JOINT ECONOMIC COMMITTEE
CHAIRMAN ERIK PAULSEN (R-MN)

REPUBLICAN STAFF STUDY

The Potential for Health Care Savings: Can Health Savings Accounts (HSAs) Bend the Cost Curve?

December 13, 2018

INTRODUCTION

Since World War II, well-meaning government policies have had the unintended consequence of contributing to medical care cost growth. Over these seven decades, more Americans became insured and insurance policies expanded coverage to include more services. However, consumers were shielded from actual prices with third-party payment increasingly replacing out-of-pocket payment, and providers encountered diminished market pressure to contain costs. Today, spending on health care amounts to one-sixth of the economy—more than in all other developed countries—and many Americans may be unaware of the full financial burden on their household budget as costs are spread across taxes, insurance premiums, and lower wages.

Government regulation, taxes, and subsidies distort markets, often causing inefficient consumer and provider behavior. America's health care industry is especially subject to inefficiencies because of decades of mounting government programs and policies, which led to higher prices and growing dissatisfaction for medical care delivery.[1]

Health savings accounts (HSAs) combined with high-deductible health plans increase price transparency and may help to reduce costs by harnessing proven economic incentives that make consumers more price conscious and providers more cost conscious. Slowing the growth of health care costs has eluded policymakers for decades, but a growing body of evidence indicates that HSAs might finally be offering some relief to hard-working Americans.

Expert witnesses at the Committee's June 2018 hearing, *The Potential for Health Savings Accounts to Engage Patients and Bend the Health Care Cost Curve,* testified that HSAs are lowering costs and saving consumers money; and that expanding access will allow more Americans to realize the benefits while accelerating overall health care cost containment.

Key Findings:

- ***Since WWII, federal health policy has focused on increasing access and coverage but not cost containment.***
- ***Health care costs are not reflected in the prices consumers pay.***
- ***Artificially low out-of-pocket expenses diminish comparison shopping and competition among providers.***
- ***HSAs allow consumers to manage their own health care dollars and motivate them to demand price transparency and seek the best value.***
- ***Expanding HSA enrollment will further competition among providers and improve industry performance to the benefit of all health care service consumers.***

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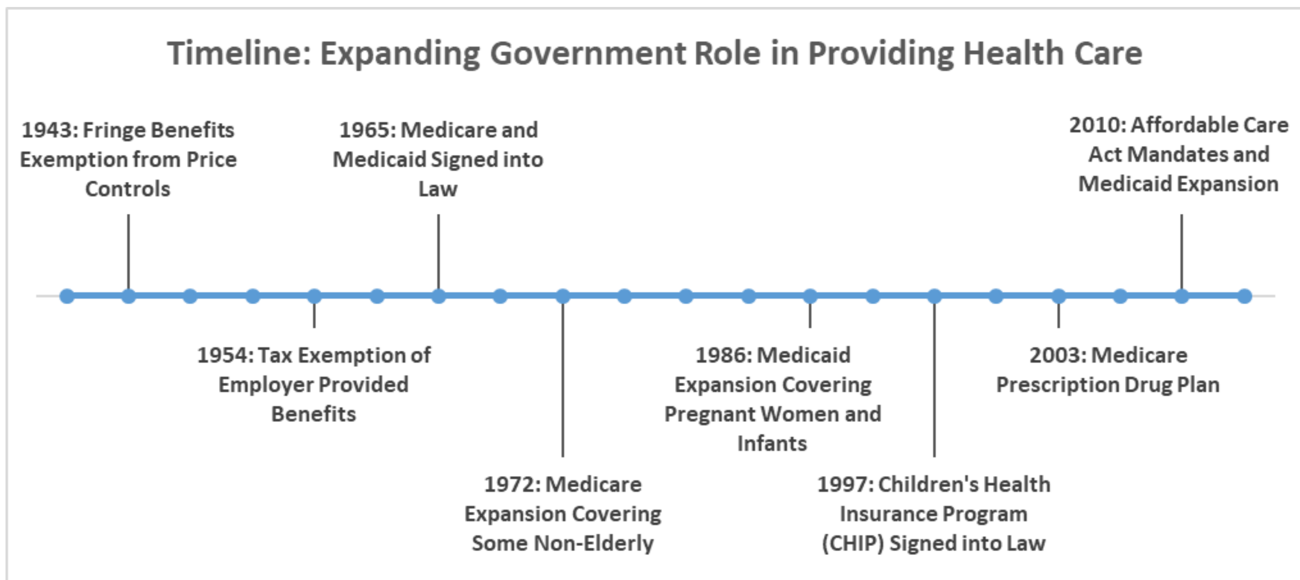
[1] Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler. *Healthy, Wealthy, and Wise: 5 Steps to a Better Health Care System,* Hoover Institution Press, 2013, p. 2; and Friedman, Milton, "How to Cure Health Care," Hoover Institution, Hoover Digest, July 30, 2001. https://www.hoover.org/research/how-cure-health-care-0

Figure 1



GOVERNMENT INFLUENCE ON AMERICAN HEALTH CARE

Consumption of health care.

Over the past century, there have been three periods of major government-induced changes to America's health care industry, as well as several smaller yet still significant events (Figure 1). The dominant periods are:

1) 1943: Exemption of fringe benefits from WWII-era wage controls;
2) 1965: Creation of Medicare and Medicaid; and
3) 2010: Patient Protection and Affordable Care Act (ACA or Obamacare).

WWII government wage controls allowed employers to provide health insurance to attract and retain scarce labor.

