

## The Impact of Expanding Pre-Deductible Coverage in HSA-Eligible Health Plans on Employee Choice of Health Plan and Cost Sharing

*Paul Fronstin, Ph.D., and Eden Volkov, Ph.D., Employee Benefit Research Institute*

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### AT A GLANCE

IRS Notice 2019-45 allows health savings account (HSA)-eligible health plans the flexibility to cover 14 medications and other health services used to prevent the exacerbation of chronic conditions prior to meeting the plan deductible. There is currently no research on the impact of expanding pre-deductible coverage on plan members. In this *Issue Brief*, we use claims data to quantify the effect of expanding pre-deductible coverage on enrollee choice of health plan and cost sharing.

#### Key Findings:

- Cost sharing shifted from deductibles to copayments and coinsurance among enrollees in HSA-eligible health plans for a number of services impacted by IRS Notice 2019-45. The same shift was not observed for enrollees in other types of health plans.
- IRS Notice 2019-45 appears to have had a negligible impact on overall cost sharing as a percentage of total spending on a number of services impacted by the notice. This may be due to the fact that employers were more likely to change cost sharing instead of eliminating it.
- Enrollment in HSA-eligible health plans among individuals with health conditions impacted by the IRS notice does not appear to have changed, as it was already trending in the direction of higher enrollment among individuals with health conditions prior to the issue of the notice.

Employers would add additional services if allowed by the IRS. There is also bipartisan, bicameral legislation that has been introduced in the U.S. Congress that would provide additional flexibility to extend pre-deductible coverage to services that manage chronic conditions. Employers and policymakers have an appetite for more flexible plan designs or "smarter" deductibles, because rising health care spending has created serious fiscal challenges.

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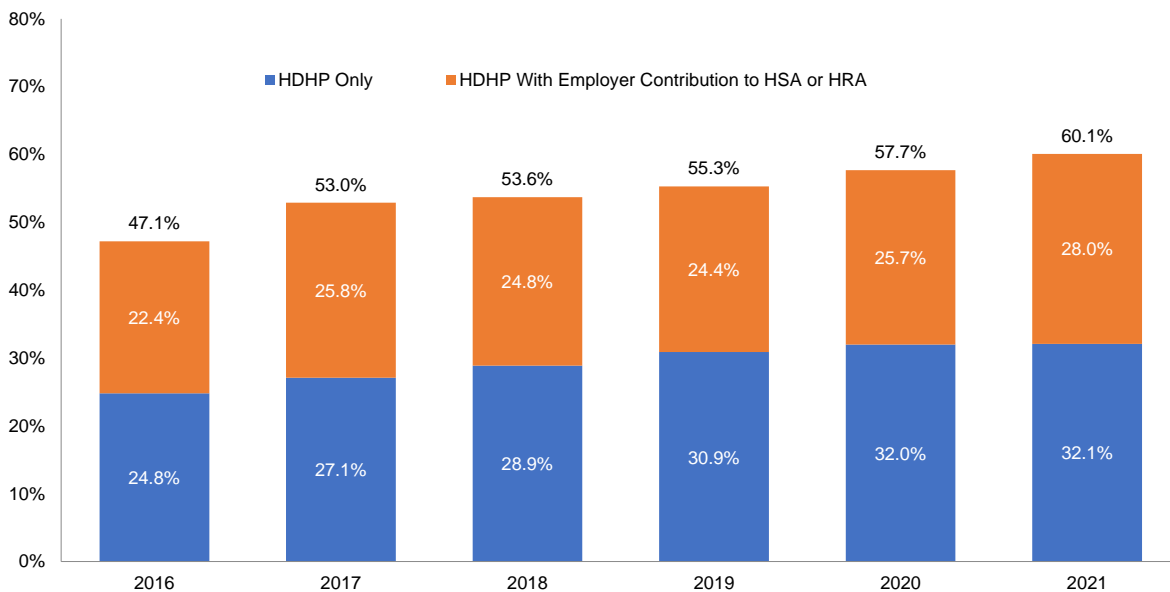
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## Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a provision that created what are commonly known as high-deductible health plans (HDHPs). At the time, these plans had to have a deductible of at least \$1,000 for individual coverage and \$2,000 for family coverage (see Appendix Figure 1). As will be discussed in more detail below, HDHPs may provide coverage of certain preventive services prior to the satisfaction of the health plan deductible. Enrollees in plans that meet these and other requirements are allowed to open and contribute to a health savings account (HSA) on a tax-preferred basis. Thus, these plans are also commonly known as HSA-eligible health plans. In 2023, these plans must have a deductible of at least \$1,500 for individual coverage and \$3,000 for family coverage. Enrollment in HDHPs accounts for over one-half of those with private health coverage (Figure 1).<sup>1</sup>

