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Testimony of

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Chairman Paulsen, Ranking Member Heinrich, and members of the Committee, thank you for the opportunity to discuss with you the many benefits and immense future promise of Health Savings Accounts (HSAs).

I am Kevin McKechnie. Since 2004 I have had the honor to serve as Executive Director and founder of the American Bankers Association's HSA Council, an organization of banks, insurers, administrators, and technology partners that represents about 94 percent of the HSAs in the United States.

HSAs are the only health insurance plans in America that allow their owners to save for the future. Every other health plan, even the ones a lot of health advocates call "good insurance," start their participants off at the beginning of the year with nothing in the bank to satisfy out of pocket expenses. Facing the future with nothing is one reason Americans are so worried about their health insurance and the relentlessly rising costs of their health care. HSAs are part of the solution.

In this presentation, I will try to give you an overview of HSAs, their history and how they work, and what makes them effective and beneficial. I'll also try to give you a taste of their amazing promise, concluding with some specific recommendations that can help you bring that promise to life.

About the ABA's HSA Council

The HSA Council is part of the American Bankers Association (ABA), the voice of the nation's $17 trillion banking industry, which is composed of small, regional, and large banks that together employ more than 2 million people, safeguard $13 trillion in deposits, and extend over $9 trillion in loans.

The Council is dedicated to advancing policies that preserve and expand banks' ability to offer Health Savings Accounts. We represent our members before Congress, the White House, and the courts, in order to preserve the ability of Americans to pay for health care using an HSA. Our job is to work every day to improve, strengthen, and expand access to account-based health care solutions for all Americans.

The chairman of our board of directors is Jim Gandalfo, a senior executive of PNC Financial Services Group. To our knowledge, ours is the only national trade association that advocates exclusively for the interests of America's rapidly expanding HSA community. We are humbled and inspired by this mission. We believe HSAs are a blessing in the lives of millions of American families, and help improve the overall quality and efficiency of health

care in America.

Back in 2004 we founded the Council with the hope that we could accelerate the adoption of HSAs and their accompanying, high-quality health insurance. And I'm pleased to report our hope has been realized—and then some.

Today, according to Devenir Research, there are more than 22 million HSAs nationwide, and they make no less than $54 billion available to help pay for the future health care needs of, we estimate, 30 to 35 million Americans. And this rapid adoption is still in its early years. We've only just started to scratch the surface.

In fourteen years, we've gone from zero HSAs to 22 million, and from nobody benefitting from an HSA to one out of every ten Americans benefiting directly from an HSA. And the other nine in ten Americans are benefitting indirectly.

The potential for future expansion of HSA ownership is immense. So is the potential for helping reduce health care costs and reducing the number of the uninsured.

This is why we believe expanding and strengthening HSAs is and must be an integral part of any serious plan to improve health care in America.

History of HSAs

Why do HSAs exist? Before I go into the details of what an HSA is and how it works, I want to take a moment to explain where the concept came from. It sprung fully grown from the mind of J. Patrick Rooney, founder and president of Golden Rule Insurance, sometime in the latter 1980s. Rooney's idea was to allow people to pair a high-deductible health insurance policy with a federally tax-advantaged savings account. (The deductible is the amount of money you have to spend before your insurance kicks in.) With this combination, Rooney reasoned, a number of good things will happen. People who sign up for the insurance will enjoy lower than normal premiums, thanks to the high deductible. And yet their coverage will not be substandard. It will be high-quality. And it will effectively be first-dollar coverage, thanks to the accompanying account, which enables the patient to cover all of his expenses up to the deductible. And this combination will save money, because any money the consumer doesn't spend, he can save and accumulate for his own future health care expenses. That will encourage him to be prudent with his purchases and shop smarter, because he'll have skin in the game. He'll spend his own money, and spend it more wisely. And that will benefit everyone. The ultimate result? Cheaper health insurance and lower health care costs for all. More people covered. More people cared for. That's Pat

Rooney's original vision for HSAs: that they can help all of us get the health care we need, when we need it, at a price we can afford.

This appealing idea was quickly picked up by smart health economists looking for ways to alleviate the nation's excessive health care cost inflation—which back then, as now, was ravaging public and private budgets.

One of the first serious legislative proposals for health savings accounts was introduced in the United States Senate 26 years ago. Importantly, the bill was bipartisan. On September 8, 1992, Democratic Senators Sam Nunn, John Breaux, Tom Daschle, and David Boren, and Republican Senators Richard Lugar and Dan Coats announced a new bill they had written, to establish what they called medical savings accounts. At the time, Congress was still in the early stages of what would become a decades-long national debate over how to help the uninsured. These Senators felt that more creativity was needed than just spending more government money to expand the number of people with health insurance. "So far," they wrote, "most of the proposals before Congress attempt to deal with access [to health care] but do not adequately address the more important factor—cost control. We have introduced legislation . . . that would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their 'own' money."

In 1996 Congress gave the new bipartisan concept a try, enacting a limited pilot-test under the name of Medical Savings Accounts. Seven years later, in late 2003, Congress took the idea national. The name was changed to Health Savings Accounts, a number of changes and improvements were made to the accounts' structure, and they were made available to some, but not all, Americans.

From the beginning, the mission of the HSA opportunity has been to help bend the cost curve downward—to reduce health care costs generally, and government health expenditures in particular—by giving consumers more skin in the game and more control over their personal medical decisions.

In this mission, HSAs have succeeded admirably.

About HSAs

What exactly is an HSA? A Health Savings Account is a tax-advantaged personal savings account that helps people pay for the cost of medical expenses, such as doctor bills and prescription drugs. The money in the account belongs to the account owner, and is not taxed so long as it is used for legitimate health care expenses. Money deposited but not spent can grow over time and thus become a nest egg for medical expenses in retirement or

be left to one's loved ones after death. Deposits can be received from other people, including your employer. There are limits on how much can be contributed to an HSA each year. In order to be able to open and contribute to an HSA, the account owner must also participate in a qualified high-deductible health plan (HDHP), more commonly known as an HSA-qualified plan. Congress has defined certain rules and protections affecting HSA-qualified plans, described in more detail below. All HSA-qualified plans must be HDHPs, but not all HDHPs are HSA-qualified.

Tax advantages. HSAs save their owners money for current health care needs by allowing them to pay for routine care with tax-exempt dollars rather than after-tax dollars. This means a big savings for the consumer. Depending on your tax bracket, using your HSA can save you an additional 15 to 40 percent on your out-of-pocket health care purchases. Only individuals with an HSA can enjoy these additional tax savings.

Specifically, as set forth in the HSA statute, which is section 223 of the federal tax code, contributions to an HSA are deductible from the HSA owner's income, any financial gain realized through interest or investments is not subject to income taxes, and funds spent from your HSA on qualified medical expenses are exempt from income taxes for the remainder of your life, meaning now and throughout retirement. Alternatively, HSA funds may be used as retirement income after age 64 without penalty, if the HSA owner pays income taxes on the distributions.

Contribution limits. Congress has limited the amount of money that may be deposited in an HSA each year. The amount grows with inflation. Back in 2004 the maximum contribution was $2,500 for an individual and $5,000 for a family. The comparable figures for 2018 are $3,450 for an individual and $6,900 for a family.

Deductible limits. A deductible is the amount of money you must pay for health care services by yourself before your health insurance kicks in. Back in 2004 the minimum deductible permitted with an HSA-qualified plan was $1,000 for an individual and $2,000 for a family. The comparable figures for 2018 are $1,350 for an individual and $2,700 for a family.

Out-of-Pocket limits. To help protect families from excessive medical costs, Congress has required that an HSA-qualified health plan must limit the amount that the individual is required to pay out-of-pocket for covered expenses. This is usually called the maximum out-of-pocket limit or OOP max. In 2004, it was set at $5,000 for an individual and $10,000 for a family. The comparable figures for 2018 are $6,650 for an individual and $13,300 for a family.

Tracking and reporting. Account owners are responsible for ensuring their HSA money is spent properly and must report their account activity on their personal income tax returns.

What can an HSA be used for? With certain exceptions, HSA funds may be used for any qualified medical expense that is deductible under section 213 of the federal tax code. While HSA funds may not be used to pay the premiums on an employer-provided health insurance plan, they may be used for premiums on COBRA continuation coverage and qualified long term care insurance. In retirement, HSA funds may be used, not only for qualified medical expenses, but also to pay premiums on Medicare Parts B and D coverage and long term care insurance. HSA funds may not be used for Medigap premiums. Under current law, once you enroll in Medicare you may no longer contribute to your HSA.

To summarize, HSAs allow people to save, tax-free, for out-of-pocket health care expenses and certain kinds of premiums during their working years, and to save for health care expenses in retirement. Those benefits distinguish it from all other kinds of tax-advantaged accounts.

When an HSA is offered as an employee benefit, it differs in a couple of important ways from other consumer-directed health products, namely, Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs). First, the funds in the HSA account are the property of the employee, and accumulate from year to year. Second, because the HSA is owned by the individual, not the employer, the funds in the account do not revert to the employer if unused. There is no "use it or lose it" rule (and that feature of FSAs has been modified). When you leave the company, you will keep the money in your HSA, but you will have to forfeit any money left in your FSA or HRA except in certain cases.

