NATIONAL WOMEN'S LAW CENTER
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Testimony of Judy Waxman, JD
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For the Hearing on Health Savings Accounts (HSAs) and Consumer Driven Health Care: Cost Containment or Cost Shift?

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Summary of Testimony of Judy Waxman, JD

The Center supports health reforms that provide high quality, comprehensive and affordable health coverage for all. Health Savings Accounts (HSAs) and Consumer Driven Health Care, however, do little to expand meaningful health insurance. They are the wrong answer to the country's health care crisis, and they will not benefit women.

Health Reform Matters for Women

When designing health reforms, women's concerns should be taken seriously for a number of reasons:

- Women make approximately 80 percent of health care decisions for their families;
- Six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families;
- Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers;
- Women are more likely to have chronic conditions that necessitate continuous health care treatment;
- Women use more prescription drugs on average, and certain mental health problems affect twice as many women as men;
- Women have more trouble affording health care since they are generally poorer than men; and,
- Women—regardless of whether they are insured or uninsured—are already more likely than men to report problems with accessing health care due to cost.

Consumer-Driven Health Care Won't Expand Meaningful Health Coverage to Women and Their Families

- Cost-sharing under consumer-driven health care is not affordable for lower- income women and their families.
- Lower-income women cannot fund their HSAs, and employers may not do it either.
- Lower-income women will not to benefit from the tax advantages of HSAs.
- Consumer-driven health plan premiums are often higher for women in the individual health insurance market.
- Women, who are more likely than men to have greater-than-average health care needs, are at greater financial risk under a consumer-driven health plan.
- Consumer-driven health care provides an incentive for women to use less cost-effective and preventive care, especially if that care is not exempt from the deductible.
- Women who need pregnancy-related care will face significant challenges under a consumer-driven health care model.

Consumer-Driven Health Care Is the Wrong Solution for America's Health Care Crisis

- Consumer-driven health care is unlikely to reduce the number of uninsured Americans.
- Consumer-driven health care will do little to contain rising health care costs.

Chairman Stark, Ranking Member Camp, and members of the Subcommittee on Health, thank you for the opportunity to testify today on behalf of the National Women's Law Center. For over thirty-five years the Center has worked to both advance and protect laws and public policies that benefit women and their families. As part of these efforts, the Center supports health reforms that provide high quality, comprehensive and affordable health coverage for all. Health Savings Accounts (HSAs) and Consumer Driven Health Care, however, do little to expand meaningful health insurance. They are the wrong answer to the country's health care crisis, and they will not benefit women.

Health Reform Matters for Women

When designing health reforms, women's concerns should be taken seriously for a number of reasons. First, women have a major stake in decisions about health care for their entire families and they often play a significant role in the care that their children, spouses, or parents receive. According to the Department of Labor, women make approximately 80 percent of health care decisions for their families.[1] Also, six in ten women report that they assume primary responsibility for decisions about health insurance plans for their families.[2] An even greater proportion, nearly 80 percent, chooses their child's doctor.[3] More women than men care for a family member—most often a parent—who is chronically ill, disabled, or elderly and in this role they typically provide assistance with medical finances such as bills or insurance paperwork and with making decisions about medical care.[4]

Women's characteristics and distinct health care needs—which are different from men's—should be taken into account when developing strategies to change the health care system. Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that necessitate continuous health care treatment.[5] They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men.[6, 7]

Women have more trouble affording health care since they are poorer than men, in general. Roughly fifty-seven percent of the adults living in poverty (i.e. with incomes below 100 percent

[1] Department of Labor, General Facts on Women and Job Based Health (2008), available at http://www.dol.gov/ebsa/newsroom/fshlth5.html (last visited May 12, 2008).
[2] Alina Salganicoff et al., Women's Health in the United States: Health Coverage and Access to Care (2002), The Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/20020507a-index.cfm (last visited May 12, 2008).
[3] Alina Salganicoff et al., Women and Health Care: A National Profile (2005), The Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf (last visited May 12, 2008). [Hereafter "A National Profile (2005)"]
[4] *Ibid.*
[5] A National Profile (2005), *supra* note 3.
[6] Elizabeth Patchias and Judy Waxman, Women and Health Coverage: The Affordability Gap (2007), National Women's Law Center. An issue brief prepared for the Commonwealth Fund, available at http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf (last visited May, 12 2008). [Hereafter "The Affordability Gap (2007)"]
[7] National Women's Law Center and Oregon Health and Science University, Making the Grade on Women's Health: A National and State-by-State Report Card (2004).

