Testimony Before the Subcommittee on Health of the Ways and Means Committee of the House of Representatives

Hearing on Lowering Costs and Expanding Access to Health Care Consumer-Directed Health Plans

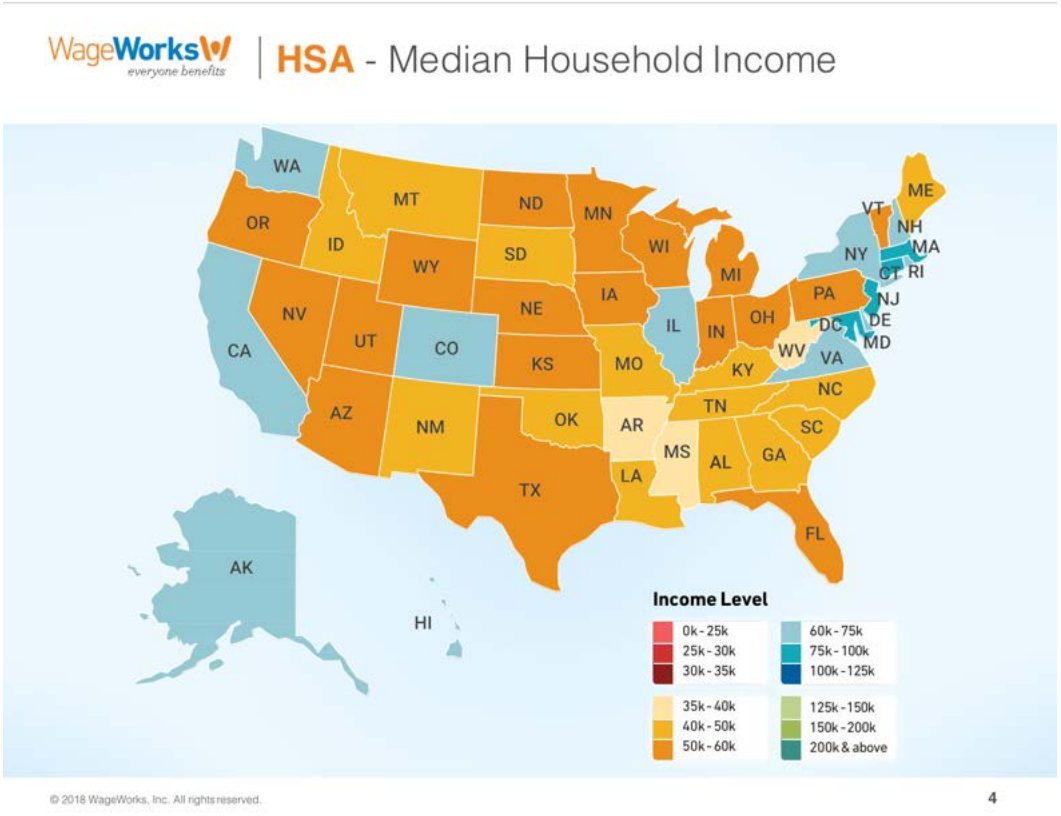
Submitted by Jody L. Dietel, ACFCI, CAS
Chief Compliance Officer for WageWorks, Inc.

June 6, 2018

Thank you, Chairman Roskam, Ranking Member Levin and members of the Subcommittee for the opportunity to speak with you today. My name is Jody Dietel. For the better part of the last decade, I have been the Chief Compliance Officer for WageWorks, Inc., a leading provider of consumer directed-benefit accounts, including account-based benefit plans which provide benefits in areas such as health care, child care, and commuting. In the health care arena, we provide administrative services for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Health Flexible Spending Accounts (Health FSAs). We appreciate the Subcommittee's interest in consumer-directed health plans as a means of lowering costs and expanding access to health coverage.