First, WWII wage and price controls were implemented during a labor shortage—America's labor force was largely redirected toward manufacturing military equipment and troop buildup. To attract and retain scarce labor, many employers offered private health insurance and other fringe benefits as part of their compensation package. In 1943, the War Labor Board ruled that controls over wages and prices imposed by the 1942 Stabilization Act did not apply to fringe benefits, which included health insurance; and in 1954, Congress clarified an earlier court ruling by adding to the tax code a provision (now section 106 of the Internal Revenue Code) excluding employer-provided health benefits from employees' gross income, effectively exempting those benefits from workers' income and payroll taxes.[2]

The tax exclusion for employer-provided health insurance does not extend to non-employer provided health insurance. Only a portion of out-of-pocket

[2]Buchmueller, Thomas C. and Alan C. Monheit, "Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform," NBER Working Paper 14839. http://www.nber.org/papers/w14839

medical expenses and health insurance premiums are tax deductible, and still, many workers fail to qualify.[3] Consequently, federal tax treatment encourages firms to provide and employees to choose employer-provided health insurance policies that cover a wide range of expenditures, which is made more attractive with relatively low copayments and deductibles. Today, 181 million of 217 million privately insured Americans are covered by employer-provided plans.[4]

Second, President Johnson permanently expanded government's role in providing health care by signing into law Medicare and Medicaid, which generally provide government health insurance for older and low-income Americans. These programs were introduced for good purposes and have helped millions of Americans, but their design—which increased consumption of sometimes unnecessary or inefficient care—has also distanced spending decisions from actual costs. Since providers are often reimbursed according to the volume of services they provide, the system can sometimes reward cost over quality. Costs and prices can rise without facing the usual reduction in demand, fueling health care inflation.

While millions of Americans have benefitted from Medicare and Medicaid, their design distanced spending from costs fueling health care cost inflation.

Since inception, both programs have expanded, covering more people and services (see Figure 1).[5] Medicare expanded in 1972 to cover Americans under age 65 with long-term disabilities or end-stage renal disease, and in 2003, a prescription drug benefit (Medicare Part D) was added. Medicaid had originally insured only those receiving cash assistance. However, in 1986, coverage extended to pregnant women and infants, and later expanded to children up to age 18 with incomes under the federal poverty level. In 1997, the Children's Health Insurance Program (CHIP) was added providing health insurance to children in families with income exceeding Medicaid eligibility but unable to afford insurance. While all these groups are deserving of care, the design of these programs has not always served them well with delivering quality care at an affordable cost.

Obamacare mandated:

- ***Nearly all Americans to buy certain health insurance;***
- ***A requirement that all policies offer "essential health benefits;" and***
- ***A ban on insurers offering discounted premiums for healthy Americans, causing premiums to rise.***

Third, and more recent, ACA required nearly all Americans to enroll in a government-approved health-insurance program or face a financial penalty (the *Tax Cuts and Jobs Act* zeroed out the penalty beginning 2019). It expanded Medicaid eligibility, created premium subsidies, and added a new government-run marketplace where Americans without employer- or government-based insurance can buy health insurance (healthcare.gov or state-run exchanges). Additionally, it set a minimum level of coverage, known as "essential health benefits," and required insurance companies to charge identical premiums in a

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[3] To deduct out-of-pocket expenses taxpayers must itemize their tax deductions and then only expenses exceeding a floor—calculated as a percent of a taxpayer's adjusted gross income (AGI)—are deductible. In 1964, a ceiling on the deduction was removed but the floor remained; and over the years the floor has been adjusted. Most recently, the Affordable Care Act increased the floor from 7.5 to 10 percent of AGI (increasing taxes), and the *Tax Cuts and Jobs Act* reduced it back to 7.5 percent of AGI (decreasing taxes) for 2017 and 2018.

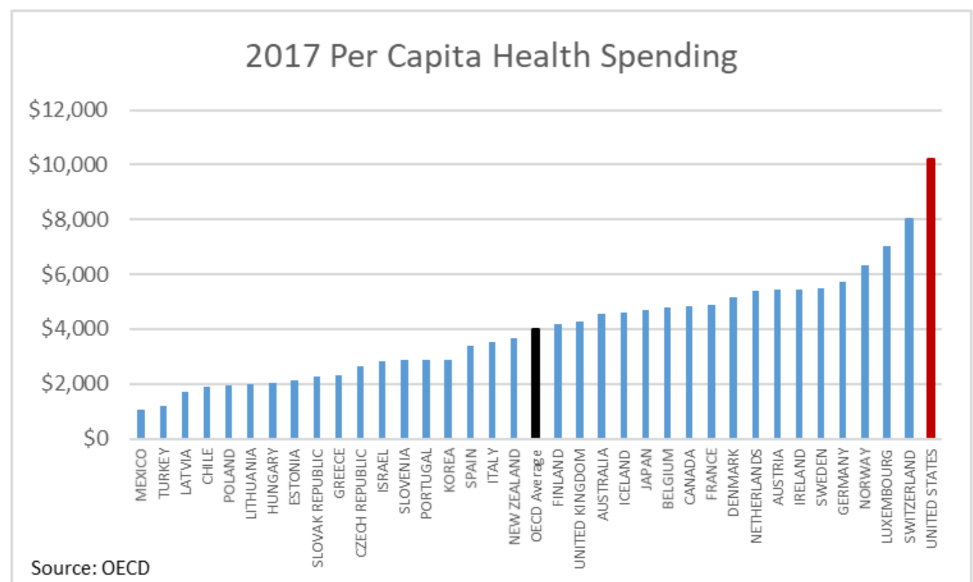
[4] United States Census Bureau, Health Insurance Historical Tables HIC-4. https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html