Most employers who offer HSA-qualified plans also contribute funds to an employee's HSA, which helps lessen the sting of the deductible.

Who can have an HSA? Many Americans are permitted to have to an HSA, but there are exceptions. People who do not have an HSA-qualified health plan are not allowed to contribute to their HSA. Nor are people who are enrolled in a government-run health insurance program such as Medicare or Medicaid.

HSA Enrollment Trends

How many HSAs are there? Devenir Research believes there are at least 22 million HSA accounts in existence and somewhere between 30 and 35 million individuals enjoying

the benefits of a Health Savings Account (approximately one-tenth of the U.S. population).

Who has an HSA? In terms of age, three out of every four current HSA owners is under the age of 50, one in four is over 50.

In terms of gender, about 57 percent of HSA owners are male, 43 percent female.

In terms of household income, WageWorks data suggests that two-thirds of this group earn less than $75,000 a year. Half make less than $60,000 a year. A little over 8 percent earn more than $100,000 a year. And just four-one-hundredths of one percent earn above $200,000. HSA owners have average incomes below $75,000 in every state in the Union except Connecticut, Maryland, Massachusetts, and New Jersey (and the District of Columbia).

What is the trend in HDHP/HSA enrollment? According to the Centers for Disease Control and Prevention (CDC), which tracks health insurance enrollment figures for the U.S. Department of Health and Human Services (HHS):

- Nearly 43 percent of non-elderly Americans—about 119 million people—are enrolled in an HDHP (both HSA-qualified and not).

That number has grown by nearly 20 percentage points since 2010.

- 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 according to the Center for Disease Control (CDC)

- The share of the total under-65 population that has an HSA account has more than doubled in just the past eight years, rising from about 8 percent in 2010 to more than 18 percent last year.

Enrollment in HDHPs is rising rapidly, and with it potential future HSA enrollment.

Alas, one area where HSAs appear to be receding is in the Affordable Care Act exchanges. According to a paper published by the Heritage Foundation on June 1 of this year, "Numerous Obamacare plans now have out-of-pocket limits that are higher than the amount that the federal law allows in order for a plan to be paired with a health savings account. . . . Because Obamacare's maximum out-of-pocket limits are higher than those for HSA-compatible plans, over half (57 percent) of all plan designs now offered on Healthcare.gov have out-of-pocket maximums that are too high for the plan to qualify as HSA-compatible." As a result, "Only 30 percent of plans sold on the federal Obamacare

exchange meet the criteria of having both a high-enough deductible and a low-enough out-of-pocket limit to qualify as HSA-compatible." But the good news is this problem can be addressed by making HSA-qualified plan designs more flexible, as I'll explain below.

Where are HSAs growing fastest? In the employer market. Account-based health plans—health insurance plans paired with HSAs and HRAs—are the fastest growing health benefits in the employer market and now account for more than 15 percent of all employer-provided coverage. More than 70 percent of employers offer account-based health plans. A growing share of employers offer only such plans. This rapid adoption rate is fueled by the relentless rise of health care costs.

Benefits of HSAs

Do HSAs work? HSA-qualified health plans are now in their 15th benefit cycle. We have 14 years of data with which to assess and judge the value of this important tool. The results are in, and the benefits are clear: HSAs work, and work well, for millions, and not, incidentally, just for the healthy and the wealthy.

Do HSAs help reduce health care costs? Yes. Companies with at least half of their workers enrolled in an account-based health plan report that their per-employee costs are over $1,000 lower than companies without an account-based health plan, according to Towers Watson and the National Business Group on Health. As former Treasury and White House economist Roy Ramthun has observed, "This is strong evidence that putting consumers in charge of their own health care dollars does in fact bend the cost curve downward."

The professional Actuaries at the Centers for Medicare and Medicaid Services (CMS) have credited HDHPs with reducing national health expenditures by 0.9 percent.

Back in 2012, researchers at the RAND Corporation published an analysis in the journal *Health Affairs*, regarding the potential impact of account-based health plans on the American health system, which suggests that if account-based health plans grow to represent half of all employer-sponsored insurance in the United States, health care spending could drop by $57 billion annually—about 4 percent of all health care spending among non-elderly Americans. The study found HSAs more cost-effective than other kinds of health plans, and estimated that if every employee were to be placed in an HSA plan, the annual savings would be as high as $73.6 billion. We think that figure greatly understates the potential savings.

Aetna reported in 2011 that employers who switched to account-based health plans

as their only plan option had saved $21.8 million per 10,000 members over the previous five years. Aetna found that employers who offered an account-based health plan alongside other traditional plan options (e.g., PPO, HMO) also had realized savings, but not as significant—only $8 million per 10,000 members over five years.

Cigna published a study in 2012 concluding that employers can save an average of $9,700 per employee over five years by switching to account-based health plans. The Cigna report concludes that if the share of Americans enrolled in account-based health plans rose to 50 percent and achieved the same results as in its study, the United States could save $350 billion over 10 years and the level of patient care would improve.

The academic evidence is strong for the existence of a positive "HSA effect," a tendency in people to spend less when using a consumer-driven, account-based approach, such as with an HSA.

Let's look closer at that evidence.

A 2009 literature review by the American Academy of Actuaries cites several industry-led studies, all of which find a measurable HSA effect when estimating the year-over-year spending reduction due to switching from a traditional health plan to a CDHP:

- CIGNA Choice Fund 2008 (4 percent spending reduction)
- Aetna HealthFund 2008 (10 percent spending reduction)
- Uniprise 2008 (15 percent spending reduction)

Importantly, all three of these studies found higher rates of preventative care use.

A literature review by RAND Corp. cites, among other studies:

- Nichols Moon and Wall 1996 (if all workers switched to a CDHP, national health expenditures could be reduced by 4 to 6 percent).
- Keeler et al 1996 (if all non-elderly insured were to enroll in a CDHP, health care spending would decline by 0 to 13 percent).
- Hahn 2005 [Humana 2005] (after switch from a PPO plan, CDHP spending was lower than expected by 25 to 35 percent).

- Baicker Dow and Wolfson 2006 (a hypothetical switch from a PPO to a CDHP would reduce individual health spending by 5 percent in short run).

- Burke and Pipich (Milliman) 2008 (CDHP plans produce 1.5 percent in savings beyond non-CDHPs).

A case study by Trumbower and West (Health Equity) 2016 finds that two Pennsylvania school districts that switched to a CDHP reduced their health spending by an adjusted net of 17.46 percent in total claims, compared to districts that continued with the previous, traditional health plan.

The only studies we've encountered that show CDHPs leading to *higher* costs in some (but not all) provider settings are by Parente, Feldman, and Christiansen, circa 2004-2007. Of these, the RAND literature review cautions: "Some of the variation in results of these studies may stem from the heterogeneous benefit designs of both the HDHPs and the conventional plans studied."

The above list is non-exhaustive, but the cumulative weight is clear. Even the least favorable study, Burke and Pipich (Milliman) 2008, shows a 1.5 percent savings from switching to a CDHP. The other studies show even higher savings.

What all this academic data tells us is that the HSA effect is real. For the record, I hereby submit a list of studies in support of this fact.

HSA Effect Studies (Select List)

American Academy of Actuaries. "Emerging Data on Consumer-Driven Health Plans: A Public Policy Monograph." May 2009. URL: https://www.actuary.org/pdf/health/cdhp_may09.pdf.

Aetna HealthFund. "Making an Impact: Seventh Annual Aetna HealthFund Study." 2008. URL: http://www.aetna.com/aetna-press/document-library/Aetna_HealthFund_2009_Study_Results_NA_Sell_Sheet.pdf

CIGNA Choice Fund. "Two Year Experience Study, 2005-2006." March 2008. [Referenced in AAA, above.]

Uniprise. "CDHP Results Discussion." March 2008. [Referenced in AAA, above.]

Baicker K, Dow WH, Wolfson J. "Health Savings Accounts: Implications for Health

Spending." National Tax Journal. Vol. 59, No. 3. September 2006.

Burke J, Pipich R. "Consumer Driven Impact Study." Seattle, Washington. Milliman Inc. April 2008. URL: http://www.hsacoalition.org/wp-content/uploads/2008/04/consumer-driven-impact-studyrr-04-01-08.pdf.

Effros R. "Increase Cost-Participation by Employees (e.g., Through High-Deductible Health Plans)." Rand Technical Report TR-562/4. Santa Monica, California. RAND Corporation. 2009. URL: https://www.rand.org/pubs/technical_reports/TR562z4.html.

Hahn P. "Health Care Consumers: Passive or Active? A Three-Year Report on Humana's Consumer Solution." Louisville, Kentucky. Humana, Inc. June 2005.

Keeler EB, Malkin JD, Goldman DP, Buchanan JL. "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association,* Vol. 275, No. 21. 5 June 1996.

Nichols L, Moon M, Wall SW. "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers." Washington, D.C. The Urban Institute. 1996.