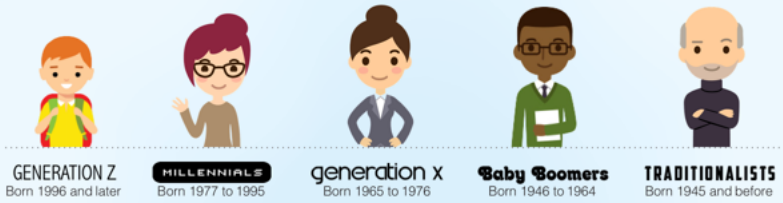
WageWorks, Inc. provides administration for nearly 85,000 employers nationwide, including the FSAFeds program offered by the Office of Personnel Management. Our services cover more than 7 million employees nationwide, the majority of whom participate in an HSA or Health FSA.

Due to the nature of our administrative services and our diverse client base, we have access to a significant amount of data which we monitor and analyze on a regular basis to help improve our services. This data provides some unique and compelling insights related to HSAs that I believe will be of interest to you as you consider ways to lower costs and expand access to these consumer-directed accounts.



An often assumed data point is that HSAs are primarily utilized by highly paid employees. Our data supports the conclusion that this assumption is incorrect. The median household income for an HSA accountholder is $57,060. In fact, HSA accountholders in just four states (Connecticut, Maryland, Massachusetts, and New Jersey) and the District of Columbia have median household incomes in excess of $75,000. In 11 other states, the median household incomes of HSA accountholders range from $60,000 to $75,000, 18 states have median household incomes ranging from $50,000 to $60,000, and in another 17 states, the median household income is less than $50,000.

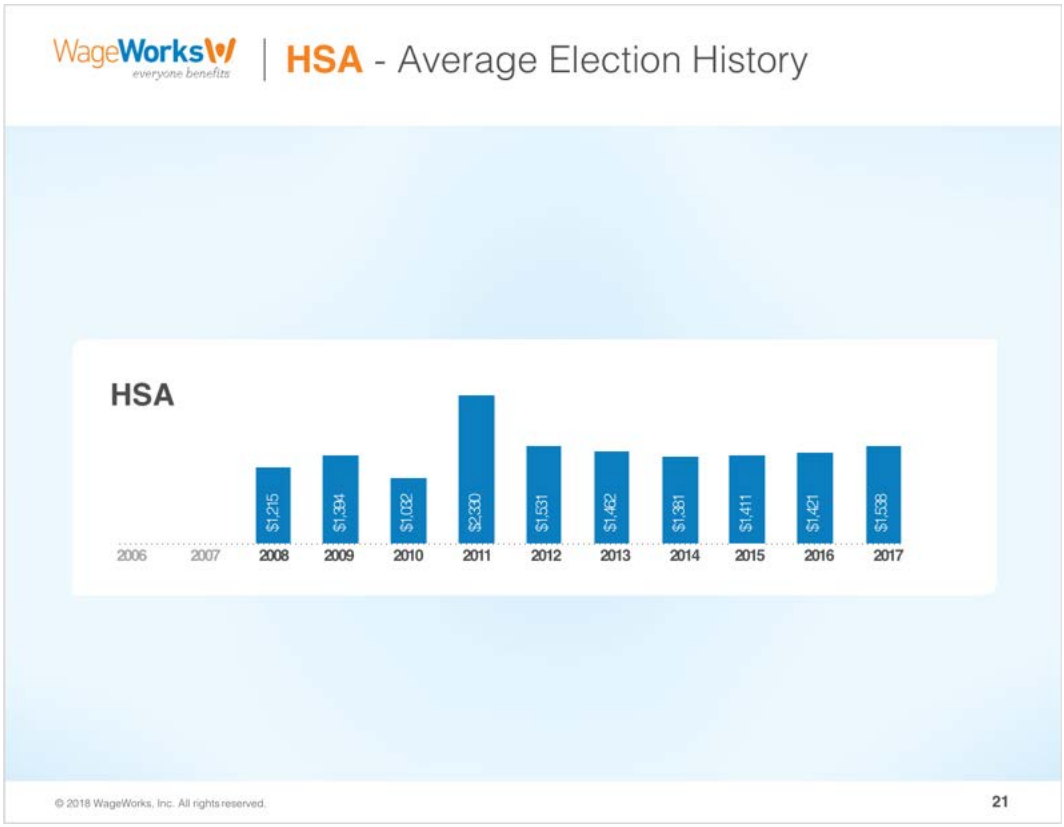
WageWorks everyone benefits | **HSA** - Participation by Generation