of the federal poverty level) are women.[8] In 2004, the median earnings of female workers (aged 15 and older) were $22,224, compared to $32,486 for men. Among full-time workers, women earn only 76.5 cents for every dollar men earn.[9]

Greater health care needs, combined with a disadvantaged economic status, make it particularly difficult for many women to afford health services. Women—regardless of whether they are insured or uninsured—are already more likely than men to report problems with accessing health care due to cost.[10] They spend a greater share of their income on out-of-pocket medical costs than men, and are more likely to avoid needed health care because of cost. In 2005, for example, nearly a third of nonelderly women reported that they did not fill a prescription because of cost, compared to just 18 percent of men.[11] Finally, uninsured and insured women alike are significantly more likely than their male counterparts to have medical bill and debt problems.[12] It is clear that many women, both the uninsured and the insured, are already struggling to afford the health care that they need. Health coverage plans that shift more of the costs of medical care to women and their families will only make this situation worse.

Consumer-Driven Health Care Won't Expand Meaningful Health Coverage to Women and Their Families

Cost-sharing under consumer-driven health care is not affordable for lower-income women and their families. Women have lower incomes than men and they typically need and use more health services. If health coverage is to be meaningful for women, it must be affordable. Consumer-driven health plans, however, require levels of cost-sharing that are prohibitively high for many women and their families. It is true that premiums for the HSA-eligible high-deductible health plans (HDHPs) are typically lower than premiums for traditional coverage, leading HSA supporters to claim that consumer-driven health plans will be more affordable for the low-income uninsured.[13,14] But, premiums account for just a fraction of the cost of insurance, and higher deductibles and other forms of out-of-pocket spending invariably counteract lower HDHP premiums. To open an HSA in 2008, individuals must be enrolled in a HDHP with an annual deductible of at least $1,100 for an individual or $2,200 for a family.[15] Policies sold in the insurance market tend to have even higher deductibles than the regulations specify. A survey of nongroup policies found that the average deductibles for HSA- and medical savings account

[8] National Women's Law Center calculations based on U.S. Census Bureau, "Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2005, Below 100% of Poverty -- All Races." Current Population Survey Annual Demographic Survey March Supplement, (2006), available at: http://pubdb3.census.gov/macro/032006/pov/new01_100_01.htm. (last visited May 12, 2008).
[9] National Women's Law Center calculations based on U.S. Census Bureau Current Population Survey 2004 Poverty Tables, available at http://pubdb3.census.gov/macro/032005/pov/toc.htm (last visited May, 12, 2008).
[10] The Affordability Gap (2007), *supra* note 7.
[11] *Ibid.*
[12] *Ibid.*
[13] U.S. White House, State of the Union: Affordable and Accessible Health Care (2006), available at http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html (last visited May 6, 2008).
[14] U.S. Department of Treasury, Health Savings Accounts (2008), available at http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf (last visited May 6, 2008).
[15] *Ibid.*

(MSA)-qualified plans in 2006-07 were $2,905 for individual and $5,329 for family coverage.[16] Moreover, out-of-pocket spending does not stop at the deductible; even after a high deductible is met, health insurance policies typically require additional cost-sharing in the form of co-payments and coinsurance.

Because women's greater health care needs and rates of use, combined with lower income, lead them to have higher out-of-pocket costs as a share of their income, more women than men are already "underinsured" (16 percent versus 9 percent).[17] The underinsured are those who are enrolled in an insurance plan that provides inadequate financial protection against catastrophic healthcare expenses. In 2003, about 12 percent of Americans were underinsured, and were almost as likely as the uninsured to go without needed medical care and incur medical debt.[18] Consumer-driven health care, by exposing the insured to even greater out-of-pocket medical costs, has the potential to contribute to the growing problem of underinsurance among Americans, particularly low-income women and their families.

