

Statement of
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to the

Committee on Ways and Means
United States House of Representatives

on

The Real World Experience of People with HSAs

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Mr. Chairman and Members of the Committee,

Thank you for the opportunity to share the experiences some real people have had in dealing with Health Savings Accounts (HSAs) and other forms of Consumer-Driven Health Care.

Before doing that, let me take a moment to thank you personally, Mr. Chairman, for the leadership you have shown in this area. You have made a real difference in the lives of millions of Americans. You have made it possible for them to acquire health insurance when they could not before. You have given them the opportunity to be active participants, rather than passive recipients, in the health care system. You have allowed them to choose the health plan that works best for themselves and their families.

I believe the enactment of HSAs has spawned a revolution in American health care. One that will lead to better quality, lower costs, improved efficiency, more accountability, and greater convenience for all Americans. It will also restore the patient-physician relationship that is the essential moment in any health care encounter.

But those system-wide effects are all in the future. Only time and experience will tell how profound the changes will be.

Meanwhile, HSAs have already helped millions of people. The effects are often hidden from Washington-based policy experts and researchers who rely on population-wide surveys and national data.

For instance, HSAs are an enormous help to people with surges of income – commissioned salespeople, seasonal workers, farmers, consultants, entrepreneurs, and the like. Washington rarely thinks about these people, assuming instead that everyone is on a bi-weekly payroll like federal employees are. But people who do not get a steady paycheck are the risk-takers and innovators of our economy. They find it very difficult to pay huge insurance premiums, month after month, year in and year out.

HSAs enable them to minimize their monthly premium obligation and fund their HSA when the money is available. Instead of paying \$600 a month, every month, they may be able to lower that to \$300 or \$400 a month, and then fund their HSA when they receive their commission checks – anytime from January of one year to April 15 of the following year.

This kind of flexibility is essential to a dynamic economy. And it was you and this Committee who made it possible, Mr. Chairman.

Here are some examples of people who have benefited from HSAs. These and more are available at our web site at -- <http://www.chcchoices.org/testimonials.php>

Chris Krupinski of Fairfax, Virginia, is a self-employed graphic designer. She owns CK Art and Design. She writes:

“I am a widow with three children and have had my own business for about 10 years. Although I have kept insurance during that time, I could only stay with a company for about a year and a half before the policy would get too expensive and I would have to look again for another company. Before finding out about HSAs, I was paying \$900 a month for a family plan that had a \$2,000 deductible for every health event. That meant when I had two knee surgeries in one year – I owed \$2,000 for each of them before my insurance kicked in.

“Then I heard about Health Savings Accounts. I now pay \$350 per month for my family, with a yearly deductible of \$3,500. Each month, I put aside another \$350 into my HSA account. That HSA account is my money, and yet, I am still paying less per month than I was under the old policy.

“The beauty of the HSA is that if I have anything left over at the end of the year, that money is mine. It gives me options, and it is much better financially. Before, when I wrote those premium checks out each month, that money was just gone.”

Lawrence Kneisley, MD, is a physician in Torrance, California. He writes:

“My son Andrew, then age 16, broke his arm (distal radius and ulna) snowboarding in December, 2003. He was hospitalized for urgent surgery at Torrance Memorial Hospital. He was admitted in the afternoon, spent about 2 hours in the OR under the care of the orthopedic surgeon who performed an open reduction under general anesthesia using a C-Arm X-ray for alignment. He was hospitalized overnight on the pediatric ward and discharged at noon the following day. Total time in the hospital-about 20 hours. The hospital charge was \$18,834.03! This did not include the orthopedic surgeon's fee. Our HSA (at the time an MSA from Medical Savings Insurance) determined that Torrance Memorial Hospital Medical Center's reasonable and customary charge to be \$4961.64. This was based on the Medicare diagnostic related group (DRG) according to the diagnosis and procedure codes provided on the hospital bill.