[5] Cogan, John F., *The High Cost of Good Intensions: A History of U.S. Federal Entitlement Programs*, Stanford University Press, 2017, pp. 375-384.

geographic region regardless of health.[6] A state's geographic area is defined by counties, three-digit zip codes, or urban-rural divide.[7] The mandated high level of benefits, along with denying insurers the ability to offer discounts to healthy Americans, drastically increased health insurance premiums. This, in turn, discouraged younger and healthier consumers from enrolling in insurance, leaving older and costlier enrollees in the insurance pool and further driving up premiums. In recent years, the Joint Economic Committee Republicans have highlighted many inefficiencies and the unfairness of this poorly designed law.[8]

Americans spend more on health care than any other OECD country.

Figure 2



All of these programs and policies have encouraged health care spending growth. From 1970-2017, health care spending increased from 6.2 to 17.2 percent of GDP; today America has the highest rate of all 35 developed countries in the Organization for Economic Cooperation and Development (OECD) countries. The second-highest country is Switzerland at 12.2 percent. On a per-person basis, American spending is 25 percent higher than the second-highest country and 2.5 times greater than the OECD average (Figure 2).[9] America's aging population does not explain the high level of health care spending, since the United States has a lower percentage of the population over age 65 than many other OECD countries.[10]

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[6] Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler. *Healthy, Wealthy, and Wise: 5 Steps to a Better Health Care System*, Hoover Institution Press, 2013, pp. 25-30.

[7] Public Health Service Act § 2701(a)(1)(A)(ii) (codified at 42 U.S.C. § 300gg(a)(1)(A)(ii)); 45 C.F.R. § 147.102(a)(1) (ii) & (b), pp. 686-687. https://www.gpo.gov/fdsys/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec147-102.pdf

[8] See Joint Economic Committee Republicans' webpage and filter by "health" issues. https://www.jec.senate.gov/public/index.cfm/republicans/analysis

[9] OECD (2018), Health spending (US dollar/capita) https://data.oecd.org/healthres/health-spending.htm (Accessed on 3 December 2018).

[10] Papanicolas, Irene, Liana R. Woskie, and Ashish K. Jha. "Health care spending in the United States and other high-income countries." *JAMA* 319.10 (2018): 1024-1039.

Cost vs. quality of health care.

Over time, America's major health care policies have focused primarily on increasing access to health insurance with little emphasis on cost containment. By ignoring economic fundamentals such as the law of demand—generally, product demand rises as price falls—and cost-benefit analysis, policies have fueled rising costs. If policies focused more on lowering costs, Americans would have more disposable income and better health outcomes. Hoover Institution's Dr. Scott Atlas explained to the Committee that:

> *The critical concept here is that reducing the cost of medical care itself is the most effective pathway to broader access to quality care and lower insurance premiums, and ultimately of course better health.*[11]

The unchecked rise in health care spending may be partly due to cost diffusion—the dissemination of health care costs. Americans pay for health care through the federal payroll tax (Medicare hospital services), other federal taxes (parts of Medicare, Medicaid, insurance subsidies in the ACA insurance exchanges, the Veterans Administration, etc.), and state taxes (Medicaid). Insurance premiums may be withheld from workers' paychecks or, for non-employer plans, paid directly to insurance companies. And while there is some degree of transparency in the aforementioned sources, lower wages and salaries are the hidden tradeoffs of employer taxes and health care spending.[12] Stated clearly in a 2013 *Social Security Bulletin*, "Workers bear most of the burden of employer health insurance contributions through lower money wages…"[13]

Lower wages is the hidden tradeoff of employer-provided health insurance.

INEFFICIENT AND UNIQUE HEALTH INSURANCE SYSTEM

Health insurance and health care are very expensive for many reasons. Among them are first, third-party payment with relatively low copayments and deductibles lowers consumers' incremental cost and removes their access to price information, leading to overuse. Second, provider pricing is not disciplined by competition and customer comparison shopping. Third, employer-provided health insurance covers a wide range of services for which competition and comparison shopping are suspended.

[11] Testimony of Hoover Institution's Dr. Scott Atlas at the Joint Economic Committee's June 7, 2018 hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033

[12] Economic neoclassical theory states that firms will pay workers in combined wages and benefits no more than their marginal revenue product—the additional revenue generated by employing a worker. As employer benefit costs, such as taxes and health care spending, rise, money wages will fall.

[13] Burtless, Gary and Sveta Milusheva, "Effects of Employer-Sponsored Health Insurance Costs on Social Security Taxable Wages," Social Security Bulletin, Vol. 73, No. 1, 2013. https://www.ssa.gov/policy/docs/ssb/v73n1/v73n1p83.html

Relatively low copayments and deductibles cause overuse and higher costs.