Figure 1  
Percentage of Persons Enrolled in a High-Deductible Health Plan (HDHP), by Employer Contribution to HSA or HRA,\* Among Those With Private-Sector Health Coverage and Employee-Only Coverage, 2016–2020



\* HSA = health savings account, HRA = health reimbursement arrangement.  
Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC).

Under the initial IRS guidance, until the deductible is met, coverage does not include "any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications" (Internal Revenue Service 2004). This narrow definition of the "safe harbor" has likely caused some plan members to go without needed care, as it is well established that increases in cost sharing for health care have been associated with deleterious consequences. Thus, the U.S. Department of Treasury issued guidance 15 years later in 2019, via IRS Notice 2019-45, to further increase the flexibility of HSA-eligible health plans to cover specific low-cost preventive services to prevent the exacerbation of chronic conditions on a pre-deductible basis (Figure 2).<sup>2</sup>

**Figure 2**  
**Chronic Disease Management Services in the Expanded Safe Harbor**

Preventive Care Service	For Individuals Diagnosed With
Angiotensin-converting enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Antiresorptive therapy	Osteoporosis and/or osteopenia
Beta blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose-lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International normalized ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density lipoprotein (LDL) testing	Heart disease
Selective serotonin reuptake inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Source: <https://vbidcenter.org/initiatives/hsa-high-deductible-health-plans-2/>

Much work has been done to examine the response to the IRS notice by employers and health plans, as well as the impact of the notice on premiums. A 2021 EBRI survey found that 76 percent of employers with 200 or more employees increased the number of drugs and services covered pre-deductible in HSA-eligible health plans as a result of IRS Notice 2019-45 (Fronstin and Fendrick 2021). Pre-deductible coverage was often added for health care services related to heart disease and diabetes care. Two-thirds of employers added pre-deductible coverage for blood pressure monitors and insulin/glucose-lowering agents, 61 percent added coverage for glucometers, and 54 percent added coverage for beta blockers. Health care services least likely to have pre-deductible coverage were peak flow meters and international normalized ratio (INR) testing (25 percent each). Most employers did not eliminate cost sharing for the pre-deductible services that were added. The percentage eliminating cost sharing ranged from 25 percent to 40 percent, depending on the service. The 2021 EBRI survey also found that most employers would add pre-deductible coverage for additional health care services if allowed by law.<sup>3</sup> A 2021 AHIP survey of health plans also found that three-quarters of health plans expanded pre-deductible coverage as a result of the IRS notice.<sup>4</sup>

When it comes to the impact of expanding pre-deductible coverage on premiums, three studies have been conducted. The 2021 AHIP survey of insurers that was noted above found that most reported either no premium increase or premium increases of less than 1 percent. Although estimates are reported, a great deal of uncertainty regarding the effect of Notice 2019-45 on premiums remains. In the AHIP survey, 15 percent of providers of fully insured plans and 29 percent of providers of self-insured plans noted that it was too early to know what impact the notice had on premiums. Another 7 percent of providers of fully insured plans and 17 percent of providers of self-insured plans reported “other” when asked about the impact of the notice on premiums. No context was given for the “other” responses, but we can conclude that 22 percent of providers of fully insured plans and 46 percent of providers of self-insured plans still did not know what impact the notice had on premiums.