Generation	Elections	Average Election	Participant Percent
Gen Z	$1,884,149	$481	0.68%
Millennials/Gen Y	$236,062,584	$846	48.44%
Gen X	$252,597,616	$1,568	27.94%
Baby Boomers	$228,262,742	$1,741	22.75%
Traditionalists	$1,241,757	$1,191	0.18%
Unknown	$7,404	$1,234	0.00%

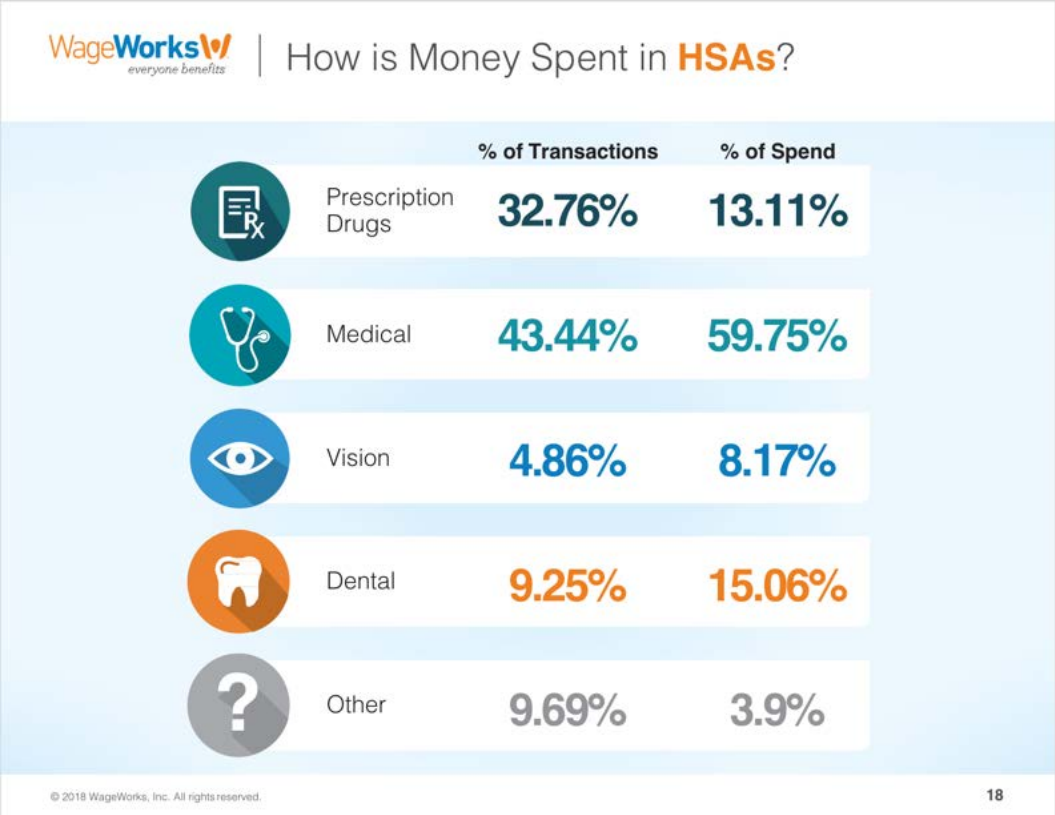
23

Another claim we often hear is that only older workers (assumed to have more disposable income) contribute to HSAs. Our data also supports the conclusion that this too is incorrect. Specifically, we found that nearly 77% of participants contributing to an HSA were born in 1965 or after, belonging to the Gen Z, Millennial and Gen X demographic. Only about 22% of our participants are Baby Boomers.



