
Potentially Avoidable Complications	$373
Total	$24,611

Source: Wearethecost.org

Costs of Care: Additional Drivers

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

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



Resource Utilization: The Care We Receive

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

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

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

Improvements to Current HSAs

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

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

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

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

Conclusion

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

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

Factors Affecting Utilization	Policy Intervention	Relevance of HSAs

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

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

---

[i] Brook, Robert H., Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Patricia Camp, Caren Kamberg, Arleen Leibowitz, Joan Keesey, and David Reboussin, *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, Santa Monica, Calif.: RAND Corporation, RB-9174-HHS, 2006. As of June 05, 2018: https://www.rand.org/pubs/research_briefs/RB9174.html

[ii] Agency for Healthcare Research and Quality (AHRQ) Statistical Brief #497. "Concentration of Health Expenditure in the U.S Civilian Noninstitutionalized Population, 2014." November 2016. https://meps.ahrq.gov/data_files/publications/st497/stat497.pdf

[iii] Center for Value-Based Insurance Design, University of Michigan. "Health Savings Account-Eligible High Deductible Health Plans: Updating the Definition of Prevention." May 2014. http://vbidcenter.org/wp-content/uploads/2014/07/HDHP-white-paper_final.pdf

[iv] America's Health Insurance Plans (AHIP). "2016 Survey of Health Savings Account – High Deductible Health Plans." February 2017. https://www.ahip.org/wp-content/uploads/2017/02/2016_HSASurvey_Draft_2.14.17.pdf

[v] Center for Value-Based Insurance Design, University of Michigan. "Increasing Flexibility to Expand Safe Harbor Coverage in HAS-HDHPs." http://vbidcenter.org/wp-content/uploads/2016/07/HSA-HDHP-Infographic-updated-2-8-18.pdf