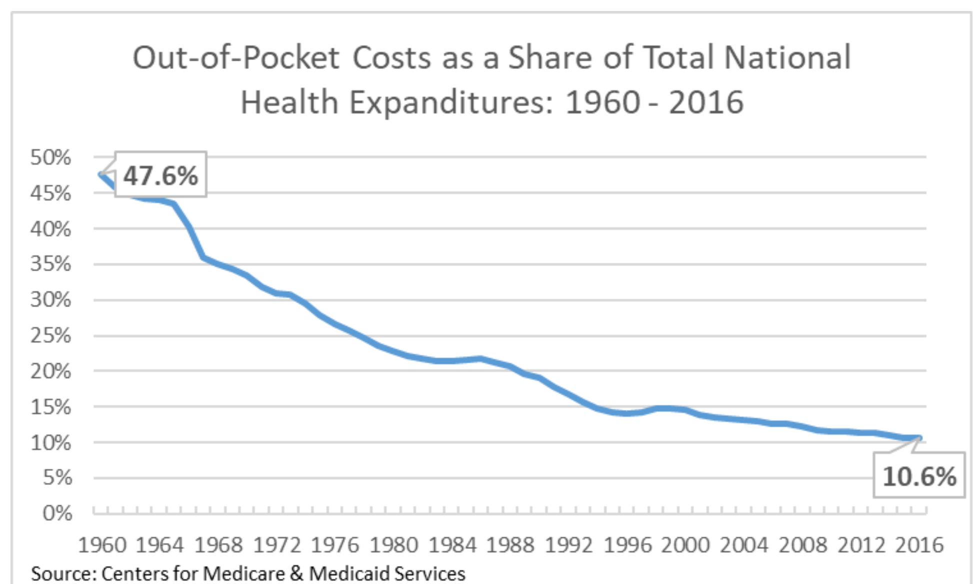
Third-party payments combined with low copayments and deductibles eliminates price transparency.

Consumers consider incremental cost and benefit before every purchase; if benefit exceeds cost—product price—consumers will make a purchase; otherwise, they forgo the product. For medical care, consumers rarely know or pay actual health care prices. Consumers typically pay low copayments or deductibles, and the balance is paid directly to the provider by third-party insurance companies or through government agencies. In other words, there is no price transparency before or at the time of the service nor price comparison shopping.

Accordingly, the benefit from physicians' office visits, for example, will almost always exceed the copayment even for minor issues, and consumers may not consider lower-cost alternatives (e.g., getting a flu shot at a pharmacy as opposed to a doctor's office). While individual consumers have faced increases in their own out-of-pocket costs in recent years, the long-term trend is that third-party payers have become increasingly responsible for health expenditures. In 2016, out-of-pocket payments as a share of total health care spending was 10.6 percent, down substantially from 47.6 percent in 1960 (Figure 3).[14] Price—the market mechanism for rationing scarce resources—has been largely removed from the decision-making process, resulting in health care overuse.

Declining share of out-of-pocket costs leads to overuse of health care services with little improvement in health outcomes.

Figure 3



HSA critics have argued that high-deductible plans discourage use, increasing health care risks; however, this assertion is not supported by evidence.[15]

[14] National Health Expenditures by Type of Service and Source of Funds: 1960 to 2016, Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[15] Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler. *Healthy, Wealthy, and Wise: 5 Steps to a Better Health Care System*, Hoover Institution Press, 2013, p. 36.

Testifying on behalf of the American Benefits Council and Mercer, Ms. Watts explained that a recent study of 26,000 individuals shows HSA users had better health outcomes than those covered by a traditional preferred provider organization (PPO).

> *[W]e matched 13,000 individuals in the PPO with 13,000 enrollees in the HSA-eligible option who shared the same demographic and risk profiles at the start of the 3-year comparative period.*
>
> *[T]he HSA-eligible plan participants maintained their health status, while those in the PPO plan saw [on average] an 8% increase in identified health risks. This fact alone would seem to suggest that the HSA-eligible plan may have been more effective at helping participants mitigate the exacerbation of existing, or onset of new, medical conditions or health risks.*[16]

Evidence shows that HSA participants are better at maintaining their health than those in a PPO.

Little incentive or opportunity for consumers to seek discounts or providers to cut costs.

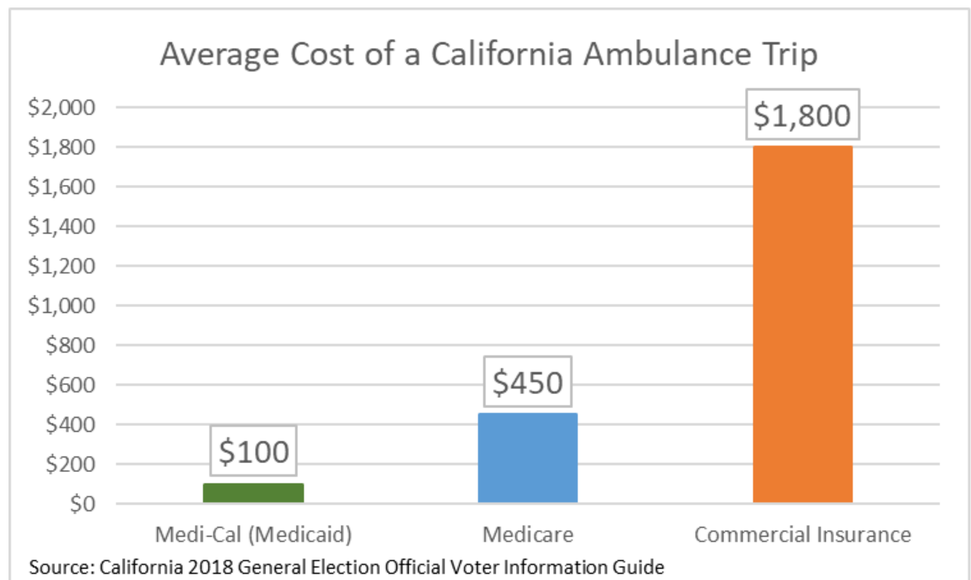
Consumers facing similar products offered by different producers will generally choose the lowest-price provider. For health care services, consumers often pay the same copayment to all providers in a class regardless of price differences. Thus, consumers have no incentive to seek out the best prices, and providers may even have an incentive to set higher prices outside their negotiation with insurance companies for benchmarking purposes.

