AHIP
Guiding Greater Health

Smarter Health Care Coalition

HSA-Eligible Health Plans Embrace Changes to Better Serve Americans With Chronic Health Conditions

September 2021

Employer-provided coverage delivers affordable access to care, effective ways to improve health, and financial security for more than 183 million Americans every day. Quality health benefits for full-time workers are a key part of the social and economic compact in the United States.

More than 32 million Americans have employer-provided coverage that, when combined with a health savings account (HSA), provides them with more control over and value for their health care.

Until recently, HSA-eligible health plans were restricted in covering care that wasn't considered preventive before a consumer satisfied their plan's deductible. But in July 2019, the Internal Revenue Service (IRS) issued Notice 2019-45, guidance which expanded the list of preventive care benefits to include many items and services used to manage chronic health conditions. Now, plans and employers may offer 14 additional items and services pre-deductible, including insulin and other glucose lowering agents, glucometers, inhalers, statins, and others.

How many health plans are leveraging this new flexibility to provide greater value to patients and consumers?

In May - June 2021 AHIP and the Smarter Health Care Coalition conducted a survey of health insurance plans to assess changes in the benefit design for HSA-eligible HDHPs. Thirty-six health plans covering every region of the country responded to the survey. For details on the survey methodology and tabulated survey results see Appendix A.

Key Takeaways

- Most HSA-eligible health plans are leveraging new regulatory flexibility to cover more chronic disease prevention services on a pre-deductible basis.
- Diabetes and heart disease are the two most commonly targeted conditions for reducing or eliminating cost sharing.
- Reduced or eliminated cost sharing for chronic disease prevention drugs and services is not resulting in a significant increase in premiums.

Analyzing Health Insurance Provider Adoption

For years, AHIP and the Smarter Health Care Coalition have advocated for the removal of regulatory barriers that prevented HSA-eligible health plans from more broadly adopting value-based benefits to improve value and lower costs. That advocacy included working with regulatory agencies and Congress to expand the HSA-eligible health plans preventive care safe harbor to ensure access to high-value services and prescription drugs that could be used to prevent and treat chronic diseases.

Following guidance in 2019 that provided new regulatory flexibility to cover certain preventive care services pre-deductible, AHIP and the Smarter Health Care Coalition wanted to evaluate the effectiveness and uptake of this new flexibility. The organizations launched a survey in May 2021. Nearly 90 health insurance providers were invited to participate. Thirty-six (36) responded to the survey, yielding a response rate of 40%. The responding health plans cover 109 million Americans (commercial enrollment only; based on the 2020 financial filings of publicly traded insurance companies, 2019 fully-insured commercial enrollment statistics reported by the NAIC and the DMHC (CA), and the 2019 national self-insured enrollment estimates by the AHRQ).

Participants included health insurance providers operating within all 50 states, the District of Columbia, and Puerto Rico. They comprised major medical insurance HSA-eligible health plans, with commercial enrollment of greater than 50,000 according to data from the AIS Directory of Health Plans: 2020.

The final survey included 7 questions. Not all participants were asked all questions.

The Qualtrics® online survey tool was used to develop and deploy the web-based survey.

The survey was conducted via email using a key informant approach. Potential survey respondents were identified based on the internal AHIP databases of health plan staff with expertise in HDHP coverage and management, with such work positions as medical directors, government affairs specialists, and commercial products directors. AHIP staff contacted potential survey respondents with knowledge of their health plan HDHP product line and asked them to reply on behalf of their plan or, if not, to pass the invitation to other plan staff involved in their plan's HDHP programs.