EBRI research using claims data and assumptions about behavioral responses confirmed the findings from the AHIP survey (Fronstin, Roebuck, and Fendrick 2022). In general, the impact on premiums of expanding pre-deductible coverage as allowed in IRS Notice 2019-45 was small. Estimated premium increases ranged from virtually zero to 1.5 percent. There was no premium increase in the conservative scenario where deductibles were replaced by coinsurance, use of health care services were assumed not increase due to lower cost-sharing, and enrollees’ related diagnoses were required. We found a 0.87 percent increase in premiums when use of health care services was assumed to increase because of the lower cost-sharing and employers did not impose any cost-sharing. If all 14 services were excluded from pre-deductible coverage with no cost sharing, use of health care services increased, and the services were covered whether or not an enrollee had a related diagnosed condition, premiums increased by 1.5 percent.

Some research has examined how expanding pre-deductible coverage to medications to manage chronic conditions has been conducted as well. One such study was conducted before IRS Notice 2019-45 was released and examined 57 drug classes used to treat 11 chronic conditions (VBID Health n.d.). It found that covering all these drug classes pre-deductible with a combination of copayments and coinsurance would increase premiums by 1.7 percent. More recently, an EBRI study used claims data to estimate the effect of expanding pre-deductible coverage beyond IRS Notice 2019-45 to 116 classes of medications. The impact on premiums of expanding pre-deductible coverage to 116 drug classes related to chronic disease management medications in HSA-eligible health plans is relatively small, ranging from 1.3 to 4.7 percent.

It is now possible to examine the impact of the IRS notice on plan enrollees. In this *Issue Brief*, we examine the impact of the notice on enrollment in HSA-eligible health plans, with the key questions being whether we are seeing more enrollees in HSA-eligible health plans with conditions such as heart disease, hypertension, depression, diabetes, and asthma than in the past, and whether fewer such enrollees are disenrolling from HSA plans. Second, we examine the impact of the notice on enrollee cost sharing, with the key question being whether we are seeing fewer enrollees in HSA-eligible health plans with deductibles for services such as insulin and inhaled corticosteroids.

## Background

Until IRS Notice 2019-45 was released on July 17, 2019, when it came to providing pre-deductible coverage of health care services in HSA-eligible health plans, employers were guided by the IRS safe harbor section 223(c)(2)(C) of the Internal Revenue Code (IRC). Employers could only provide coverage of the following services prior to the satisfaction of the plan deductible:

- Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Future Project, and HRSA and the Institute of Medicine's (IOM's) committee on women's clinical preventive services (required by Section 2713 of the Patient Protection and Affordable Care Act of 2010 (ACA) and IRS Notice 2013-57).<sup>5</sup>
- Periodic health evaluations such as annual physicals and select preventive screenings not listed above (optional, per Internal Revenue Service (2004)).
- Obesity weight-loss programs and tobacco cessation programs (optional, per Internal Revenue Service (2004)).
- Drugs taken by asymptomatic individuals to prevent the manifestation of disease (optional, per IRS Notice 2004-50).<sup>6</sup>

Increases in consumer out-of-pocket costs for health care have been associated with deleterious consequences. These include financial stress, worse disease control, increases in hospitalizations, and exacerbation of health disparities, particularly among those with chronic medical conditions and lower household incomes.<sup>7</sup> Peer-reviewed literature has demonstrated that selectively lowering cost sharing for high-value chronic disease management medications can meaningfully improve adherence; reduce the risk of adverse health outcomes; and, in some cases, reduce expenditures Lee et al. (2013).

With IRS Notice 2019-45 in place, HSA-eligible health plans are now able to adopt a more flexible benefit design, offering more protection for certain medical services through a value-based insurance design (V-BID) plan structure. As the market for HSA-eligible health plans grows, it is important that these plans use this flexibility to allow for effective health management for all beneficiaries. A targeted strategy exploring coverage for certain high-value, clinically indicated health services prior to meeting the deductible will produce more effective, clinically nuanced designs, without fundamentally altering the original intent and spirit of these plans. Adoption of voluntary, clinically nuanced, and expanded HSA-eligible health plan benefit designs has the potential to mitigate cost-related non-adherence, enhance patient-centered outcomes, allow for lower premiums than most preferred provider organizations (PPOs) and health maintenance organizations (HMOs), and substantially reduce aggregate health care expenditures.