There is also an oft-stated assumption that individuals "stuff" large amounts of money into their HSAs. However, our data illustrates generally consistent average annual contributions over time, ranging from a low of $1,032 in 2010 to a high of $1,538 in 2017.[1] With annual contribution limits ranging from $2,900 to $6,760 during the same time frame (depending on whether the accountholder has single or family health coverage), this contribution data stands in opposition to the notion that employees are using HSAs for means other than funding their medical expenses.

[1] 2011 may be an outlier at $2,330 due to the accelerated movement to implement High-Deductible Health Plans (HDHPs) as a response to the many of the changes enacted under the Affordable Care Act (ACA) that became effective in 2011.



We also analyzed the data for spending trends among the participant accounts that WageWorks administers. While it may be assumed that accountholders are using their HSA as a long-term savings vehicle, we found that accountholders are largely spending-down their balances. For example, our data shows that over the last seven years, amounts ranging from just 25% to 35% of annual contributions are carried into the next year for future out-of-pocket expenses. At the same time, we found that 66% of transactions and 69% of spending is on both inpatient and outpatient care at health care providers, while almost 33% of transactions and 13% of spending is attributed to prescription drugs.

BARRIERS EMPLOYERS FACE WHEN ESTABLISHING CONSUMER-DIRECTED HEALTH PLANS

Employers are challenged when designing health care plans to meet multiple objectives such as containing costs, maintaining a healthy and productive workforce, providing coverage tools for those with chronic conditions and providing access for employees to manage rising out-of-pocket costs. Unfortunately, many of the existing HSA rules have not kept pace with innovative design solutions that many employers want to utilize.

For example, the existing HSA eligibility rules limit an employer's ability to offer value-based insurance designs intended to help pay for specified chronic care services necessary to improve treatment adherence and condition management. Specifically, in cases where an employer wants to design an otherwise HSA-qualified High-Deductible Health Plan (HDHP) to pay for

certain chronic care services before the deductible is met, this design – while advantageous to an employee with a chronic condition – will render this employee ineligible to contribute to an HSA.

Currently, HSA-qualified HDHPs are permitted to cover certain "preventive services" before the deductible is met without disqualifying HSA participation. However, coverage for "other services" is considered coverage before the deductible is met, thus disqualifying covered individuals from contributing to an HSA. These other services can include reducing or eliminating cost-sharing or deductibles for specified high-value medications and services, such as medications to control blood pressure or diabetes, and may save money by reducing future expensive medical procedures and improving the health status of the patient. Value-based insurance designs have been shown to improve adherence to medication regiments, quality measures, health outcomes, and patient experience, yet these designs adversely affect an employee's eligibility to contribute to an HSA.

Employers are also largely prohibited from offering certain telemedicine services or access to near-site/on-site clinics while also maintaining an employee's eligibility to contribute to an HSA. Such services and access in most cases are considered "coverage under the deductible" and thus disqualify employees from contributing to an HSA, even though the employee is covered under an HSA-qualified HDHP.

It is important to note that telemedicine allows patients to save transportation costs and time, provides access to care for individuals living in rural areas and other underserved locations, and also reduces the need for individuals to miss work due to doctor's appointments and other medical care. Additionally, it helps patients avoid waiting rooms where other ill patients are waiting for provider visits—thus reducing the chance of secondary illness.

Access to near-site or on-site clinics began in the 1980s, usually as a way to treat occupational injuries typically in heavy-industry or manufacturing industries. As those industries declined, so did the number of employers with on-site clinics. However, in the past 10 years or so, on-site clinics have experienced a renewed popularity as they give employers the opportunity to better control healthcare delivery costs. Additionally, many on-site clinics offer lower or no co-pays to employees. On-site clinics have been shown to improve employees' focus on preventive care, including diagnostic screenings and flu shots. The increased access to on-site clinics may reduce absenteeism because employees are less likely to work while ill or develop a more serious illness (which requires them to remain at home) due to lack of appropriate medical care.