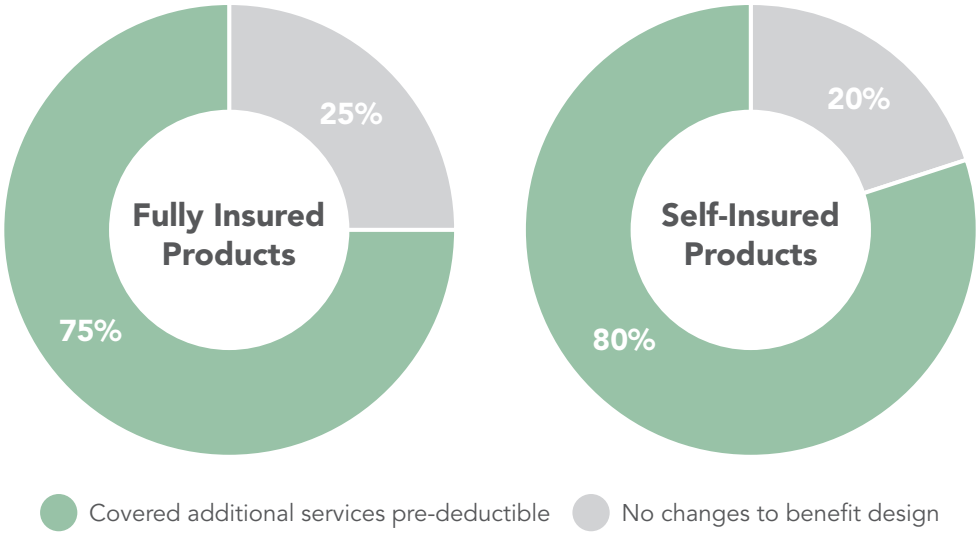
Insurance Providers Embrace New Flexibilities Across Health Plans

The 36 responding health plans operate in all Census regions, and include large national plans, regional plans, and plans operating in a single state, or just part of a single state. Given a relatively robust response rate and a wide range of plans submitting the responses, both geographically and in terms of size, the survey data could be regarded as broadly representative of the national HDHP insurance industry.

Most respondents offer HSA-eligible health plans for both self-insured and fully insured lines of business: 100% reported offering it in their fully insured products, and 83%in their self-insured line of business. At least part of this difference may be explained by the fact that not all responding health insurance providers offer self-insured products.

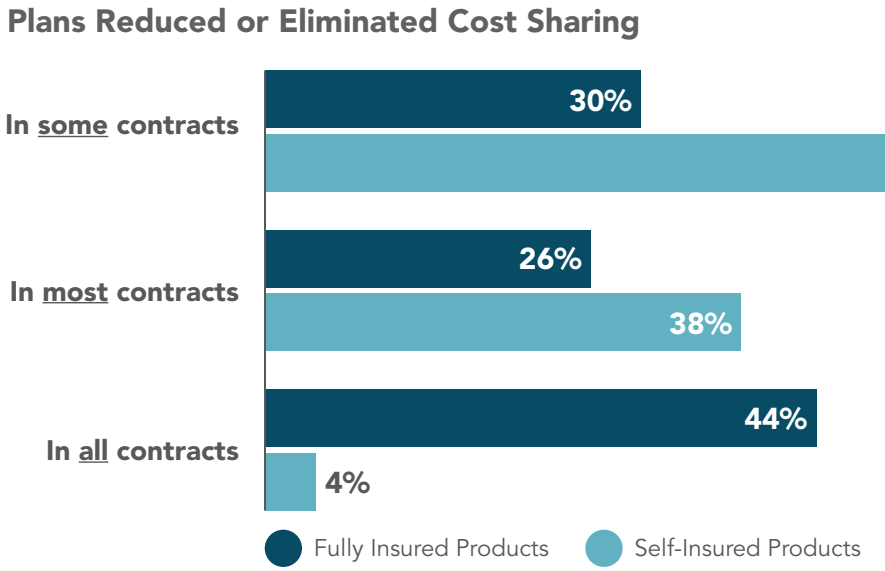
Most respondents modified their HSA-eligible health plans to cover more chronic disease prevention services on a pre-deductible basis: 75% covered additional services without applying a deductible in their fully insured products, and 80% in their self-insured products (see Figure 1).

Figure 1. Most responding health insurance providers leveraged new flexibilities to cover new chronic disease prevention services pre-deductible in HSA-eligible Health Plans.



However, expansion in coverage was not uniform across all contracts. While nearly half of survey participants that made changes reduced or eliminated cost sharing in all their fully insured contracts, only 4% of reporting plans did so in all of their self-insured contracts, where employers have a much larger control over the specifics of their benefit design (see Figure 2).

Figure 2. Health insurance providers leveraged this new flexibility more frequently in their fully insured plans than in self-insured plans.



Health insurance providers targeted a variety of chronic health conditions with two conditions targeted by almost all plans: diabetes (96% of plans in both fully insured and self-insured products), and heart disease (targeted by 73% in fully insured products and 74% in self-insured products).

Table 1. Chronic Conditions Targeted in Fully Insured Plans.