“Medical Savings Insurance paid the hospital \$2,019.36. I paid the remainder, \$2,942.28. I felt this was fair and reasonable. After some investigation and discussion, the hospital accepted this amount as payment in full.

“The lesson I learned was that if Medical Savings Insurance had not investigated and challenged the claim amount that the hospital wanted to charge, I would have been forced to pay most of the inflated bill. I got educated to the fact that hospitals accept lower but still profitable rates from big insurers such as Blue Cross and various HMO's such as Health Care Partners and still make money. They then charge smaller insurers, and patients with MSA's (now HSA's) huge markups, some 350% in my son's case when compared to Medicare and the HMO contracted rate. Certainly if the Medicare payment rate and HMO payment rate are acceptable to a hospital then the self-paying patient deserves the same deal.”

Ian Duncan, an actuary in Hartford, Connecticut writes:

“Susan and Clark Furlong own a small organic farm outside Phoenix. They supply local markets with fresh produce and sell their products on the Internet. They have three children: Tucker, 6, Will, 4, and Tess, 2. Susan has a background in diabetes and lactation education, and works part time for Lotter Actuarial Partners. As a part-timer, she’s not eligible for benefits, so she and Clark shopped around for a high-deductible policy, eventually buying one from Fortis. Their policy covers 100 percent of medical costs after a \$4,800 family deductible. The quarterly premium is \$753, before contributions to the optional medical spending account. The Furlongs decided to forgo the optional drug rider, self-insuring their drug benefits because they’re not on any maintenance medications.

“As parents of young children, the Furlongs have their share of emergency room visits. Recently, Will fell while playing a recorder, which scraped the back of his throat, resulting in a fair amount of blood and discomfort. The Furlongs wanted to have Will examined by a doctor. The first decision they faced was: hospital emergency room or walk-in medical center? The walk-in medical center was closer and likely to be cheaper, so that’s where they went. Because the Furlongs didn’t have comprehensive first-dollar insurance, the medical center wanted payment in advance before the doctor would see Will, so they paid the \$200 fee. But the doctor decided that he couldn’t help, and told the Furlongs they should go to the emergency room. Before they left the walk-in center, Susan negotiated her advance payment back.

“Two things immediately differentiate the Furlongs’ response under the high deductible plan, compared with a typical insured’s response: first, a cost-benefit evaluation of the clinic vs. emergency room setting, and second, getting their money back from the clinic.

“In the emergency room, the Furlongs faced a decision about having an X-ray, which they decided to do after discussing cost and benefits with the physician. Will was checked out and given a clean bill of health, although he was uncomfortable and couldn’t swallow. His physician prescribed Augmentin (a name-brand antibiotic) and Lortab elixir (a brandname painkiller). Susan checked both of these carefully, particularly the antibiotic, which cost \$94.99 per prescription. The painkiller cost \$27.39. In the end, she chose a generic antibiotic (Amoxicillin) at \$69.69 and a generic painkiller (\$14.79). There wasn’t much the Furlongs could do about the emergency room costs, but every other expense associated with the accident was checked carefully and evaluated. They made each decision before incurring the expense. How carefully would an indemnity plan member evaluate similar expenses?

Jeffrey Dunham runs a trust and investment company in San Diego, California. He writes:

“We looked at (no... put through the ringer) the pros/cons of HSA's for at least a year perhaps two for the 45-ish employees of our trust and investment company. We looked at its effect on single folks, on married folks, on those with families, on older employees,

on younger ones..... You get the picture. We heard every potential heart ache we could think of. Yet, in the end I did it because it allowed (forced) the employees to have a vested interest in the health care choices they made. It touched everything from what they ate.... to how much they exercised..... to whether they needed to see the doctor... or not..... and whether they needed the 2nd - 3rd opinion.... or not. They got to have the care they wanted when they needed it..... and benefit from the savings they created by good decisions. It was fair for them... fair for us. We all now had "skin in the game"..... for what these costs would look like in the years ahead.