Unfortunately, most telemedicine and near-site/on-site clinics disqualify employees from contributing to an HSA because such telemedicine services or access to near-site/on-site clinics are considered impermissible coverage below the statutorily mandated deductible for HSA-qualified HDHPs (for 2018, the minimum deductible for an HSA-qualified HDHP is $1,350 for single and $2,700 for family coverage).

Additionally, some employers are establishing direct primary care relationships, which provide primary care for a fixed fee. These arrangements are shown to improve access to preventive services, better health outcomes and provide more coordinated care for patients, often with significant cost savings. These too disqualify a participant from contributing to an HSA.

There are other eligibility requirements that are fairly rigid, preventing employees from contributing to an HSA. These include the inability for a working senior who is eligible for Medicare Part A or an individual covered by Indian Tribal Health Services or TriCare to contribute to an HSA. This inability also extends to those covered by a health care sharing ministry, which is designed as a consumer-directed option. Also, an employee whose spouse has a Health FSA is prevented from contributing to an HSA, even though this employee is covered under an HSA-qualified HDHP.

Currently, HSA accountholders who are older than age 55 can make catch-up contributions of $1,000 annually. Unfortunately, current law requires a spouse to make their catch-up contribution to a different account, which is confusing and administratively burdensome for the consumer. This is another example of "eligibility rigidity" that should and could be addressed for the purposes of removing outdated barriers to HSA adoption and use.

WITH THE INCREASED NUMBER OF HIGH-DEDUCTIBLE HEALTH PLANS (HDHPs), CONGRESS SHOULD MAKE IT EASIER TO ACCESS AN HSA

Outside data indicates that an increasing number of employers are moving to HDHPs. This trend will only increase the important role played by HSAs. According to Kaiser Family Foundation's (KFF) 2017 Employer Health Benefits Survey,[2] 58% of covered workers are employed in a firm that offers more than one health plan type. Seventy percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 30% in small firms. About 57% of covered workers work in firms that offer one or more HDHPs with Savings Options. Among covered workers in firms offering only one type of health plan, those in large firms are more likely to be offered an HDHP with Savings Options (36%) than those in small firms (23%). Among covered workers in firms offering only one type of health plan, 30% are in firms that only offer an HDHP with Savings Options.

In recently released data from the 2017 National Health Interview Survey,[3] 43.7% of people under age 65 with private health insurance were enrolled in an HDHP, including 18.2% who were enrolled in a consumer-driven health plan (i.e., an HDHP paired with an HSA) and 25.5% who were enrolled in an HDHP without an HSA. Among those with private health insurance, enrollment in HDHPs has generally increased from 25.3% in 2010 to 43.7% in 2017.

[2] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.
[3] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

HDHPs are attractive to both employers and employees alike as they generally have lower premium costs. Data from the KFF 2017 Employer Health Benefits Survey supports this proposition: "The average annual premiums for covered workers in an HDHP with Savings Options are lower for single coverage ($6,024) and family coverage ($17,581) than overall average premiums. The average premiums for covered workers enrolled in PPO plans are higher for single ($6,965) and family coverage ($19,481) than the overall plan average."[4] It is important to note, however, that there are wide variations in premiums based on several factors, including group size, region, industry, age demographics, wage level, union status and firm ownership. These factors and the impact on premiums are also discussed in the KFF report.

Common sense changes to address the eligibility issues discussed above would serve to make HDHPs paired with an HSA far less confusing and more workable for American workers and employers. Additionally, while average contributions are not anywhere near the maximum HSA contribution limits (as illustrated by our data, discussed above), accountholders should be able to protect themselves against the maximum out-of-pocket exposure they have, so contribution limits should be aligned with the HSA out-of-pocket limits (for 2018, the HSA out-of-pocket limits are $6,650 for single and $13,300 for family coverage). As a reference point, the Milliman Medical Index (MMI) reports out-of-pocket costs reaching $4,704 in 2018, up from $4,534 in 2017.[5] Out-of-pocket costs are expected to continue to increase each year.