Trumbower B, West W. "Making the HSA Switch: Changing to an HSA-Qualified Health Plan Resulted in Significant 1st-Year Savings in Two Pennsylvania School Districts." Health Equity, Inc. 2016.

Do HSAs help people pay for health care in retirement? Yes. In fact, HSAs are the *only* tax-advantaged savings vehicle that allow Americans to save for health care costs in retirement. FSAs and HRAs do not, because the money belongs to the employer and remains with the employer after the employee leaves. Non-HSA-qualified plans (PPO, HMO, and indemnity) do not, because they have no savings component and the participant has to renew the policy annually. HSAs also differ from traditional IRAs and 401(k)s in one important respect: funds withdrawn from an HSA that are spent on health care expenses are not taxed. Thus HSAs are unique and in these critical ways superior to other account-based approaches. Indeed, one could argue that HSAs are the most attractive and consumer-friendly form of health coverage currently available in the United States today.

To understand how beneficial an HSA can be in retirement, consider the following illustration. Today about 30 to 35 percent of retirees' living expenses are health-related. But Medicare only covers about 60 percentof the average retiree's medical costs. As a

result, the average couple retiring this year, according to Fidelity Investments, will face an estimated $275,000 in health care expenses not covered by Medicare. Due to the tax laws, this couple, forced to use post-tax dollars, will have to spend $334,000 to $380,000, just to cover those $275,000 in uncovered health care costs. But retirees with an HSA will face a much lower hurdle, for two reasons. First, they are allowed to use their HSA funds to pay for health care costs not covered by Medicare. Second, HSA withdrawals are not taxed. (Funds withdrawn from a traditional IRA or 401(k) are taxed.) So our illustrative couple, if they maintain an HSA before retiring, will get to reduce their total health care expenses during their golden years by $59,000 to $105,000—thanks to their HSA.

Do HSAs give patients more control over their health care? Yes. Having an HSA tends to induce consumers to take a more active role in managing their own care, because they have skin in the game. A 2012 survey by the independent Employee Benefits Research Institute (EBRI) suggested that enrollees in account-based health plans were more likely to check whether their plan would cover their care, talk to their doctor about treatment options and costs, talk to their doctor about prescription drug options and costs, ask for a generic drug, check the price of service before seeking care, use an online cost-tracking tool, and develop a budget to manage health care expenses. Insurers have reported similar findings.

HSAs fuel price transparency, consumer empowerment. As a result of the rapid spread of HSAs and other account-based health plans, there has been an information revolution, alongside the HSA revolution. People with account-based health plans are demanding better information about the price and quality of their health care options, and the market is responding. Dozens of new companies have appeared, with names like MediBid, ZendyHealth, and Healthcare Blue Book, which offer consumer-reports style information and online comparison tools to help patients make smart choices among medical providers and treatments.

Criticisms of HSAs

Are HSAs are only for the healthy? The evidence to support this idea is thin. Intuitively, it makes little sense, since HSA coverage is effectively first-dollar coverage, and as I'll explain below, the account can be particularly helpful to people with chronic medical conditions.

Are HSAs only for the wealthy? No. In terms of income, HSA owners are average. Median household income in the United States is currently about $59,000. The median household income for an HSA account holder, according to WageWorks, is $57,060. In terms of age, three out of every four current HSA owners is under the age of 50, one in four

is over 50. That tells us most HSA owners are still in the boost phase of their earning years, while a minority are in their high-earning years. Two-thirds of this group earn less than $75,000 a year, half make less than $60,000 a year, a little over 8 percent earn more than $100,000 a year, and just four-one-hundredths of one percent earn above $200,000. That confirms that HSA owners are far from being Monopoly Men in silk top hats.

In our view, most criticisms of HSAs are really just criticisms of non-HSA-qualified HDHPs. The account is an innocent bystander. An HSA is a tax-advantaged account that helps you pay your deductibles. If policy makers are concerned about high deductibles being unaffordable for some patients, then we think the appropriate response would be to make HSA-qualified plans more flexible. We suggest some ways to do that, below.

Are HSAs really just a disguised investment vehicle? No. According to the experts at Devenir, the average HSA balance is a little more than $2,000 and 78 percent of HSA account holders have less than that amount in their account. This indicates the accounts are being used for their intended purpose: to pay for routine health care expenses.

Are HSA holders vulnerable to excessive charges? No. Just like everyone else with insurance, individuals enrolled in HSA-qualified plans receive the benefit of discounted prices for medical services negotiated by their health plan. Choosing an HSA in no way denies you the benefits of group purchasing and negotiated discounts.

Do HSAs hurt Americans with chronic diseases? Just the opposite. HSAs are especially helpful to people with medically complex chronic conditions, for a couple of reasons. First, having an HSA enables the patient to purchase prescription medications with tax-advantaged dollars rather than with after-tax dollars. Second, HSA-qualified health plans provide true catastrophic protection, by virtue of their annual limits on out-of-pocket expenses, which apply to both medical and pharmacy expenses. Protection against excessive out-of-pocket spending has been a feature of HSAs from the beginning.

Do HSAs offer "skimpier" coverage than traditional insurance? No. Covered benefits and services in an HSA-qualified plan are generally identical to those in a traditional plan, not "skimpier" as some critics believe. What *is* different is the share of the covered benefits paid for by the plan as opposed to the patient. For example, an HSA-qualified plan might cover 60 or 70 percent of the cost of covered benefits, whereas a traditional HMO or PPO plan might cover 80 or 90 percent. But on the other hand, the traditional HMO or PPO may have a higher premium than the HSA-qualified plan, and might also have a skimpier network of doctors and hospitals. We can't really call one or another plan "skimpier" without comparing all the various features and costs of both. As a general matter, HSA-qualified plans resemble other kinds of insurance in every respect except the deductible—

and even that distinction is fading as deductibles continue to rise everywhere.

Do HSA holders go bankrupt due to high out-of-pocket costs? No more so than other Americans, and probably less so. As we've mentioned, every HSA-qualified plan comes with built-in out-of-protection expense protection. And the HSA protection kicks in at lower limits than under non-HSA plans.

Ways to Improve HSAs

Can HSAs be improved? Yes. HSAs work well, but they need some improvements. Currently HSA plans are discriminated against, compared to other co-pay plans. Under current rules, you are not allowed to contribute to an HSA and also:

1. Be enrolled in Medicare.
2. Receive Social Security benefits.
3. Be enrolled in a traditional health plan.
4. Have access to TRICARE or the Indian Health Service or the VA.
5. Be covered by a health care FSA.

Additionally, with today's HSAs you are not allowed to:

6. Have access to employer or retail medical clinics at no cost.
7. Have access to telemedicine at no cost.
8. Have access to high-value chronic disease management at no cost.

To address these weaknesses, and make HSAs even better, Congress should make them 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.

Expanding flexibility is also important. HSA owners want, deserve, and in many cases need more flexibility. Certainly HSAs should be able to cover value-based services like direct primary care, expenses associated with chronic care management, and telemedicine services. Flexibility and choice are vital to the HSA concept. Every patient is different. As HSAs become more popular, their flexibility must grow.

HSAs and Chronic Disease

Can HSAs be improved for people with chronic diseases? Yes. There is one important weakness in the current HSA model: people with chronic diseases have higher prescription and health care costs and tend to meet their deductible quickly due to prescriptions. In one sense, that's not a problem, because their insurance kicks in as soon as they've met the deductible. But in another respect, it's a big problem, because their comparatively rapid and frequent depletion of their account means these vulnerable Americans have no good way to save tax-free for health care costs in retirement. To make matters worse, current law actually prohibits an HSA-qualified plan from covering chronic disease below the deductible. Any plan that offers such pre-deductible coverage is disqualified from being paired with an HSA and the individual who purchases such a plan is prohibited from contributing to his or her HSA.

Policy Recommendation: *Pass the Chronic Disease Management Act.* To address this problem, and help Americans with chronic illnesses, the ABA's HSA Council supports enactment of the Chronic Disease Management Act, introduced as S.2410 by Senators John Thune (R-South Dakota) and Tom Carper (D-Delaware) and as H.R.4978 by Representatives Diane Black (R-Tennessee) and Earl Blumenauer (D-Oregon). This bipartisan legislation would allow HSA-qualified plans to cover high-value health care services and medications associated with chronic disease management without a deductible. Importantly, it would do so in a voluntary rather than a mandatory way.

HSAs and Medicare, Medicaid

Should HSAs be an option for people on Medicare and Medicaid? Yes. Currently the 138 million people—roughly four in ten Americans—who are enrolled in Medicare or Medicaid (59 million of them in Medicare, 79 million in Medicaid) are barred by law from contributing to an HSA. We can see no good policy reason for this form of discrimination against the poor, the elderly, and the disabled.

Why should Medicare seniors have access to HSAs? Because allowing Medicare seniors to have an HSA would not only benefit vulnerable elderly and disabled patients and their medical providers, but also, importantly, would benefit taxpayers, because, as we've seen, HSAs are a powerful tool for helping to bend the cost curve downward without bureaucratic rationing.