In some instances, governments award firms exclusive multiyear contracts, eliminating most competition for the contract period. Consider California's emergency transportation ambulance system for 911 calls. Firms submit bids (payment to the county) for the exclusive right to respond to emergency calls in a geographic zone. Competing bidders receive reimbursements for patients covered by Medicare and Medicaid (Medi-Cal in California) that are generally below their costs but are free to charge commercial insurance providers much higher prices (Figure 4).[17] The lack of competition combined with below-cost reimbursements by government insurance means that private insurers will encounter artificially high costs with little opportunity for the insurer, much less the consumer, to negotiate a lower price.

[16] Testimony of Tracy Watts on Behalf of the American Benefits Council and Mercer at the Joint Economic Committee's June 7, 2018 hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033

[17] California 2018 General Election Official Voter Information Guide, p. 62-63. https://vig.cdn.sos.ca.gov/2018/general/pdf/complete-vig.pdf

Figure 4



The absence of market forces in large swaths of health care removes consumers' opportunities and producers' incentives to restrain cost growth.

Health insurance covers both rare and routine expenses.

The insurance concept is to pool risk. That is, with enough customers, insurers collect sufficient funds (premiums) to cover large irregular individual claim payments. Premiums are based on the total expected payout, which is a function of the amount insured and the probability of occurrence. By insuring only rare events, the probability of payment is lower, and accordingly, premiums are lower.

Covering rare costly events, as well as routine health care spending, drives up premiums.

Insurance policies for businesses, homes, and automobiles, for instance, are designed to cover expensive, rare, and randomly occurring events; they do not cover routine expected costs. For example, auto insurance covers damage from accidents and theft, but not routine car maintenance and repairs. Health "insurance," on the other hand, is unique and commonly covers both rare events (e.g., unexpected major surgeries and extended hospital stays) as well as routine expenses such as annual checkups and frequently occurring minor illnesses and injuries. Consequently, health insurance policies cover many services, paying administratively set prices, which policyholders could otherwise purchase directly from competing vendors at market-determined prices. Premiums go up because they cover more than rare events and price competition ceases.

Milton Friedman on health care.

Nobel laureate Economist Milton Friedman and his wife Rose Friedman explained in their book *Free to Choose: A Personal Statement* how spending efficiency—in which spenders economize and seek the highest value—is

maximized only when consumers spend their own money on themselves.[18] Their perspective on America's welfare programs makes clear why third-party government- and private-insurance payment leads to inefficiencies.

Table 1

Whose Money	**On Whom Spent** You	 Someone Else
Yours	**I** -Strong incentive to economize -Strong incentive to maximize value	**II** -Strong incentive to economize -Doesn't maximize value
Someone Else's	**III** -Doesn't Economize -Strong incentive to maximize value	**IV** -Doesn't economize -Doesn't maximize value

When consumers spend their own money on themselves they economize and seek maximum value. Third-party spending, which dominates America's health care, does neither.

Friedman's four-quadrant table illustrates efficiency maximization as box I—a situation in which consumers are spending their own money on themselves. When spenders purchase items with their own money for someone else (box II) they will economize but fail to choose an item that maximizes the recipient's values (e.g., a gift the recipient didn't want); when spenders purchase items for themselves with someone else's money (box III) they will maximize value but not economize (e.g., business expense account); and the most inefficient scenario is when someone spends someone else's money on another person (box IV), the spender fails to economize or maximize value (e.g., third-party health care spending).

More than two decades later, America's health care system had changed little; in 2001, Friedman wrote the following:

> *Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party…The second is that nobody spends somebody else's money as wisely or as frugally as he spends his own.*[19]

In 2018, nearly twenty years after Friedman's 2001 observations, America's health care industry remains fundamentally unaltered, except for health savings accounts. HSAs and high-deductible health plans empower consumers to make

[18] Milton and Rose Friedman, *Free to Choose: A Personal Statement*, Harcourt Inc. 1980. The book was turned into a PBS mini-series.
[19] Friedman, Milton, "How to Cure Health Care," Hoover Institution, Hoover Digest, July 30, 2001. https://www.hoover.org/research/how-cure-health-care-0

health care decisions using their own money, moving more spending from box IV to box I; and while not a panacea for rising spending, they potentially can reduce health care costs.

HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE PLANS

Health savings accounts are tax-exempt trusts created as part of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* that are used to pay or reimburse certain medical expenses such as doctor visits and prescriptions.[20] HSA eligibility requirements are:

Health savings accounts offer tax benefits and motivate consumers and producers to pursue cost-savings.

1. You are covered by a high-deductible health plan (HDHP) on the first day of the month;
2. You have no other health coverage;
3. You are not enrolled in Medicare; and
4. You can't be claimed as a dependent on someone else's tax return.