“At first there were many nay-sayers. What if this ... what if that..... yet, by the time enrollment came around the word began to spread that the company was doing something good for them.... giving them more options -- more choices. Far more than we thought signed up for the HSA option. I expect more to follow each open enrollment period. In short - it worked better than we had expected.

“It took some pushing to get it done. It was worth the effort.”

Evelyn Preston recently purchased a non-group HSA in Michigan. She writes:

“I only have one prescription and knowing I will now pay for it with my HSA dollars, I checked on the prices. Before, this was not much of a concern to me as I would have paid my \$15 copay for a prescription regardless of where I bought it. It turns out that Walgreens, where I had been having it filled, charges \$18 more than Meijer. Of course, now I've switched my prescription to Meijer.

”I was talking to my son, married with 2 children. They pay \$5 co-pay so it doesn't matter to them where they get their prescriptions filled...again totally convenience. Now that the dollars are coming out of my medical savings I will look at price.”

Kirby Nielsen is a broker in Worthington, Ohio. He writes:

“The critics of HRAs and HSAs have it about 180 degrees wrong in their assessment of chronic health problems and High Deductible Health Plans.

I have "Paraneoplastic Syndrome" that involves the failure of my immune system. It is a rare disease that few physicians remember hearing about in Med School. In short, my immune system makes antibodies to fight cancer that (for me), has not yet appeared. In fact my antibodies are actually bad guys that are destroying my peripheral nervous system. My deterioration is progressing slowly due to my willingness to push immune suppression therapy to the limit.

“My annual medical bills run over \$30,000 per year for the two years I have lived with this diagnosis (the amount approved by the insurance company). This year I have a high deductible health plan and it is so much better than my old traditional plan with a \$250 Deductible 80/20 to \$10,000 with a physician's co-pay and an Rx card.

“The first thing with a chronic condition is not so much the advantage of choice (which would be an advantage to a healthy person) as to whether or not to have tests and other medical services; it is that all these expenses go directly to my deductible early in each plan year. Another way to put it is I get to fulfill my \$4,000 deductible quicker.

“Secondly, when I reach my deductible, I have 100% coverage. Believe me; having met my deductible and having 100% coverage does not encourage more health care spending. A person who is chronically ill is tired of tests and medical services and would rather not get more health care. Our motive is only to find the underlying cause, treat symptoms, and relieve pain. I met my deductible 6 weeks into the plan year and now I have no more co-pays, no Rx card, and no hassles at all other than the disease itself.

“With the HDHP, I pay the same out of pocket as I used to pay, but I hope I have shown some of the reasons why a HDHP is really a good deal for a person with a complicated and expensive chronic health problem.

Ben Cutler is President and CEO of US HealthGroup in Fort Worth, TX. He writes:
“USHEALTH Group is a small (under 200 employees) insurance company headquartered in Fort Worth, Texas. In March of 2005, we received a renewal notice from our group insurance carrier, UnitedHealthcare. The plan was costing \$5,600 per employee prior to any rate increase. As expected, the renewal notice from United was hefty -- a 19% increase which translated to a new cost per employee of \$6,600!

“Fortunately, we had requested a quote from United for an alternative high deductible HSA qualified plan. Neither our broker or United recommended that we do a complete conversion, feeling it was far too radical a move. Against their advice, we decided to install an HSA programs featuring \$2,000 individual, and \$4,000 family deductibles. The premium savings were compelling; instead of a 19% increase, the high deductible premium was 28% less than we had been paying. That lowered our cost per employee from \$6,660 to just under \$4,000. These savings, combined with a small increase in the employee cost sharing of the premium allowed the company to contribute \$1,750 for individual and \$3,500 for family into the HSA account and match additional employee contributions up to the full deductible.