Policy Recommendation: Permit Medicare HSAs for Working Seniors. The ABA's HSA

Council has proposed, and President Trump (in his FY 2019 budget) and several Members of Congress have endorsed, the idea of allowing employed seniors who reach Medicare enrollment age to continue participating in their employer's HSA-qualified health plan, and thus continue contributing to their HSA, while enrolled in Medicare. Importantly, seniors who voluntarily participate in the option would not be allowed to rely on Medigap supplemental coverage, and Medicare would not cover any of their health care costs below the deductible. When the senior leaves the employer plan, he or she will switch to normal Medicare without penalty. At firms with greater than 20 employees, Medicare secondary payer rules would apply, with respect to HSA-qualified coverage. (Employers with fewer than 20 employees are currently exempt from those rules.) Thanks to these strong safeguards, the proposal would certainly reduce federal expenditures—or at the very least, it would not increase them. An analysis by benefits firm Benefit Strategies finds that in every scenario, regardless of firm size, for each individual who opts in, the Treasury is likely to receive a net gain of $8,000 compared to current law. Only in one rare scenario, in which a Medicare-eligible person is working for a firm with fewer than 20 employees but is not receiving Social Security benefits, will the net savings to the Treasury be less than $8,000—in that case, it will most likely be a wash. A budgetary cost estimate by the policy consultancy Adams Auld LLC projects a net savings to the Treasury of $72.3 billion over ten years.

Policy Recommendation: Permit HSAs in original (fee-for-service) Medicare and Medicare Advantage. We believe every Medicare beneficiary should have the option of an HSA. To make this possible, Congress could take any of a number of possible approaches. Perhaps the simplest is to declare traditional fee-for-service Medicare coverage and Medicare Advantage plans to be HSA-qualified (that is, not prohibited coverage). If a person is enrolled in Medicare or an MA plan, he or she is automatically eligible to make and receive contributions to an HSA. There are other possible approaches, more complex than this. But the goal and basic effect would be the same. Most likely, Congress would want to prohibit Medigap supplemental coverage for those Medicare beneficiaries who have an HSA, since the savings account would cover the deductibles, copays, etc., and having Medigap coverage would dissipate the beneficial behavioral effects of having an HSA. Also, a Medicare senior could save money by not having to pay Medigap premiums, and could instead deposit that money into the account. Meanwhile, the government could also make contributions to the account. It might, for example, calculate the dollar savings that would result from reduced utilization (thanks in part to the absence of Medigap) and then use some of all of that savings to make a contribution to the HSA. This proposal can be structured to be budget neutral.

Should low-income Americans have access to HSAs via Medicaid? Yes. Currently, HSAs are not offered in Medicaid, and Medicaid enrollees are not allowed to contribute to an HSA. There is a model, however, for an accounts-based approach in Medicaid, pioneered in the state of Indiana. The Indiana experiment, known as HIP 2.0, is distinguished by three main features, relative to conventional Medicaid. It offers: 1) a more modern benefit design, featuring choice of health plans, and a HSA-like savings account, which is managed by the patient (with rollover rewards to encourage prudent account management); 2) more sensible cost-sharing rules that help reduce waste; and 3) more generous reimbursement rates for doctors and hospitals, which increases patient access to care. Indiana Medicaid officials report that HIP 2.0 has reduced overall program expenditures by 6 percent, on average, while increasing patients' access to care, along with their satisfaction and happiness. Remarkably, these savings are occurring despite a significant boost in provider reimbursement rates. In Indiana, increasing the reimbursements has so far enabled the state to add more than 6,700 new providers to serve Medicaid enrollees, including those who are not participating in HIP 2.0. Almost 30 percent of providers surveyed report a decline in bad debt, and nearly 40 percent have seen a reduction in charity care. Indiana's experiment shows a "better Medicaid" is possible—better for patients, providers, and taxpayers.

> *Policy recommendation: Permit HSAs in Medicaid, by statute.* The ABA's HSA Council has proposed, and drafted legislation, to create a new HSA option within Medicaid. We commissioned a study by the respected Milliman firm to help us gauge the likely financial effects of our Medicaid HSA proposal. Milliman reported: "Full replacement of current Medicaid with a Medicaid HSA would save an average state 6% of their Medicaid budget." Using this assumption, and refining the proposal per our guidance, the policy consultancy Adams Auld LLC found that, if Medicaid HSAs as we propose to structure them became the default approach in 20 states, in adult, non-disabled populations, the likely federal savings would be on the order of $25 billion over a decade. The new statutory option would differ from HIP 2.0 in some ways. Unlike in Indiana, where the money in the account ultimately belongs to the government, the money in a Medicaid HSA would be the account owner's property, regardless of who contributed the money. And of course it would have to be paired with a high-quality, HSA-qualified high-deductible health plan (HDHP). In our draft legislation, the deductible is set at $2,500 in 2019 and is adjusted annually to rise with medical inflation. The full amount of the deductible is deposited in the account each year, with a small portion of this amount coming from the individual, but most of it from the state. For example, the state might contribute $2,350 and the individual $150. Any expenses above the deductible would be paid for by the state, with no further cost-sharing payments required from the individual. (Most people do not reach their deductible, in a given year.) The system would promote

prevention. Similar to a traditional HSA, preventive services, such as annual examinations, recommended mammograms, and smoking cessation programs, are covered without charge to the participant and are not counted against the deductible amount of $2,500. Once the participant meets the deductible by way of the account, all further benefits are fully covered without cost-sharing. When a Medicaid HSA owner leaves the Medicaid rolls, he or she retains the money in the HSA, which can be rolled over into a traditional HSA or, alternatively, cashed out and spent (after payment of any applicable taxes and penalties). Importantly, doctors and hospitals serving Medicaid HSA owners would receive more generous reimbursement for their services, and the pleasure of serving patients who care more about their health care decisions because they have more "skin in the game." The successful Indiana model is a proven way to increase patient participation and engagement in their care and reduce wasteful expenditures in Medicaid while improving patient care. It should be replicated nationally.

Conclusion

HSAs are a success. They work, and work well. While they can't solve every problem, they have all the incentives in the right place. They let people save for the future. They promote transparent pricing. They respect individual responsibility, the hallmark of every financial transaction. HSAs follow well known and proven insurance principles. They save money and help get more people covered.

But they could be even better. Dozens of good HSA-improvement bills, many of them bipartisan, have been introduced in the current Congress. By our count, there are at least 30 such bills in the House and 15 in the Senate. We support virtually all of them. But the following proposals top our priority list, for a number of reasons. These ideas are vetted, bipartisan, and affordable. Some would actually save taxpayer money. Individually and together, they can dramatically strengthen the proven, successful HSA model.

1. Enact the Paulsen-Hatch Health Savings Act (H.R.1175, S. 403).

   Paulsen-Hatch, the flagship HSA expansion bill of the current Congress, would improve and strengthen HSAs in a host of ways. Among other things, it would allow several new classes of Americans to have an HSA, including Medicare seniors, Indian Health Service enrollees, health care sharing ministry members, subscribers to direct primary care practices, and people who use on-site workplace medical clinics. It would also allow HSAs to be used for over-the-counter medications, and not just for prescription drugs as under current law.

2. Enact the Kelly-Blumenauer Bipartisan HSA Improvement Act (H.R.5138).

   Kelly-Blumenauer would improve HSAs in several ways. It would harmonize HSAs with current rules regarding health insurance options for adult children up to age 26, and improve coordination between HSAs, FSAs, and HRAs. It would also permit excepted insurance benefits to be included in an HSA-qualified plan. And it would extend tax deductibility to certain amounts spent on sports and physical fitness activities, thus making these health-promoting activities permissible uses of HSA funds.

3. Enact the Thune-Carper-Black-Blumenauer Chronic Disease Management Act (S.2410, H.R.4978).

   As described above, this compassionate bipartisan measure would allow an HSA-qualified health plan to cover care for medically complex chronic conditions, with no deductible.

4. Create an additional method of determining HSA-qualification using the more flexible actuarial value (AV) approach.

   Earlier, we noted the problem of HSA-qualified plans becoming squeezed out of the ACA exchanges by the rapid rise of health costs. Here's a way to slow or reverse that trend. In addition to the current-law approach to deductibles, which fixes the minimum deductible at, say, $3,450, why not allow a consumer to have whatever level of deductible he or she wants, consistent with an overall health plan actuarial value of say, 80 percent? This would make it much easier for health plans offered on the ACA exchanges to be HSA-qualified. And it also would improve the availability of such plans outside the exchanges as well as in the employer-sponsored group market. The higher the threshold, the greater the number of plans that will qualify for an HSA. At 70 percent, the number of plans that count as HSA-qualified would basically double from its current level. At 80 percent, that number would roughly quadruple. This simple reform would increase the HSA holder's freedom of choice, allowing him to find a personally satisfying combination of deductibles, premiums, and cost-sharing.

5. Increase HSA contribution limits to match the statutory limit on out-of-pocket expenses for HSA-qualified plans.

Making HSAs more flexible requires an increase in allowable contributions, up to the out-of-pocket maximum, currently $6,650 for individuals and $13,300 for families, in order to help pay for these additional services.

6. End the discrimination against HSAs in Medicare and allow Medicare HSAs for working seniors.

   See our detailed description and explanation above.