Lower-income women cannot fund their HSAs, and employers may not do it either. In theory, out-of-pocket medical costs can be paid from a woman's tax-advantaged HSA, but lower-income women (who are disproportionately represented among uninsured women) are not likely to have the cash resources to adequately fund the account. In fact, many women enrolled in a consumer-driven health plan have to forgo opening an HSA altogether. In the years 2005 through 2007, close to half of all HSA-eligible plan enrollees did not even open an HSA.[19] In other words, these individuals and families had the high deductible, but not the tax-advantaged account that is supposed to help make that high deductible affordable. While employer HSA contributions could help spread the burden of out-of-pocket medical costs, employer surveys estimate that roughly half of small and large firms offering HSA-eligible health plans for families do not contribute anything to their employees' HSAs.[20]

Lower-income women will not benefit from the tax advantages of HSAs. Most lower-income women and families do not face high enough tax liability to benefit in any significant way from the HSA tax arrangement. HSA tax breaks selectively reward richer Americans, and a very poor family with no taxable income would not benefit from a tax deduction at all. Deposits to an HSA account reduce a participant's taxable income by the amount of the contribution - since tax rates increase as income increases, the deduction is a better deal for the more affluent. Reports on the income level of HSA account holders support this notion; nonelderly tax filers who reported HSA activity in 2005 had an average adjusted gross income of about $139,000,

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[16] America's Health Insurance Plans, Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits (2007), available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf (last visited May 12, 2008).
[17] The Affordability Gap, 2007, *supra* note 7.
[18] Cathy Schoen, Michelle M Doty, Sara R Collins, and Alyssa L Holmgren, Insured But Not Protected: How Many Adults Are Underinsured?, Health Affairs Web Exclusive (2005). W5-289–W5-302. Underinsured adults include continuously insured individuals who satisfied one of three conditions: annual out-of-pocket medical expenses amounting to 10 percent of more of income; among low-income adults, out-of-pocket medical expenses amount to 5 percent or more of income; or health plan deductibles equal or exceeding 5 percent of income.
[19] U.S. Government Accountability Office, Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes (2008). GAO-08-474R.
[20] *Ibid*.

compared to about $57,000 for other filers.[21] Furthermore, though HSAs were designed to be used as a tax-saving method to accumulate funds for health care expenses in retirement, some evidence suggests that these accounts are more often being used as tax shelters by higher-income individuals.[22]

Consumer-driven health plan premiums are often higher for women in the individual health insurance market. If a woman decides to purchase a consumer-driven health plan in the non-group insurance market, she will likely encounter an additional barrier to affordability. Many women who purchase an HSA-qualified health plan in this market are charged a higher monthly premium than their male counterparts for the exact same benefit package, solely because they are female. Indeed, insurers are allowed to consider gender when setting non-group health insurance rates in 40 states and the District of Columbia, including the home states of both Chairman Stark and Ranking Member Camp. Our research indicates that a 34-year-old female constituent in the California's 13th District (represented by Chairman Stark) who is seeking a non-group HSA-qualified health plan would be charged between 4 and 45 percent more than a male peer for nearly half of the plans available to her. If she were living in Michigan's 4th District (represented by Ranking Member Camp), that same woman would be charged more than a male peer for every non-group plan available to her – she would pay between 15 and 48 percent more for the exact same benefit plan. One might assume that these premium disparities are based on the fact that, unlike their male counterparts, women of childbearing age can make insurance claims for maternity care. However, most non-group HDHP policies do not cover maternity benefits at all. Of the 18 HDHP plans available to a 34-year-old woman in the California district, just four offered some type of maternity coverage, and none of the 34 plans available in the Michigan district covered pregnancy-related care.[23]

Women, who are more likely than men to have greater-than-average health care needs, are at greater financial risk under a consumer-driven health plan. Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care than men. If health insurance is to be meaningful for women, it must cover the services that they need without exposure them to significant financial risk. However, those who need the most health care—including women with disabilities and chronic conditions—are most likely to struggle to meet increased cost-sharing requirements of high-deductible health plans. These individuals often experience higher medical costs and are more likely to spend amounts up to their deductible each year. Healthy people with very low medical expenses, on the other hand, are especially advantaged under an HSA arrangement since their HDHP premiums are lower than under traditional insurance plans *and* they pay trivial out-of-pocket amounts.

Consumer-driven health care provides an incentive for women to use less cost-effective and preventive care, especially if that care is not exempt from the deductible. Consumer-driven health care also has implications for women's preventive health service use. Because consumer-

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[21] *Ibid.*

[22] Edwin Park and Robert Greenstein, GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals (2006). Center on Budget and Policy Priorities, available at http://www.cbpp.org/9-20-06health.htm (last visited May 12, 2008).