“We thought we were prepared for a sizable employee backlash, but we underestimated the level of employee objection. People were not at all happy with this change. Working with our broker and United, we prepared a comprehensive education and communication campaign that included several evening sessions where spouses were invited. Armed with a more comprehensive understanding of how the plan would likely impact them financially, employees grudgingly accepted the change.

“One big concern was the financial consequences of a sizable medical expense before sufficient funds were accumulated in the employees HSA. We agreed to provide an interest free loan up to the full HSA contribution if that occurred, with repayment coming from future employer contributions into the employees account. As it turned out, several employees took advantage of that financial bridge.

“As an additional employee incentive, First HSA, our HSA plan administrator, was able to provide 6.15% interest on employee account balances. The behavioral change occurred almost instantaneously. Now employees were spending their own money for healthcare services. Within a few weeks, the stories of what happened when employees became “shoppers” and not just consumers of healthcare services began to emerge:

- Kim is a 42-year-old divorced mother of two. Her eldest son was diagnosed with ADHD. Neither Kim nor her daughter had health issues. Kim was quite concerned about how she was going to afford the expensive medications for her son on her \$27,000 a year salary. She came to see USHEALTH Group’s human resource officer Jan Fogg to find out how the new HDHP was going to work for her. Jan and Kim researched the costs of the required medications and applied them to a financial outlay model demonstrating how the plan could be used in situations like this. The answer to her particular problem was first and foremost a timing issue. She was able to get her son’s first prescriptions filled on the previous plan and by the time she needed refills, she would have enough to pay for them out of her HSA. It was also important that she use the 90-day mail-in prescription method rather than monthly trips to the pharmacy which saved her quite a bit of money overall.
- Mary Jane is a 47-year-old employee who has bronchitis and asthma. She was quite skeptical about having the necessary funds in her HSA to pay for her monthly medications. When we implemented the new HDHP, Mary Jane immediately went to her doctor and explained how the plan worked and that she would not have enough money in the account to pay full price for her medications. Her doctor was able to supply her with enough samples that would last until her account had a sufficient balance to start paying for regular prescriptions on her own. Mary Jane’s doctor further understands that not only medications, but office visit costs must be paid in full by the HDHP patient. It is her practice to not require any payment at the time of visit, but to allow the billing process to run its course through the insurance company for repricing and then issue a bill once the EOB has been created. The entire process can last nearly two months, allowing the patient to have delayed billing. For Mary Jane, the HSA plan works and she even has accumulated enough at the end of the calendar year to have money in her account for the next deductible year.
- Jerald is a 56-year-old employee and one of a handful of employees who has a chronic condition (diabetes) which requires several doctor office and lab visits per year in addition to maintenance medications. He has elected to pay for the costs from his personal checking account, leaving his HSA intact. By doing a cost comparison on the best method of purchasing his medications, he is able to manage his purchases through either the mail-order method or a monthly purchase at his local pharmacy. His HSA continues to grow and earn interest at 6.15%. At 56, Jerald is hoping his HSA account will accumulate a sufficient sum to cover excess medical expenses when he retires.

- Jack, a 36-year-old employee with a family, did some research on his own during the weeks of education prior to the implementation of the HDHP and HSA and found that his doctor understood the issues Jack's family might have with the HSA and supported the idea of ordering maintenance medications at twice the strength to allow for pill-splitting and thus, a cost savings of almost 50% on his family's medications. Jack was ahead of his time. Several months into the plan year, the carrier issued a notice to covered employees that recommended pill-splitting. Several employees have been diligent about "comparison shopping" for healthcare services, such as x-rays or colonoscopy fees, and have shared that information with other employees who have also been able to realize a cost savings.

"The final piece of good news recently arrived in the form of UnitedHealthcare's 2006 renewal notice. The Company's broker was all smiles as he communicated that based on United's projection of a 67% loss ratio under the new plan, United was offering a mid single digit renewal increase!!! As USHEALTH Group's management had hoped, the new HSA plan was a huge success for all concerned!!!"