7. Allow HSA options in Medicare and Medicaid programs like the Trump Administration's Medicare Advantage MSA proposal.

   We support the Administration's suggested improvements to the existing Medicare Advantage MSA option. Under this proposal, people could roll their HSA funds over into an MA-MSA and contribute to it—things that are currently not permitted.

HSAs help tens of millions of Americans afford good-quality health care. They're a truly powerful tool for improving the quality of care while driving down its cost. With a few sensible improvements, they can help Americans access better care now while saving for their future.

Thank you for this opportunity to testify.

John Breaux
Louisiana

Committees:
Commerce, Science, and Transportation
Finance
Special Committee on Aging

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September 8, 1992

Dear Colleague:

The United States is faced with a crisis in health care on two fronts: access and cost control. So far, most of the proposals before Congress attempt to deal with access but do not adequately address the more important factor--cost control. We have introduced legislation that will begin to get medical spending under control by giving individual consumers a larger stake in spending decisions.

We have introduced a bill, the Medical Cost Containment Act of 1992 (S. 2873), which would allow employers to provide their employees with an annual allowance in a "Medical Care Savings Account" to pay for routine health care needs. This allowance would not be subject to income tax if used for qualified medical expenses. Any money not spent out of a given year's allowance could be kept by the employee in an account for future medical needs during times of unemployment or for long term care. In order to protect employees and their families from catastrophic health care expenses above the amount in the Medical Care Savings Account, an employer would be required to purchase a high-deductible catastrophic insurance policy.

Unlike many standard third party health care coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their "own" money. That is, money that they would otherwise be able to save in their account for future needs.

Once a Medical Care Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 50% of the uninsured are uninsured for four months or less.

Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services. With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

Figure 7.3

We feel that, while the Medical Care Savings Account concept does not provide the total solution to the crisis in health care access, it does begin to address the critical aspects of increasing costs and utilization by consumers.

We hope that you will join us as cosponsors of this legislation. If you have any questions please contact us or have your staff contact Laird Burnett of Senator Breaux's staff at 4-4623.

Sincerely,

John Breaux

Richard Lugar

David Boren

Dan Coats

Tom Daschle

Sam Nunn

Figure 7.3a

Devenir Research

2017 Year-End HSA Market Statistics & Trends

report release date: 2.22.2018

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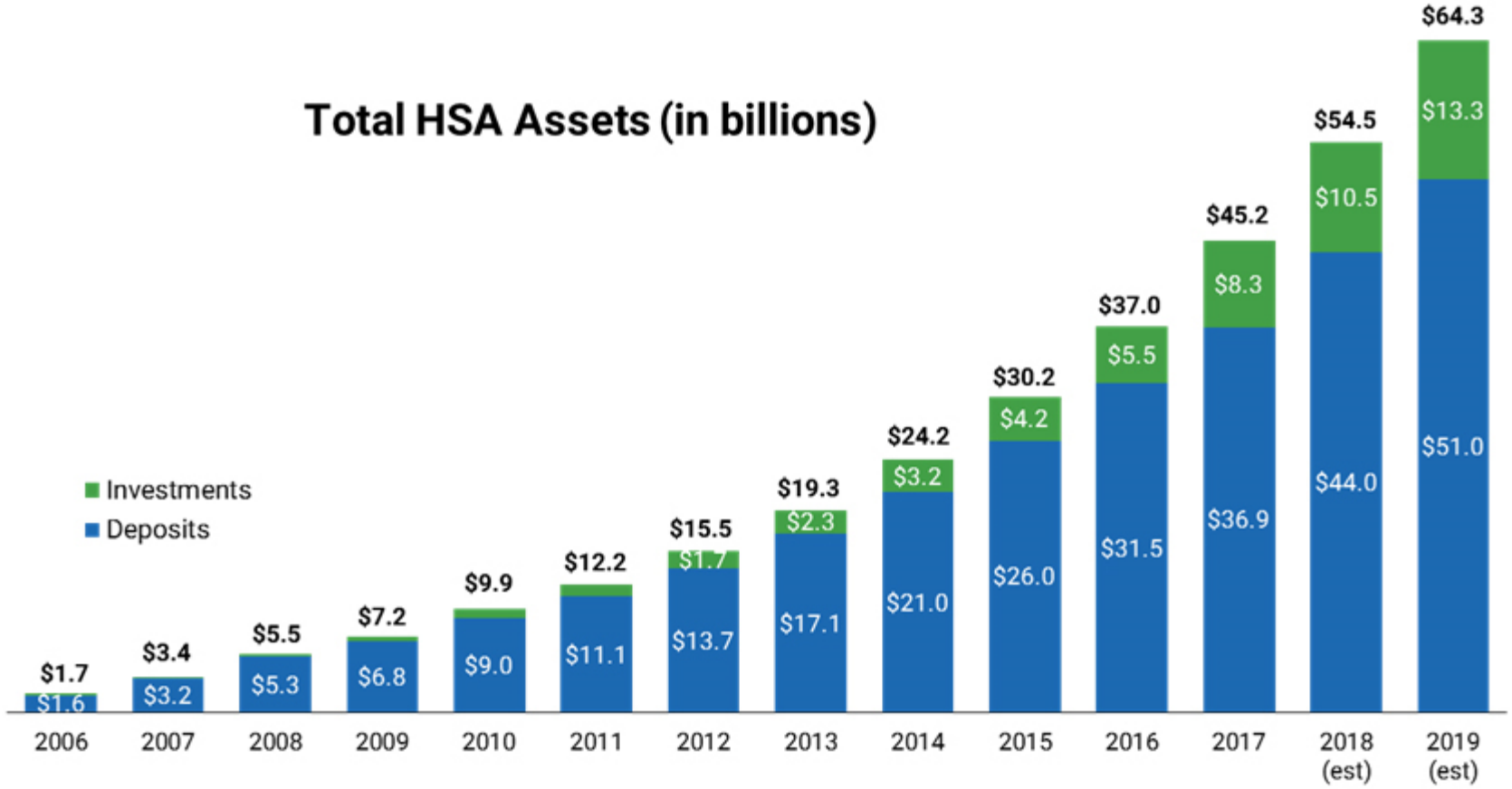

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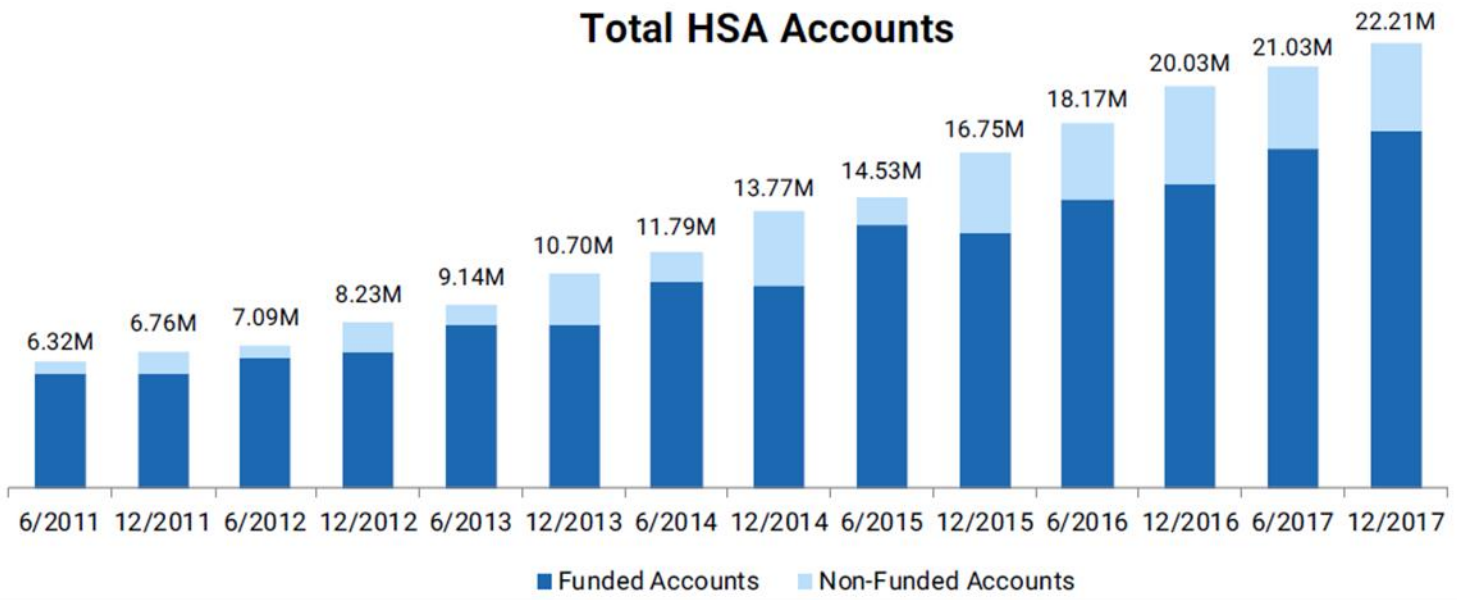