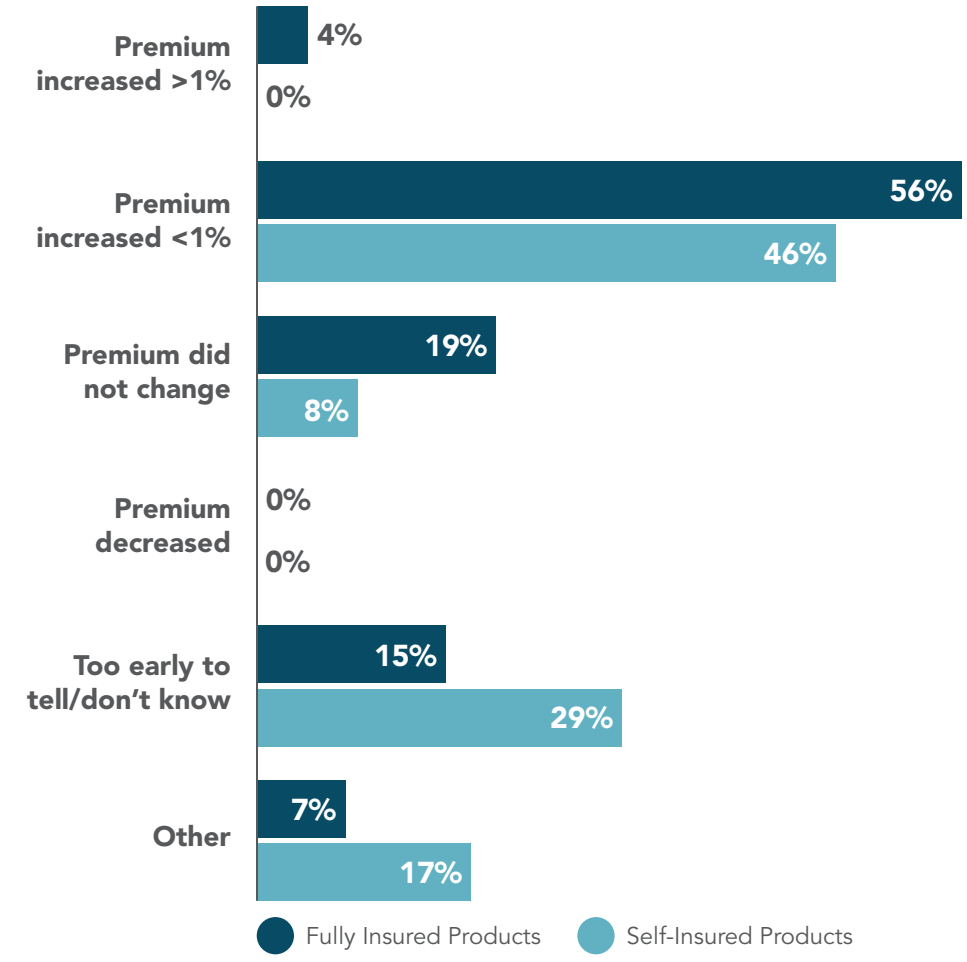
	In some fully insured products	In most fully insured products	In all fully insured products	Not targeted
Asthma	19%	15%	19%	46%
Bleeding disorders	8%	12%	19%	62%
Congestive heart failure	23%	23%	12%	42%
Coronary artery disease	23%	19%	15%	42%
Depression	15%	19%	15%	50%
Diabetes	23%	31%	42%	4%
Heart disease	23%	27%	23%	27%
Hypertension	23%	27%	15%	35%
Liver disease	8%	8%	19%	65%
Osteoporosis	12%	15%	8%	65%
Other (please describe)	12%	4%	12%	73%

Table 3. Chronic Conditions Targeted in Self-Insured Plans.

	In some self-insured products	In most self-insured products	In all self-insured products	Not targeted
Asthma	30%	26%	4%	39%
Bleeding disorders	13%	17%	9%	61%
Congestive heart failure	39%	17%	4%	39%
Coronary artery disease	39%	22%	4%	35%
Depression	39%	9%	9%	43%
Diabetes	57%	30%	9%	4%
Heart disease	39%	26%	9%	26%
Hypertension	39%	22%	4%	35%
Liver disease	13%	17%	9%	61%
Osteoporosis	30%	9%	4%	57%
Other (please describe)	9%	4%	9%	78%

Survey participants that reduced or eliminated cost sharing for chronic disease prevention drugs and services did not report a significant increase in premiums as a result of those changes. Most respondents communicated that premiums increased by less than 1% or did not change at all (75% for fully insured products and 54% for self-insured products). Only 4% of plans experienced an increase in premiums greater than 1% for their fully insured products, and none for self-insured products (see Figure 3).