OTHER CHALLENGES EMPLOYERS FACE

Another challenge for employers is the Cadillac Tax. While delayed until 2022, this excise tax still looms large. As currently enacted, it appears that employee contributions to HSAs and Health FSAs will be included in the calculation of the Tax. To keep costs below the thresholds, employers may have no other choice but to limit the amount employees may contribute to their HSA or Health FSA, which ends up hurting employees who need help paying for their out-of-pocket costs. A Commonwealth Fund issue brief indicates this: "Thus, at least initially, these savings accounts, rather than enrollee cost-sharing or other plan features, are likely to be affected most by the tax as employers act to limit their HSA contributions."[6] More pointedly, in response to the Cadillac Tax, the American Health Policy Institute found that about 19% of large employers were already curtailing or eliminating employee contributions to Health FSAs and about 13% of large employers were curtailing or eliminating employee contributions to HSAs.[7]

[4] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.

[5] http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf. The Milliman Medical Index (MMI) is an actuarial analysis of the projected total cost of health care for a hypothetical family of four covered by an employer-sponsored preferred provider organization (PPO) plan. Unlike many other healthcare cost reports, the MMI measures the total cost of healthcare benefits, not just the employer's share of the costs, and not just premiums.

[6] http://www.commonwealthfund.org/publications/issue-briefs/2016/june/cadillac-tax.

[7] http://www.americanhealthpolicy.org/Content/documents/resources/AHPI_Excise_Tax_October_2015.pdf.

It is important to note that Health FSAs are additional tools valued by working Americans because FSA funds are available in their entirety on the first day of the year, rather than needing funds to accumulate before reimbursing expenses. In fact, based on anecdotal data from WageWorks participants—and common sense—shows that those with chronic or serious illnesses often fare better with a Health FSA than an HSA because their spending occurs early in the year, and the immediate availability of Health FSA elections (even though funds have not actually been contributed yet) helps participants afford their sometimes significant out-of-pocket costs. In addition, FSAs can be designed to coordinate with HSAs, paying for dental and vision expenses, while allowing the HSA to pay for out-of-pocket costs under the medical plan.

Finally, most employer plans today have high deductibles. For example, KFF's 2017 Employer Health Benefits Survey notes that 81% of covered workers are enrolled in a plan with an annual deductible, and that the average annual deductible for single coverage is $1,505,[8] which is higher than the HSA-qualified HDHP's statutory minimum deductible (e.g., for 2017, the minimum deductible for an HSA-qualified HDHP was $1,300 for single coverage). This and other design challenges often lead to confusion about whether a plan is actually an HSA-qualified plan or a just an HDHP with features that render an employee ineligible to contribute to an HSA. A simple way to resolve this confusion is by changing the law to refer to an HDHP that preserves an employee's eligibility to contribute to an HSA as an "HSA-Eligible Health Plan," which is a change that would be welcomed by the employer community.

WageWorks recognizes the opportunity Congress has to enact meaningful HSA policy changes and follows closely the various legislative proposals in both the House and Senate that will address many of the eligibility issues I have raised herein. These include changing the name of an HDHP that otherwise qualifies as an HSA-qualified HDHP to an "HSA-Eligible Health Plan," fixing the eligibility issues faced by those with "other coverage" such as Indian Tribal Health Services, TriCare, Medicare Part A, and those whose spouse may have a Health FSA and allowing employers greater freedom in plan design to include chronic care services, direct primary care, value-based coverage and telemedicine, along with access to on-site or near-site clinics. We thank the Committee on Ways and Means for all of their efforts to enact common sense HSA reforms, and we would be happy to serve as a continued resource as these proposals move through the legislative process.

Thank you for your time. I look forward to answering any questions you may have, and can be reached at Jody.Dietel@WageWorks.com or 650.577.6372.

[8] http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017.