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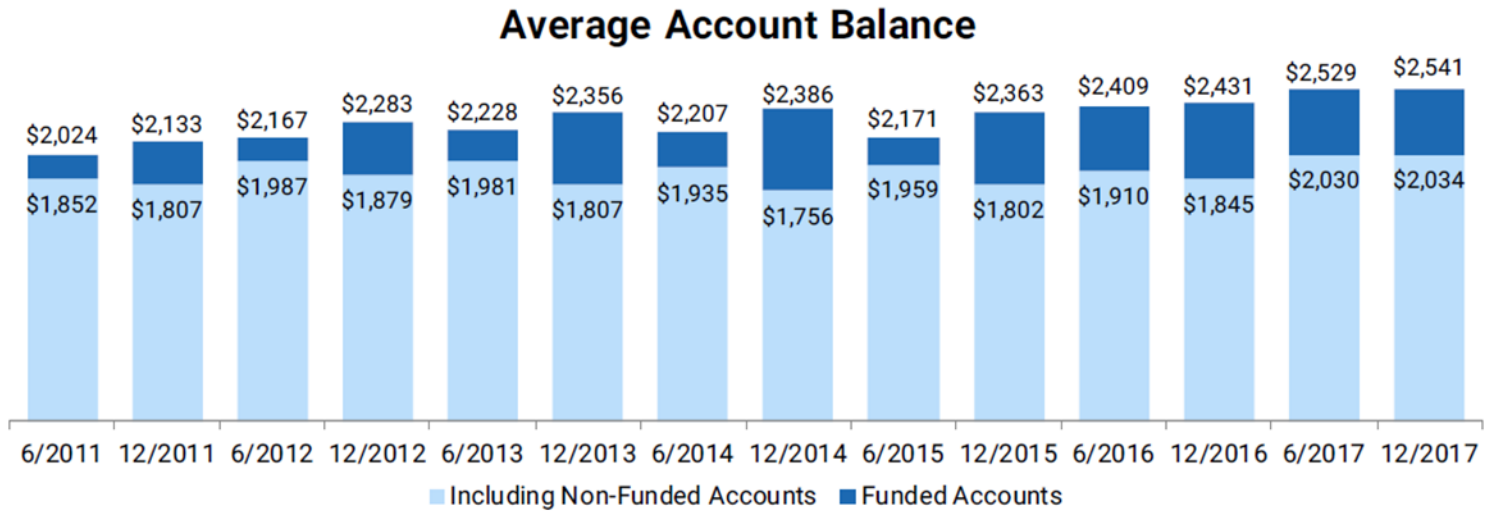

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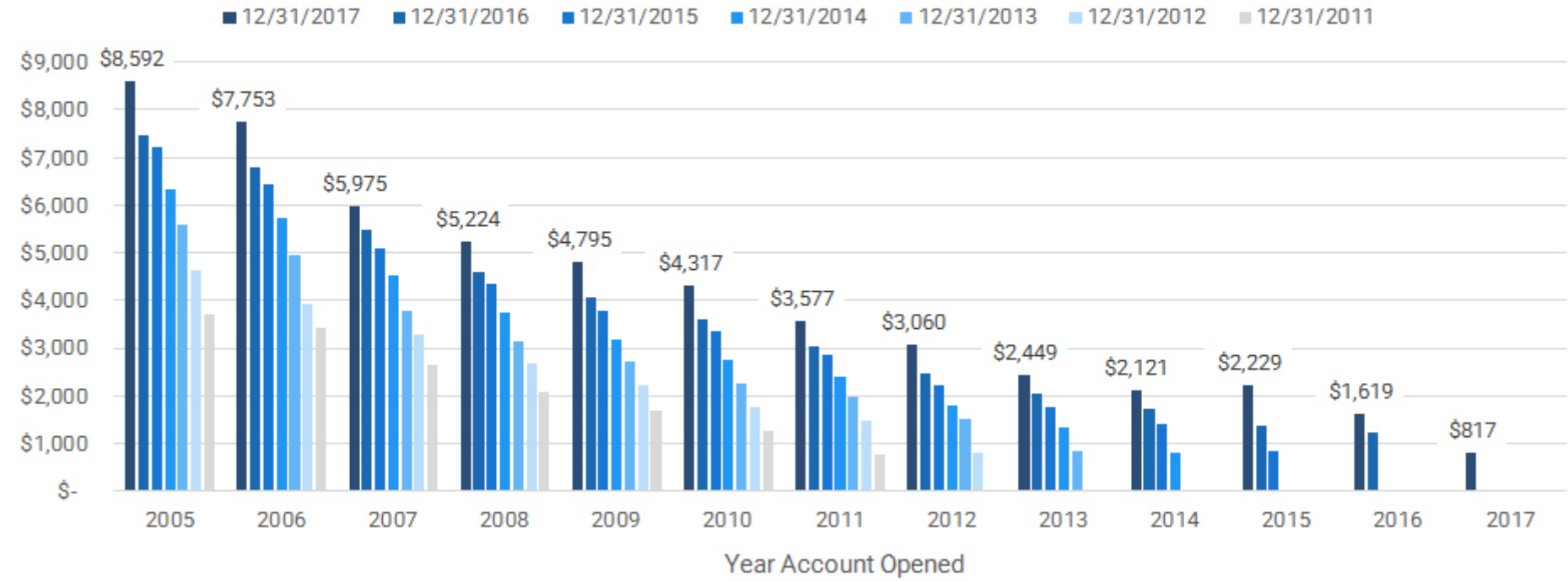
Average Balance By Year The Account Opened



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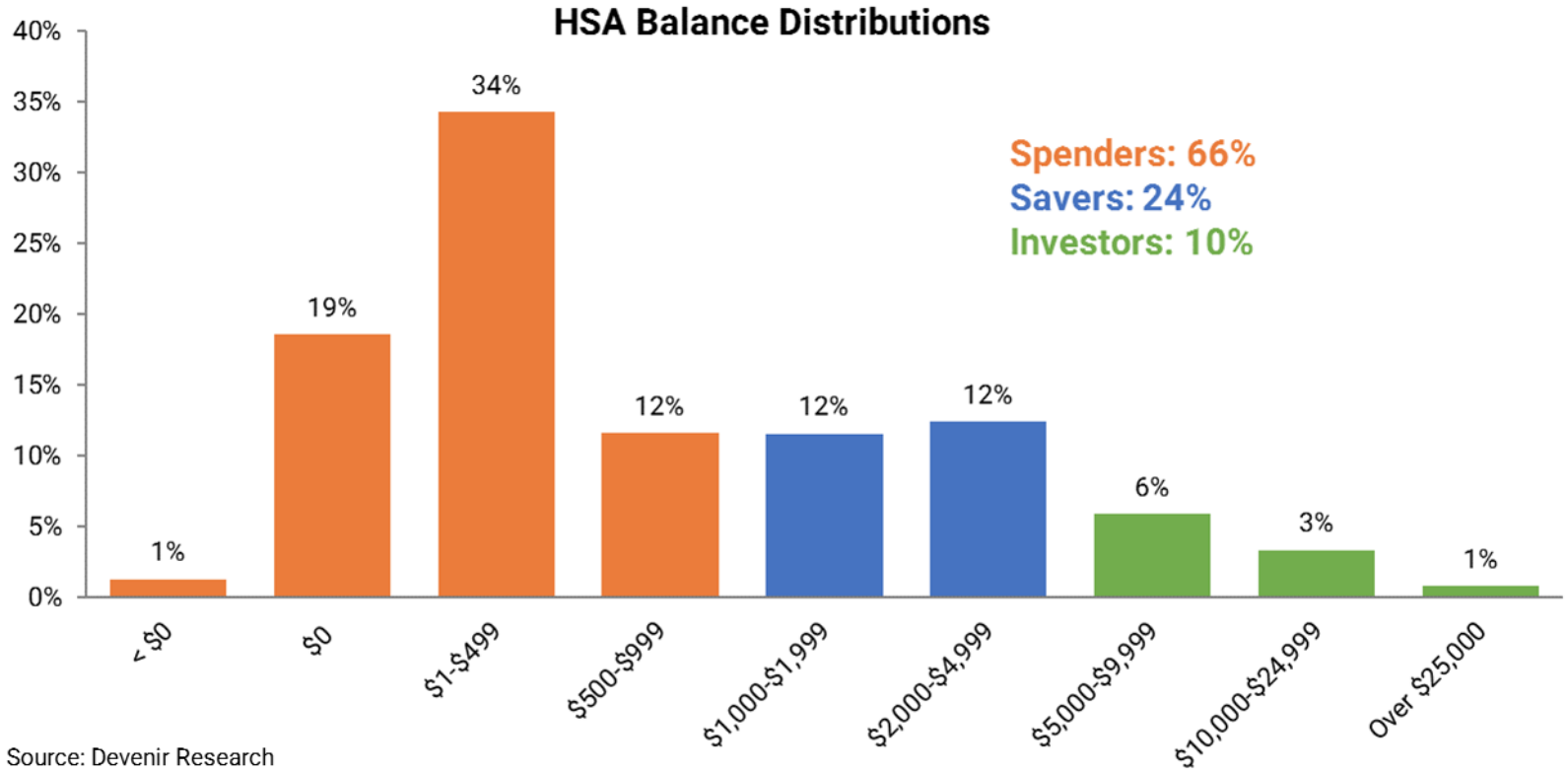