According to Notice 2019-45, the list of preventive services that can be covered pre-deductible will be reviewed on a periodic basis. In fact, the guidance specifically states that the periodic review is expected to occur approximately every five to 10 years. For patients and employers alike, 10 years may be a long time to wait for such coverage decisions to be made given the pace of research on plan design and medical innovation. There are already examples of services that may meet the criteria for pre-deductible coverage that were omitted from Notice 2019-45. For example, the notice identifies angiotensin converting enzyme (ACE) inhibitors to prevent exacerbations for individuals diagnosed with congestive heart failure (CHF), diabetes, and/or coronary artery disease. Patients who either do not respond to or have an adverse reaction to ACE inhibitors are usually switched to angiotensin receptor blockers (ARBs) to prevent the same exacerbations. However, ARBs are not included in the list of 14 services in Notice 2019-45, and thus they cannot be covered pre-deductible in HSA-eligible health plans. Similarly, serotonin-norepinephrine reuptake inhibitors (SNRIs) may be an effective treatment for patients with depression who do not respond to selective serotonin reuptake inhibitors (SSRIs).

Furthermore, there is already an appetite for adding more services, as evidenced by the Chronic Disease Management Act, which was reintroduced in the U.S. Congress as recently as March 2023. This bipartisan, bicameral legislation would provide HSA-eligible health plans with additional flexibility to provide pre-deductible coverage for services that prevent the exacerbation of chronic conditions.

## Data and Study Sample

For the present study, we utilized the 2018 and 2021 Marketscan<sup>®</sup> Commercial Database. Data from 2018 were used because they represent the last full year preceding IRS Notice 2019-45. Data from 2018 were compared with those from 2021 for several reasons. For one, 2021 was the first year in which we observed a larger percentage of employers adopting some form of pre-deductible coverage. Furthermore, a crucial component of this analysis is using diagnosis codes to identify enrollees with conditions affected by the IRS notice, namely diabetes, depression, heart disease, asthma, and osteoporosis/osteopenia. Individuals were less likely to seek out treatment in inpatient and outpatient settings due to the COVID-19 pandemic, the exact settings that issue the diagnosis codes needed by this analysis to identify affected enrollees. Thus, we used the 2021 data to measure the impacts of the 2019 IRS policy change. Using diagnosis codes from the inpatient and outpatient service files, we defined health condition indicators. We also used procedure and medication codes from the inpatient, outpatient, and prescription drug files to identify the medication and services utilized by enrollees through the plan year.

The database comprised member health insurance eligibility information as well as medical (inpatient and outpatient) and pharmacy claims. Our sample in both years included policyholders, spouses, and dependents, all under age 65, who were enrollees in their health plan for the full year. We also required that an individual's claim data have full information on prescription drug and mental health services spending. In 2018, our sample included 2.1 million enrollees in HSA-eligible health plans and 11.3 million enrollees in other health plans. In 2021, our sample included 1.7 million enrollees in HSA-eligible health plans and 6.8 million enrollees in other health plans.

## Methods

To capture the impact of IRS Notice 2019-45, we compared the health plan enrollment and cost sharing of enrollees with health conditions impacted by the notice in HSA-eligible health plans and other health plans between 2018 and 2021. Specifically, we focused on enrollees with diabetes, depression, heart disease, asthma, and osteoporosis/osteopenia, because IRS Notice 2019-45 gave employers the option to expand coverage of prescription drugs and services used by these enrollees outside of their plan deductible. The first part of our analysis compared enrollment in HSA-eligible health plans with other health plans between 2018 and 2021 among enrollees with these health conditions to see if this notice had induced enrollees with the affected health plans to enroll in HSA-eligible health plans more so than in other health plans.