Figure 3. Reducing or eliminating cost-sharing for chronic disease prevention drugs and services did not result in significant premium increases.



Factors Impacting Adoption

The survey invited respondents to share their experiences in implementing chronic disease coverage changes following the 2019 IRS guidance, lessons learned, or anything else they wanted to share regarding management of chronic health conditions in these health plans. Respondents provided a breadth of insight on many aspects of chronic disease coverage, with some common themes emerging. Specifically, respondents focused on coding challenges, issues in coverage of prescription drugs, and mental health parity considerations.

No Cost Sharing as a Client's Choice. Several respondents stressed that they offered a choice for pre-deductible chronic disease prevention drugs and services to their self-insured clients, but the uptake varied and was client-specific.

Coding Challenges. Cumbersome requirements to document eligible diagnoses lead to many services being ineligible for consumers, with some health insurance providers not doing it at all to avoid increasing the administrative burden for plans and providers. One plan expressed interest in more coding guidance from the IRS.

Focus on Reducing Rx Cost Sharing. Some respondents communicated that the IRS guidance was structured in such a way that it made it much easier to implement changes for prescription drugs used to treat chronic conditions, but not for medical services. However, respondents still experience specific coding challenges for pre-deductible-eligible drugs.

Mental Health Parity considerations. Respondents noted that it is important to remember the mental health parity rules in place and that updating medical benefits may require changes to mental and behavioral health benefits, which adds complexity when complying with the law while adding benefits.

Satisfaction with Pre-Deductible Coverage of Insulin. Enrollees report satisfaction with added insulin benefits, including the certainty over the monthly cost-sharing, with at least one plan stating the added benefit has "greatly helped members in being compliant with managing their diabetes."

Building Upon What Works

We asked survey participants which additional services covered pre-deductible would most likely improve patient satisfaction. The most mentioned type of service was primary care visits at 81% (see Table 4). One respondent commented that many patients with chronic disease seek their management with primary care physicians (PCPs) and not specialists. Another respondent added that the pre-deductible coverage of primary care visits would be beneficial for the first one to three visits but not for all of them.

Another commonly mentioned choice was the permanent ability to offer telehealth services pre-deductible (64%). One respondent commented that *"covering telehealth services (excluding audio-only services) pre-deductible will increase customer satisfaction without having a significant increase in premiums"*. Another respondent clarified the pre-deductible coverage of telehealth would only be beneficial for certain specialties, such as primary care and Mental Health/Substance Abuse.

The last of services selected by the majority of plans as most likely to improve patient satisfaction if covered pre-deductible was mental and behavior services (53%). Some plans, though, had concerns about how such coverage could be impacted by mental health parity regulations.

Some responses raised the question of what the purpose of a HDHP is if more services are covered pre-deductible, which raises important policy considerations for future rules governing these plans.

Finally, respondents said there could be value in decoupling HSAs from the health plan: *"Rather than making HDHPs more complicated in order to offer more benefits while still maintaining HSA qualification, it would make more sense to make HSAs eligible for ALL plan types and preserve the pricing strategies associated with true deductible/coins HDHPs"* and *"… such changes will further narrow the gap of premiums. It would be beneficial to continue to push for decoupling of HSAs from HDHPs rather than slowly continue to minimize their value."*

Next Steps

With more than 32 million Americans enrolled in HSA-eligible health plans, a majority of whom live with at least one chronic health condition, policy changes are necessary to allow more Americans to save for future health care expenses in tax-advantaged accounts while ensuring that those living with chronic health conditions have access to the high-value care they need without the burden of a deductible. These could include expanding the preventive care safe harbor to allow for additional items and services to be covered pre-deductible or de-coupling HSAs from prescriptive, high-deductible health plans.

Table 4. Pre-Deductible Coverage Of Additional Services To Most Likely Improve Patient Satisfaction.

Services	%
Primary care office visits	81%
Permanent ability to offer telehealth services pre-deductible	64%
Coverage of mental and behavioral health services	53%
Visits to specialists to manage chronic conditions	44%
Coverage for additional drugs or services used to treat chronic conditions not included in Notice 2019-45 issued by the IRS in 2019	42%
Permanent ability to offer testing, treatment, or vaccinations pre-deductible in response to public health emergencies	33%
Visits to on-site medical clinics	22%
Other	25%