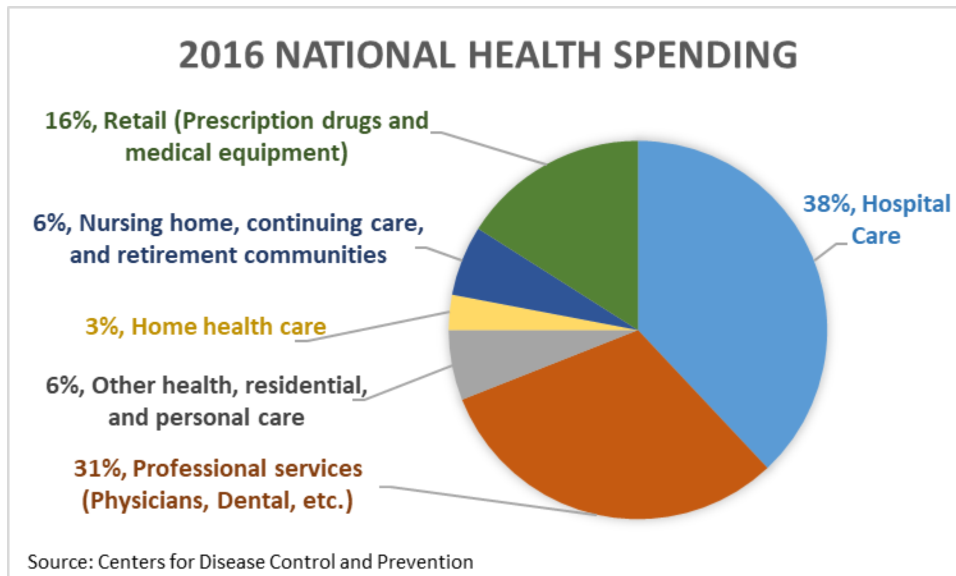
The 2018 minimum deductibles are $1,350 for an individual and $2,700 for a family (there are exceptions for preventive care); the out-of-pocket maximum is $6,650 for an individual and $13,300 for a family; and contributions cannot exceed $3,450 for an individual and $6,900 a family (these amounts are indexed each year for inflation). Amounts an employer contributes to an HSA are not considered part of the employee's gross income for purposes of income and payroll taxes. Additionally, individuals can deduct from income taxes the amount they or someone other than their employer contributes to their HSA. All withdrawals from the account for qualified medical expenses are tax free. An HSA can be set up at a bank, insurance company, or IRS-approved trustee for an individual retirement account (IRA) or Archer medical savings account. Unused funds roll over from year to year, and the earnings on amounts invested in HSAs are also tax-free; consequently, the funds are never subject to income tax when used for approved health care expenses. The accounts are portable—they follow the consumers even if they change employers or leave the workforce.[21] And, after age 64, HSA funds—both deposits and investment returns—can be used for retirement income; withdrawals would be subject to income tax but not the 20 percent penalty that would normally apply to withdrawals for non-medical purposes.

Paying for more health care out-of-pocket makes consumers more price-conscious. HSAs motivate consumers to manage their account balance while considering future health care needs and retirement. The desire to protect savings in HSAs creates a strong incentive for consumers to seek value by shopping around, encouraging providers to keep prices competitive and

[20] "MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003," Government Publishing Office, P.L. 108-173, Section 1201. https://www.gpo.gov/fdsys/pkg/PLAW-108publ173/html/PLAW-108publ173.htm
[21] "Health Savings Accounts and Other Tax-Favored Health Plans," Internal Revenue Service, March 2018. https://www.irs.gov/publications/p969

transparent. The cost of LASIK corrective eye surgery fell dramatically, for example, because customers paid out-of-pocket, forcing providers to compete on price.

Figure 5



Consumers can value shop for many health care products and services.

While some may argue that there are situations where unexpected medical needs prevent consumers from price shopping (e.g., an emergency room visit), Hoover Institution's Dr. Scott Atlas testified that most non-elderly health care spending—60 percent of private-insurance payments and 60 percent of Medicaid payments—is for outpatient care, and consumers are often able to consider various providers.[22] Figure 5 presents a breakdown of total national health care spending by type, showing the various spending components; frequently consumers have opportunities to value shop for retail prescriptions, medical equipment, professional services, and others health-care products and services.

Outpatient health care accounts for the majority of non-elderly health payments, and HSAs can empower consumers to shop for value.

High annual deductible policies have considerably lower premiums than low-copayment and low-deductible policies.[23] Testifying on behalf of the American Benefits Council and Mercer, Ms. Watts stated:

> *[T]he results from our nationwide survey indicate that HSA-eligible plans save about 20% on plan costs when compared to PPO plans and are 6% less costly than PPO plans with deductibles over $1,000.*

[22] Testimony of Hoover Institution's Dr. Scott Atlas at the Joint Economic Committee's June 7, 2018 hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033

[23] "Employer Health Benefits: 2018 Annual Survey," The Kaiser Foundation, p. 9. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018

> *I would note for the Committee that the success of HSA-eligible plans in reducing plan costs is one of the few strategies proven to help "bend the cost curve" and, in turn, help manage premium costs for employees.*[24]

A 2016 study of large employers that offered consumer-directed health plans in the form of HSAs and high-deductible health plans found significant long-term cost reduction and importantly, no evidence of worse health outcomes:

Evidence is mounting that HSAs lower insurance plan costs and slow health care cost growth.

> *In summary, in the first large multi-employer study to investigate long term [Consumer Directed Health Plan] CDHP spending impacts we find reductions in health care cost growth in all three years post CDHP offer and do not detect increases in any component of health care spending. These findings do not support either the concern that decreases in spending will be a one-time occurrence or that short-term decreases in spending with a CDHP will result in increases in spending in the long term due to complications of forgone care.*[25]

Americans' growing demand for HSAs.