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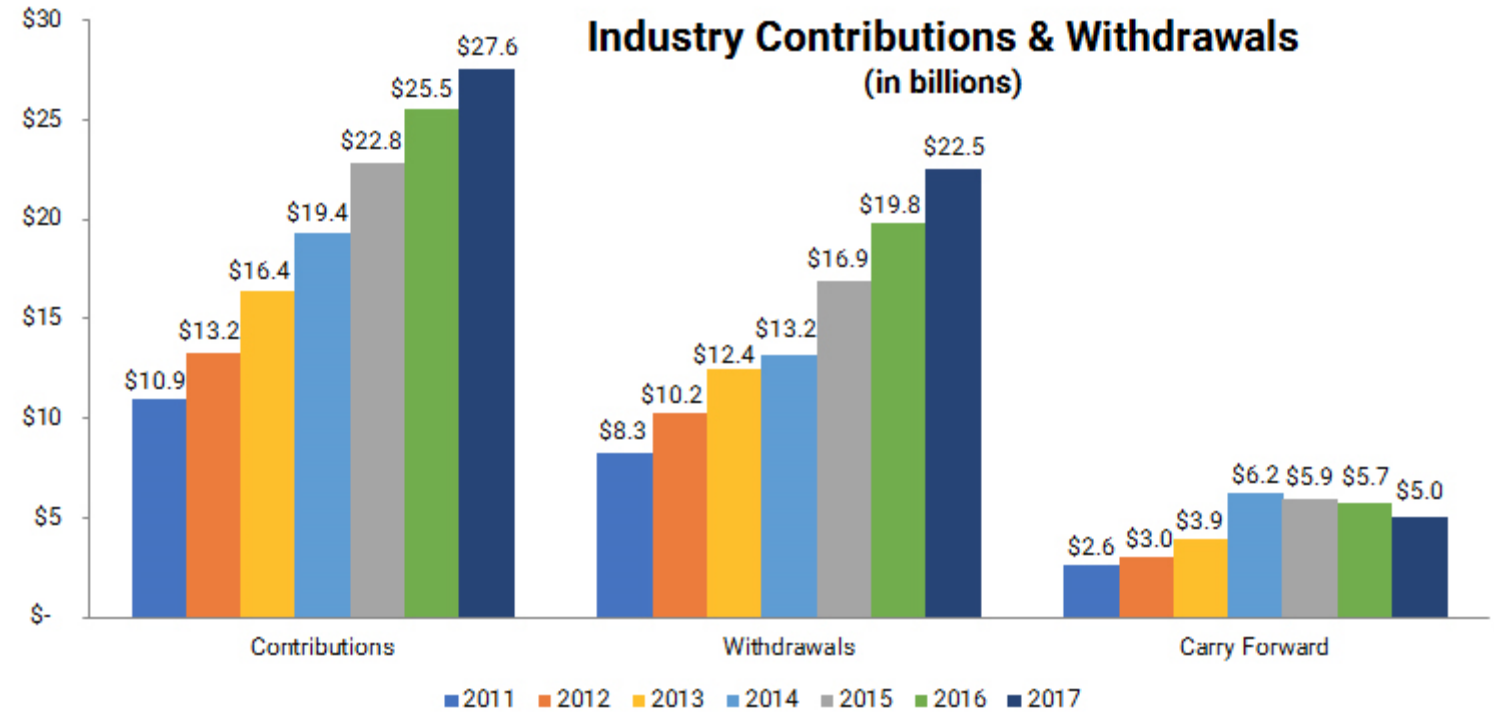

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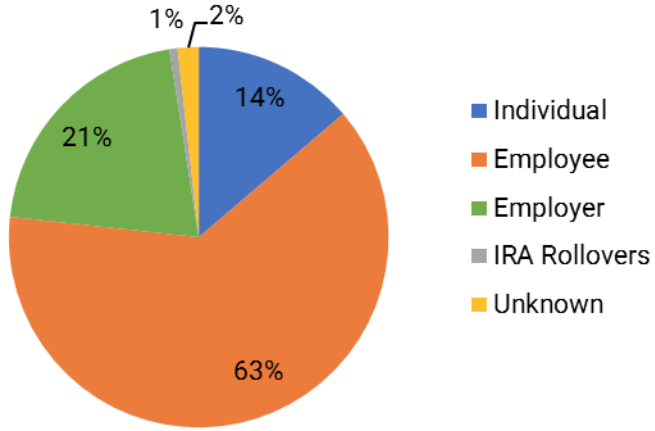
Contributions 2017 ($)



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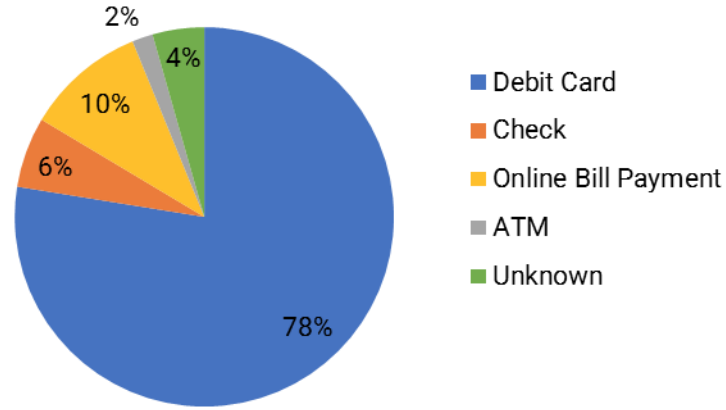
Withdrawals 2017 ($)



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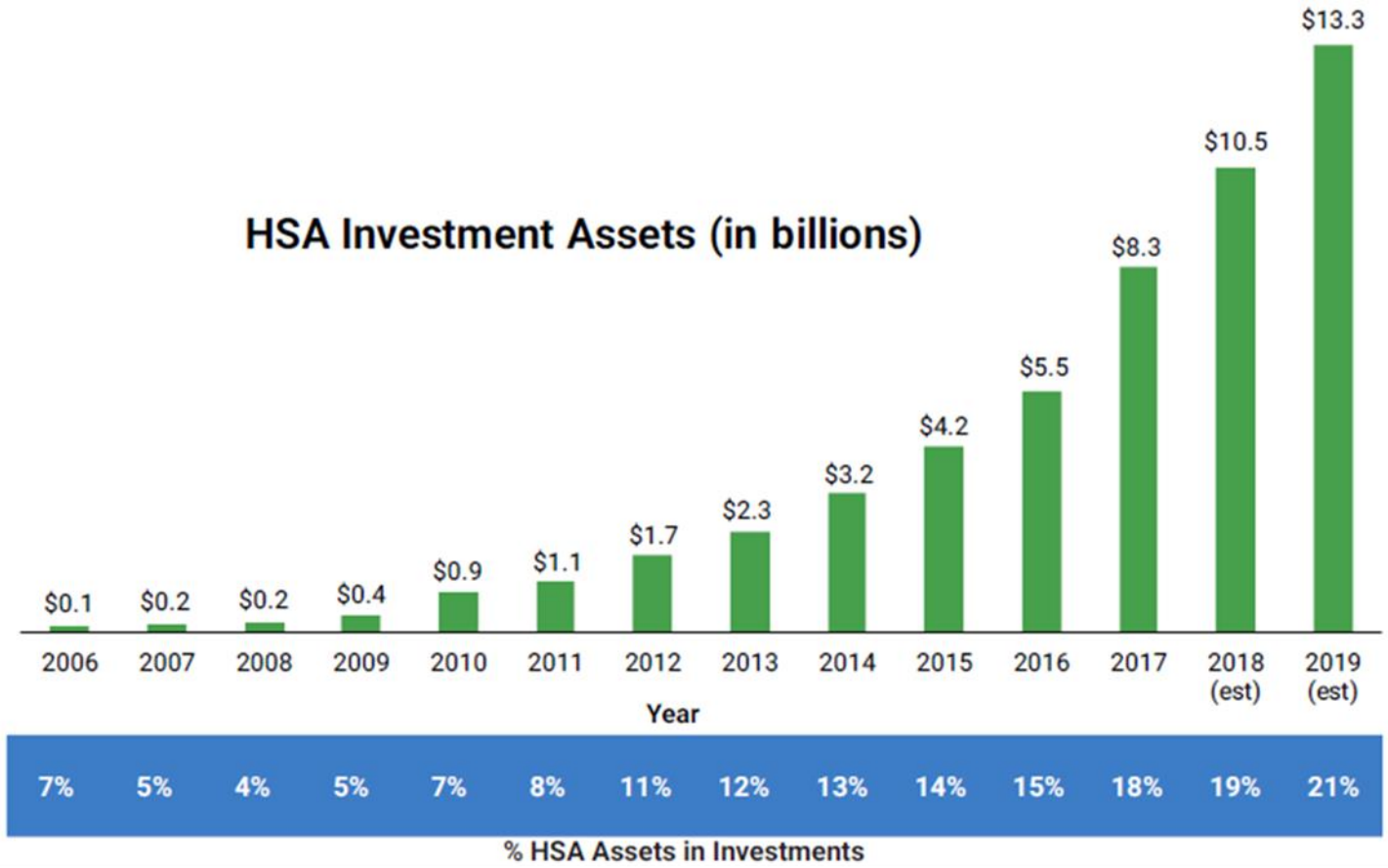