[23] Independent analyses carried out by National Women's Law Center (2008), using information from www.ehealthinsurance.com on HAS-qualified health plans for women residing in zip codes 94538 (Fremont/Alameda, California) and 48640 (Midland, Michigan).

driven health plans shift more costs to the insured, they provide an incentive to use less (and therefore spend less) on health care. HSA guidelines do permit certain preventive services to be exempt from the deductible, but this is a voluntary option for health plans. In a 2007 survey, more than fifty percent of individuals enrolled in an HSA-qualified health plan reported that their deductible applied to all health care services, including preventive care.[24] Moreover, prescription drugs—even those that serve a preventive rather than treatment purpose—are generally not exempt from a deductible.[25]

The majority of American women use a form of contraception that can only be accessed with a prescription; in the year 2002, for example, 82 percent of women aged 15-44 who had ever had sexual intercourse reported that they had used the oral contraceptive pill.[26] Women who use a prescription drug for family planning would be responsible for the full cost of their birth control under a consumer-driven health plan; this presents a cost-related barrier to service use, especially for lower-income women.

Participating in an HSA/HDHP could have a negative impact on women's health if they delay or go without necessary care because they cannot afford to meet the high deductible. Poor women and their families, who have less income to contribute to an HSA and may not have enough funds in their accounts to cover their health care needs in a given year, would be particularly vulnerable to this harmful consequence. A recent survey found that, compared to those enrolled in more comprehensive plans, consumer-driven health plan enrollees were significantly more likely to avoid, skip or delay necessary health care or medications because of the cost.[27] Indeed, this type of plan aims to discourage utilization of unnecessary health care, but increased cost-sharing has the potential to discourage the use of cost-effective and necessary preventive care at the same time. The landmark RAND Health Insurance Experiment demonstrated that greater out-of-pocket spending requirements reduced costs by encouraging patients to use less health care - including necessary care that is strongly supported by evidence.[28] A more recent study of rates of biennial breast-cancer screenings in Medicare plans with different levels of cost-sharing for mammography demonstrated that even nominal copayments were associated with significantly lower screening rates compared to plans with full coverage. These effects of cost-sharing were magnified among women living in lower-income areas.[29]

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[24] Paul Fronstin and Sara R Collins, Issue Brief No. 315: Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey (2008), The Employee Benefits Research Institute, available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3897 (last visited May 12, 2008). [Hereafter "2007 Consumerism in Health Care Survey"]

[25] A survey of insurers offering consumer-driven health plans found that less than 6 percent of these plans included coverage for prescription drugs as a preventive, exempt benefit. See: Association for Health Insurance Plans, A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007 (2007), available at http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf (last visited May 12, 2008).

[26] William D. Mosher, et al., "Use of Contraception and Use of Family Planning Services in the United States: 1982-2002," Advance Data From Vital & Health Statistics No. 350, at 15 (2004).

[27] 2007 Consumerism in Health Care Survey, *supra* note 25.

[28] Joseph P Newhouse, Free for All? Lessons from the Rand Health Experiment, Insurance Experiment Group (Cambridge, MA: Harvard University Press; 1993).

[29] Amal Trivedi , William Rakowski and John Z Ayanian, Effect of Cost Sharing on Screening Mammography in Medicare Health Plans (2008), New England Journal of Medicine 358(4):375-83.

Women who need pregnancy-related care will face significant challenges under a consumer-driven health care model. In particular, consumer-driven health care has specific consequences for maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. Pregnant women enrolled in a consumer-driven plan might be exposed to high out-of-pocket costs, particularly when complications arise. As demonstrated in our research on the health plans available in two districts in California and Michigan, most individual HDHP policies exclude coverage for normal maternity care altogether, so that expenses for these services would not even count towards the deductible. For plans that do cover maternity care, unlike other preventive services such as well child-care, prenatal care is typically subject to a HSA-qualified deductible, and this significant cost-sharing might keep some women from obtaining prenatal care services. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the issue. A 2007 study demonstrated the range in out-of-pocket maternity care costs that women could face under several different consumer-driven health plan options – from a low of $3,000 for an uncomplicated pregnancy with vaginal delivery to a high of $21,194 for a complicated pregnancy with a Cesarean section delivery. [30]

Consumer-Driven Health Care Is the Wrong Solution for America's Health Care Crisis

In addition to the problems that HDHP/HSA arrangements pose for individual women and their families, this strategy is unlikely to deliver on its promise to help solve America's health care crisis.