The number of people enrolled in HSA-eligible high-deductible insurance plans has risen dramatically in recent years. In 2005 there were roughly one million people enrolled in such plans, and by 2017 the number had grown to nearly 22 million enrollees.[26] A 2016 survey by the United Benefit Advisors found that HSAs were offered in 24.6 percent of employer-sponsored plans.[27] According to Devenir, an HSA services firm, in 2017 HSA accounts had $42.7 billion in assets. These assets increased by 23 percent from the previous year.[28] Also in 2017, more than 18 percent of private insurance holders under age 65 were enrolled in high-deductible plans with HSAs, nearly double the percentage in 2011 (Figure 6).[29]

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[24] Testimony of Tracy Watts on Behalf of the American Benefits Council and Mercer at the Joint Economic Committee's June 7, 2018 hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033

[25] Haviland, Amelia M., Matthew D. Eisenberg, Ateev Mehrotra, Peter J. Huckfeldt, and Neeraj Sood, "DO 'CONSUMER-DIRECTED' HEALTH PLANS BEND THE COST CURVE OVER TIME?" National Bureau of Economic Research, March 2015, p. 28. http://www.nber.org/papers/w21031.pdf.

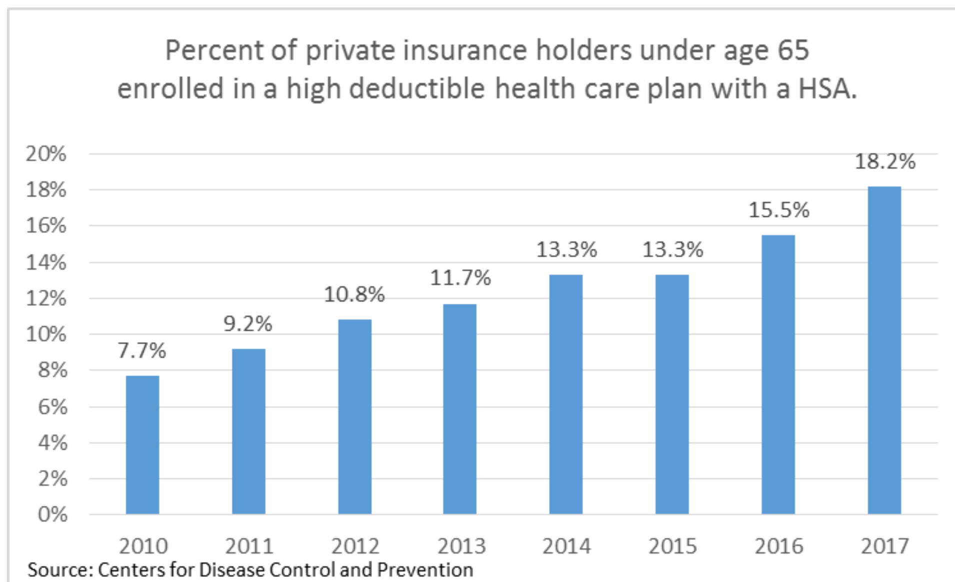
[26] "Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools," America's Health Insurance Plans, April 2018, p. 3. https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf

[27] "Special Report: How Health Savings Accounts (HSAs) Measure Up," United Benefits Advisors, May 2017, p. 3. https://cdn2.hubspot.net/hubfs/182985/docs/2016-uba-special-report-on-hsa-and-hra.pdf?__hssc=53194871.3.1494885129355&__hstc=53194871.a6472f37f42db6e5db8ca07ddc54cbc2.1492704751422.1494599688646.1494885129355.4&__hsfp=1283505112&hsCtaTracking=989ee4a8-56ed-40a5-96b0-1f7928061d7c%20percent7Cb4111d6d-ba0b-4233-bea2-e1d51e004695

[28] "2017 Midyear HSA Market Statistics & Trends Executive Summary," Devenir Research, August 16, 2017, p. 3. http://www.devenir.com/wp-content/uploads/2017-Midyear-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf

[29] "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017," Centers for Disease Control and Prevention-National Center for Health Statistics, May 2018, p. 6. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf

Figure 6



Americans are moving from traditional health care plans to cost saving HSAs with high-deductible plans.

American Bankers Association HSA Council's Kevin McKechnie testified: "By 2020, just 18 months from now, 50 percent of the U.S. workforce are projected to be enrolled in an HDHP that is also HSA-qualified…"[30]

Today, more Americans have access to HSA and provider-specific quality information. America's Health Insurance Plan (AHIP) reports that 88 percent of insurers offer access to HSA information, 82 percent offer access to health care cost information, 77 percent offer access to hospital-specific quality data, and 69 percent offer physician-specific quality data.[31] As more Americans learn about HSAs, enrollments rise, and insurers provide more price and quality data to their customers.

Further, it is important to note that the savings and efficiency gains can extend beyond private insurers to government workers and Medicaid recipients, as Indiana has shown.

A Case Study: Indiana.

In recent years, the State of Indiana has implemented HSAs in Medicaid and as a state employee insurance option. In 2010, then-Indiana Governor Mitch Daniels explained in a *Wall Street Journal* op-ed how HSAs impact consumer behavior:

[30] Testimony of American Bankers Association HSA Council's Kevin A. McKechnie at the Joint Economic Committee's June 7, 2018, hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033
[31] "Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools," America's Health Insurance Plans, April 2018, p. 5. https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf

> *It turns out that, when someone is spending his own money alone for routine expenses, he is far more likely to ask the questions he would ask if purchasing any other good or service: "Is there a generic version of that drug?" "Didn't I take that same test just recently?" "Where can I get the colonoscopy at the best price?"*

Indiana shows that government employees and Medicaid recipients can also benefit from HSAs.

