

**Statement  
of the  
American Hospital Association  
before the  
Committee on Ways and Means  
of the  
U.S. House of Representatives**

**“Hearing on Lowering Costs and Expanding Access to Health Care through Consumer-Directed Health Plans”**

**June 6, 2018**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (approximately 100 of which sponsor health plans), and 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on consumer-directed health plans and their relationship to lowering costs and expanding access to care for patients.

Health care affordability is a significant challenge for many individuals and families, and we appreciate policymakers’ exploration of potential solutions to address this issue. This hearing will consider whether consumer-directed health plans can be a part of the solution. The AHA defines consumer-directed health plans as those plans that pair a health savings account (HSA, usually tax-advantaged) with a high-deductible health plan (HDHP). Patients use funds from the HSA to pay for most services until a minimum deductible has been reached; the HDHP covers some limited preventive care, as well as catastrophic costs. These plans generally offer lower premiums than more conventional insurance products and, therefore, may appeal to more cost-conscious consumers or those who expect to have fewer health care needs.

Consumer-directed health plans may be an appropriate form of coverage for some individuals, including those who have high health care literacy and sufficient means to fund their HSAs or otherwise cover higher upfront costs. However, the AHA is concerned about the ability of these plans to lower costs and expand access to care for individuals who may not be aware of the limitations of such coverage and who do not have the means to fund their HSAs or otherwise pay for initial care out of pocket.



Hospitals and health systems report that increased enrollment in HDHPs over the past several years has *reduced* access to care and subjected patients to costs they cannot afford. In addition, patients enrolled in HDHPs appear to delay care until they have reached their deductible or are in an emergency situation, which could lead to poorer health outcomes.

While we recognize that these types of health plans are intended to promote consumer engagement in their health, we are concerned that the evidence does not currently support this assertion. Hospitals and health systems report that many patients in HDHPs do not understand their coverage. Instead of being active purchasers, patients are often surprised to learn what their health plan does and does not cover when they are at the point of care, and this information may not contribute to shopping for the best value but rather to opting not to pursue care at all.

The impacts identified above may vary if an entity besides the patient, such as an employer, funds the HSA. However, employer funding of HSAs is on the decline, and this is not an option for the millions of consumers who rely on the individual market. According to United Benefit Advisors, “The average employer contribution to an HSA is \$474 for a single employee (down 3.5 percent from 2015 and 17.6 percent from five years ago) and \$801 for a family (down 9.2 percent from last year and 13.7 percent from five years ago).”<sup>1</sup> These figures account for approximately a third of what the minimum deductible must be for a plan to qualify as an HDHP. Therefore, even when employers do contribute to an HSA, patients retain the bulk of the financial responsibility.

## **IMPROVING ACCESS & REDUCING THE COST OF COVERAGE**

Without addressing the underlying cost of care, insurance benefit designs like HDHPs and HSAs simply “shuffle the deck chairs.” In other words, HDHPs do not necessarily reduce the right costs (e.g., low-value care or medically unnecessary care), they shift responsibility for upfront costs from one entity to another – first from the payer to the consumer and then to providers in the form of bad debt. We encourage Congress to pursue actions that will help improve the cost of coverage without putting access to care at risk, including:

1. Addressing the underlying drivers of high cost, such as the unsustainable growth in prescription drug prices; duplicative, unnecessary and potentially harmful regulatory and administrative burden; and high rates of chronic disease; and
2. Promoting enrollment in comprehensive health care coverage to share costs across the broadest population possible, including through stabilizing the health insurance marketplaces.

We recognize that HDHPs coupled with HSAs will continue to be an attractive option for some individuals. We encourage Congress to improve on these by re-examining the services that insurers may offer pre-deductible or which may be covered by funds in an HSA. For example, we specifically support expanding insurers’ ability to cover care for chronic conditions pre-deductible. This change would help remove financial barriers patients may face while managing their health. In addition, we strongly encourage the federal and state governments, employers and

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<sup>1</sup> United Benefit Advisors, “Special Report: How Health Savings Accounts Measure Up,” May 2017.

other payers to coordinate on a robust consumer education campaign on the importance of having health coverage and how to use it. The campaign should specifically address how different types of health plans may affect both premiums and upfront, out-of-pocket costs.

## **CONCLUSION**

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning access to care and the affordability of coverage. We are deeply committed to working with Congress, the Administration, and other health care stakeholders to ensure that all individuals and families have the health care coverage they need to reach their highest potential for health.