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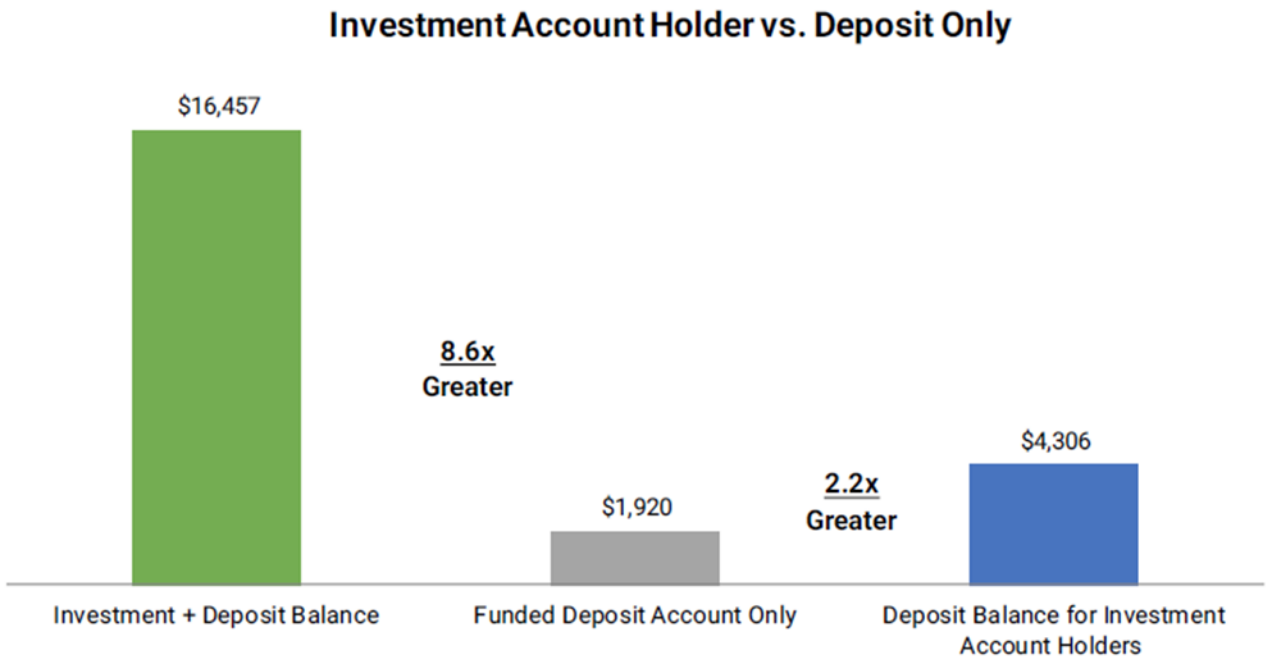
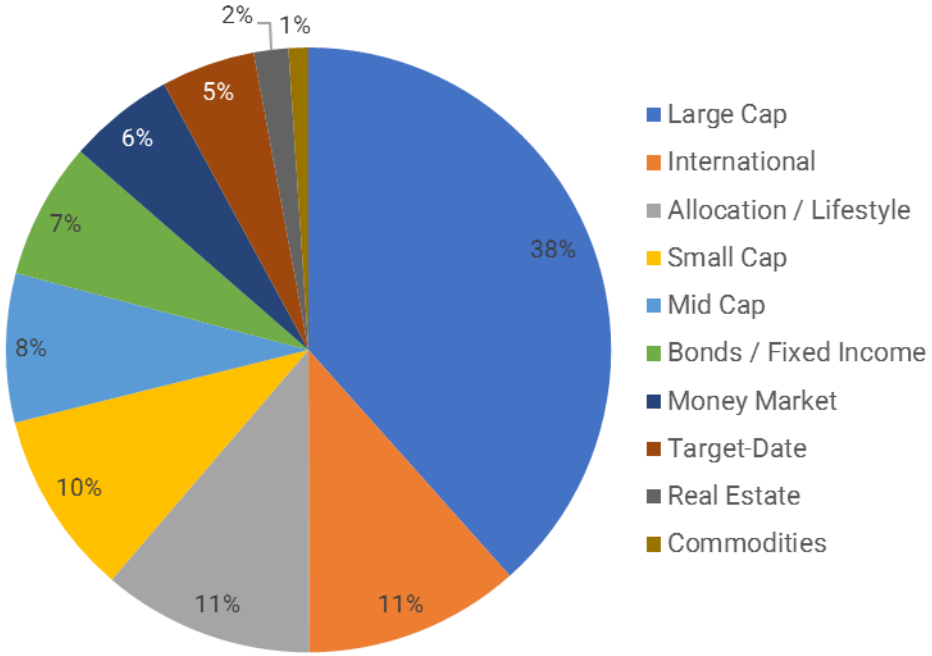


Source: Devenir Research

HSA Mutual Fund Holdings by Asset Class ($)



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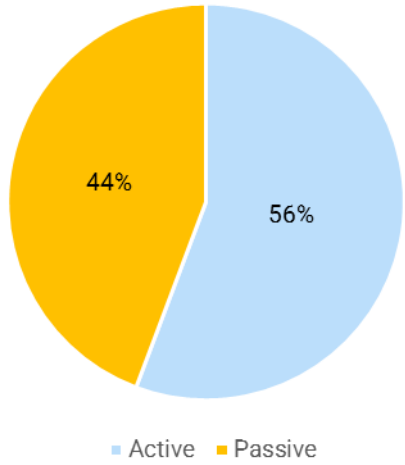
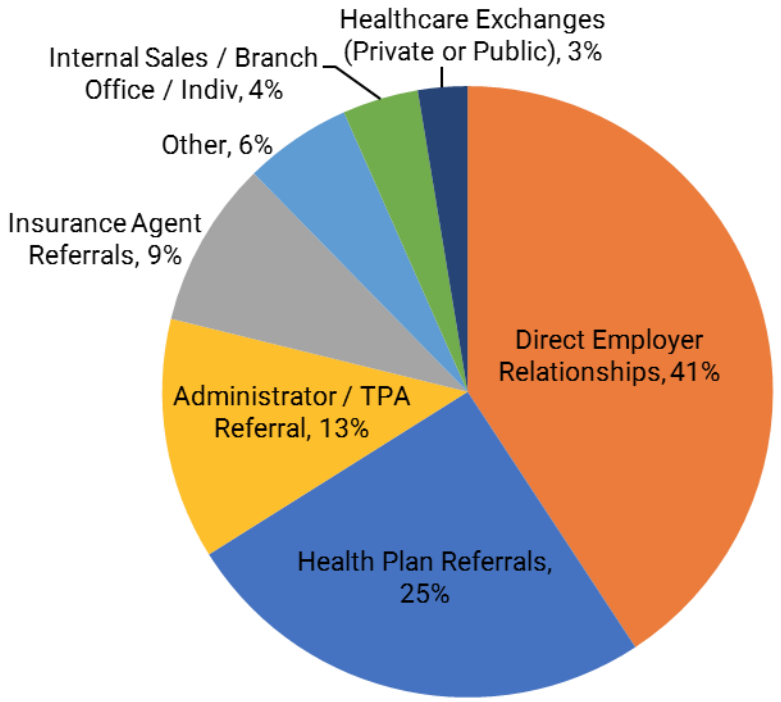
Active vs. Passive Holdings



Source: Devenir Research

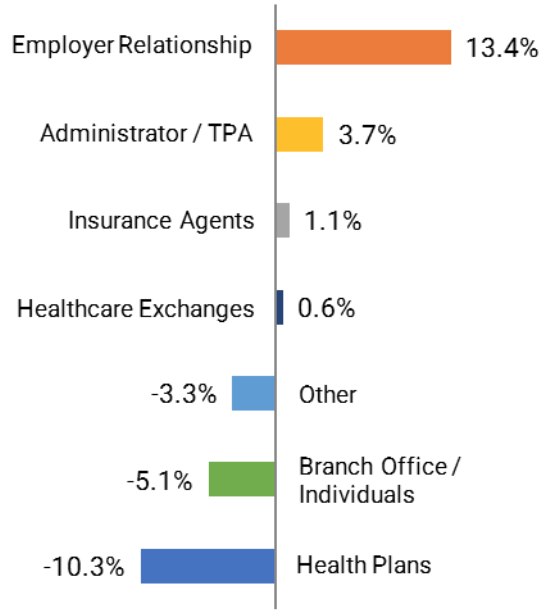
% of New Accounts Attributed to Various Partnerships in 2017



Source: Devenir Research

New Account Source Trend

12/31/17 vs 12/31/15



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