Governor Daniels also noted that: state employees enrolled in the consumer-driven plan were expected to save more than $8 million in 2010 compared to their coworkers in the traditional PPO alternative; workers switching to the HSA would be adding thousands of dollars to their take-home pay (even if employees had health issues and incurred the maximum out-of-pocket expenses, they would still be hundreds of dollars ahead); and HSA customers seem highly satisfied since only 3 percent have opted to switch back to the PPO.[32]

Making HSAs better.

The aforementioned evidence suggests that many Americans are benefiting from HSA-based cost containment and recognize the value in having greater control over their routine health care expenses. At the Committee's June 2018 HSA hearing, witnesses praised HSAs and offered recommendations to increase benefits, expand access, and offer greater flexibility to Americans. Several of these are addressed in *Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018* (H.R. 6199), *Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018* (H.R. 6311), and *Protect Medical Innovation Act of 2018* (H.R. 184), all of which passed in the House of Representatives in July 2018 and were sent to the Senate.

By increasing benefits, accessibility, and flexibility, more Americans can enjoy HSA cost savings.

Below are recommendations made by witnesses at the hearing.

Increase benefits by:

- raising the maximum annual contribution limit;
- removing restrictions for Medicare Advantage and Medical Savings Accounts (MSA); and
- allowing usage for over-the-counter drugs and non-prescription health products.

Expand HSA access to:

- Medicare, Medicaid (without states having to request a federal waiver), and Social Security recipients;
- TRICARE, Indian Health Services, and Veterans Administration enrollees; and
- holders of traditional or catastrophic insurance policies.

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[32] Daniels, Mitch, "Hoosiers and Health Savings Accounts," *Wall Street Journal*, March 1, 2010. https://www.wsj.com/articles/SB10001424052748704231304575091600470293066

Increase flexibility by allowing:

- usage for elderly parents;
- access to concierge physicians, employer or retail medical clinics, and telemedicine;
- HDHP insurers to pay for high-value chronic disease management before the deductible is met; and
- permit tax-free rollover of funds at death to other family members, not just a spouse.

Hearing witnesses also noted that many plans offered in the ACA insurance exchange come with very high deductibles but are disqualified from being used with HSAs because their out-of-pocket limits are too high, exceeding the limit allowed for HSA-compatible HDHPs.

American Bankers Association HSA Council's Kevin McKechnie testified:

> *Congress should make them [HSAs] available to more people, and make their basic plan design more flexible. Expanding the usefulness of HSAs to a larger audience will be good for everyone, because it will accelerate adoption and thus accelerate cost reduction.* [33]

Declining prices from increased health care competition will clearly benefit those enrolled in HSAs, but the lower prices will ultimately reach non-HSA participants as well. In other words, the existence of HSAs lowers prices for all health care consumers.

CONCLUSION

America's health care industry has a spectacular history of innovation and delivery that has benefitted Americans and the entire world. However, 70 years of non-market policies—from WWII wage controls to the increasing role of government in health care—have added inefficiencies that inflate prices. The ACA alone resulted in a simultaneous increase in premiums and deductibles, which conceptually, should have an inverse relationship.[34] There are certainly other sources of rising health costs and inefficiencies. For example, our medical liability system encourages providers to order tests and procedures that may be unnecessary in order to prevent being sued later for medical malpractice. However, third-party payment systems for a wide range of services and the almost complete lack of competition are key drivers of today's high health care and health insurance costs.

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[33] Testimony of American Bankers Association HSA Council's Kevin A. McKechnie at the Joint Economic Committee's June 7, 2018 hearing, "The Potential for Health Care Savings Accounts to Engage Patients and Bend the Health Care Cost Curve." https://www.jec.senate.gov/public/index.cfm/hearings-calendar?ID=F5C36697-435D-4A45-AB94-6B285D327033

[34] Atlas, Scott, "Americans are 'winning' on health care as Trump administration chips away at ObamaCare," FoxNews, August 6, 2018. https://www.foxnews.com/opinion/americans-are-winning-on-health-care-as-trump-administration-chips-away-at-obamacare

To pay for rising insurance costs, employers substitute benefits for money wages. HSAs can potentially reverse this trend, generate savings for employers, and increase workers' take-home pay.

HSAs give consumers greater control over how their money is spent, much of which is currently administered by insurance companies, providers, and government. HSAs motivate consumers to carefully monitor health spending: question the necessity of retaking expensive tests; inquire into the availability of cheaper alternatives like generic drugs; and shop around for lower-price health care providers (e.g., doctors and medical supplies). At the same time, the HDHP offers protection from unexpected and excessive medical costs.

There is growing evidence that consumer-directed plans reduce health care spending. By one estimate, if half of the employer-sponsored insurance policies incorporated HSAs, national savings in health care spending could total $57 billion annually.[35]

By empowering consumers to make wise choices and promoting greater price transparency, America's health care system will be better able to deliver high quality at an affordable cost. Specifically, moving toward tax-preferred HSAs combined with an HDHP, consumers are put in charge of their health care spending for most routine services, and by having "skin in the game" they will make better health care decisions.

Russell Rhine
Senior Economist

[35] Haviland, Amelia M., et al. "Growth of consumer-directed health plans to one-half of all employer-sponsored insurance could save $57 billion annually." *Health Affairs* 31.5 (2012): 1009-1015. https://search.proquest.com/docview/1015201853?pq-origsite=gscholar