Consumer-driven health care will do little to contain rising health care costs. Most of America's health care costs are incurred by only a small percentage of very sick or injured individuals, for expensive treatments related to major illnesses or end-of-life care. The cost of this care exceeds the high deductibles required under HSAs and would still be paid for by the health plans; simply put, HSA arrangements won't contain those high-end expenditures. For example, one study found that only 21 percent of total health spending falls below the minimum deductible level for an HSA-eligible health plan.[31] Additionally, if consumer-driven plans disproportionately attract healthier and wealthier individuals—as research demonstrates they have done[32]—sicker and poorer Americans will be concentrated in traditional, comprehensive insurance plans. This segments the pool of insured lives, so that risk is no longer spread between those with high and low medical expenditures – as a result, premiums for those in traditional plans will be driven even higher. A recent actuarial study of six large employers who offered both consumer-driven and more traditional health plan options to their workforce found that, indeed, a disproportionately younger and healthier population selected the consumer-driven option. Notably, most of the reduction in health costs that these employers experienced under

[30] Karen Pollitz et al. *Maternity Care and Consumer-Driven Health Plans* (2007), a Report for the Henry J Kaiser Family Foundation, available at http://www.kff.org/womenshealth/upload/7636.pdf (last visited May 12, 2008).
[31] Linda Blumberg and Leonard Burman, Most Household's Medical Expenses Exceed HSA Deductibles (2004), Tax Notes.
[32] 2007 Consumerism in Health Care Survey, *supra* note 25.

the consumer-driven health plan option could be attributed to the more favorable risk profile of the workers enrolled in that type of plan.[33]

Consumer-driven health care is also unlikely to reduce the number of uninsured Americans. A 2004 analysis indicated that HSAs would be used predominately by people who are already insured, and that gains in coverage would be offset by the loss due to employers canceling insurance on the assumption that the availability of new subsidies makes employment-based coverage unnecessary. Analysts estimate that HSAs could in fact *increase* the number of Americans lacking health insurance.[34] Additionally, in 2006 nearly two-thirds of the nonelderly uninsured were poor or near-poor, with incomes at or below 200 percent of the federal poverty level (which was $40,000 for a family of four in that year).[35] These lower-income families are unlikely to have the resources to participate in a health plan with high levels of cost-sharing; a recent study found that among households with at least one uninsured member, less than half had sufficient gross financial assets to meet the minimum HSA-related deductible.[36] Furthermore, since many lower-income families earn too little to have any tax liability, coverage proposals which rely on tax deductions— such as the HSA initiative—will have little impact on the low-income uninsured. So far, research on consumer-driven plans confirms this notion, since surveys of plan enrollees in both 2006 and 2007 found that adults in this type of plan were no more likely to have been uninsured prior to enrollment in their plans than those enrolled in traditional coverage plans.[37]

Conclusion

As a growing number of national and state leaders move forward to address the failing health care system, there have never been so many opportunities to ensure that women have access to the health care they need. In order to address the challenges that women face in getting health care for themselves and for their family members, health reform strategies must include policies that will help women and their families obtain meaningful health insurance. Coverage that provides the most comprehensive benefits at the most affordable cost will go the farthest to improve women's health and financial security, but consumer-driven health care plans do not fit this description. Instead, the mechanics of HSA/HDHP arrangements shift much of the risk of needing expensive care from employers and insurers to women and their families. This can deter financially concerned enrollees from getting medically necessary care when they need it, and those with higher-than-average medical expenditures— including women—may take on significant financial risk. Moreover, contrary to the claims of their proponents, strategies that

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[33] Jack Burke and Rob Pipich, Consumer-Driven Impact Study (2008), a Milliman Research Report, available at http://www.milliman.com/expertise/healthcare/publications/rr/consumer-driven-impact-study-RR04-01-08.php (last visited May 12, 2008).

[34] Edwin Park and Robert Greenstein, Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured (2004), Center on Budget and Policy Priorities, available at http://www.cbpp.org/5-10-04health.htm (last visited May 12, 2008).

[35] Henry J Kaiser Family Foundation, Distribution of the Nonelderly Uninsured by Federal Poverty Level, 2006 (2008), available at www.statehealthfacts.org (last visited May 11, 2008).

[36] Paul D Jacobs and Gary Claxton, Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans (2008), Health Affairs web exclusive, available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.3.w214 (last visited May 6, 2008).

[37] 2007 Consumerism in Health Care Survey, *supra* note 25.

rely on consumer-driven health care do little to address two major and interrelated problems with the American health care system - the increasing ranks of the uninsured and rising health care costs. Health Savings Accounts, and consumer-driven health care in general, are not an acceptable answer to the nation's health care crisis.

Thank you for this opportunity to testify. I welcome your questions.