In the second part of the analysis, we studied the changes in cost sharing in these respective plans among those with these affected health conditions from 2018 to 2021 to test whether the IRS notice led to a change in cost sharing. We specifically focused on cost-sharing changes for six of the 14 classes of medication and services specified as prescription drugs and services that could now be covered pre-deductible due to the IRS notice. The medications and services were insulin and other glucose-lowering agents, selective serotonin reuptake inhibitors (SSRIs), statins, beta blockers, and antiresorptive therapy.

For both sets of results, we evaluated changes over time among enrollees in HSA-eligible health plans but also used the comparison group of the unaffected enrollees (those in other health plans) to show how these outcomes would have likely trended in the absence of the IRS intervention.

## Results

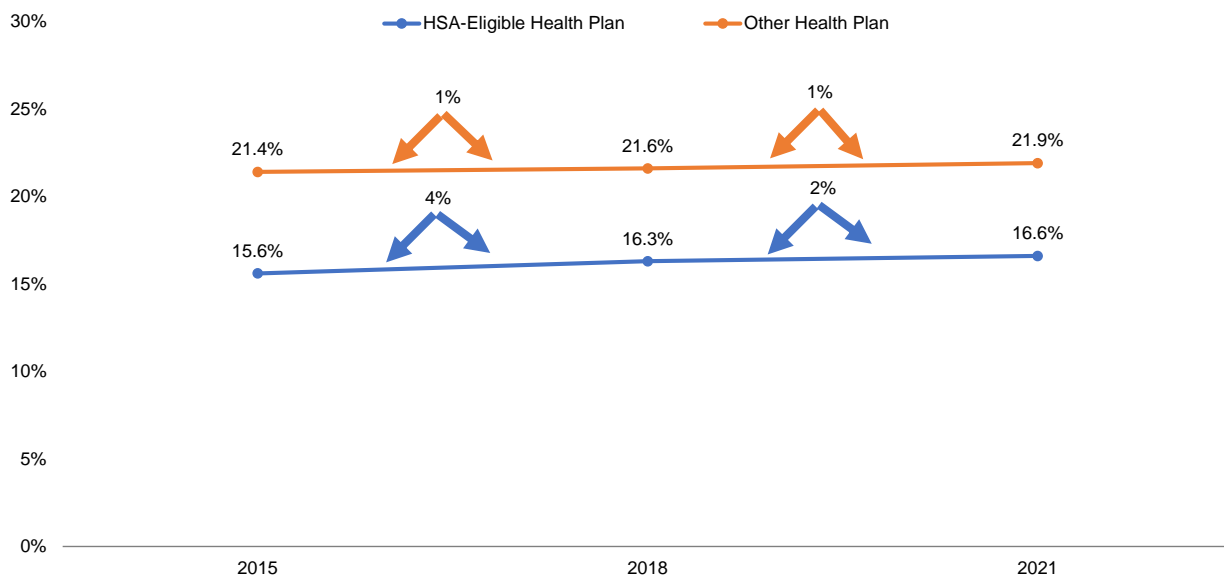
In this section, we present the findings on the impact of expanding pre-deductible coverage in HSA-eligible health plans on enrollees. Specifically, we look at the impact on plan choice and cost sharing.

### Plan Choice

IRS Notice 2019-45 allowed employers and health plans to expand pre-deductible coverage to services related to the treatment of heart disease, hypertension, depression, diabetes, asthma, osteoporosis/osteopenia, liver disease, and bleeding disorders. As a result, we would expect to see an increase in the percentage of plan members with these conditions. For example, diabetics might find HSA-eligible health plans to be more attractive if insulin and retinopathy screenings were no longer subject to the plan’s deductible.

On the one hand, we did find that the percentage of plan enrollees with any of these conditions increased. Between 2018 and 2021, the percentage of plan enrollees with any of these conditions increased from 16.3 percent to 16.6 percent, a 2 percent increase (Figure 3). In other health plans, the percentage of plan enrollees with any of these conditions also increased 0.3 percent. Because there were fewer HSA plan enrollees with any of these conditions than other health plan enrollees, the percentage change in enrollees with any of these health conditions in other health plans increased only 1 percent.

Figure 3  
Percentage of Plan Enrollees With Health Condition, and Change in Enrollment



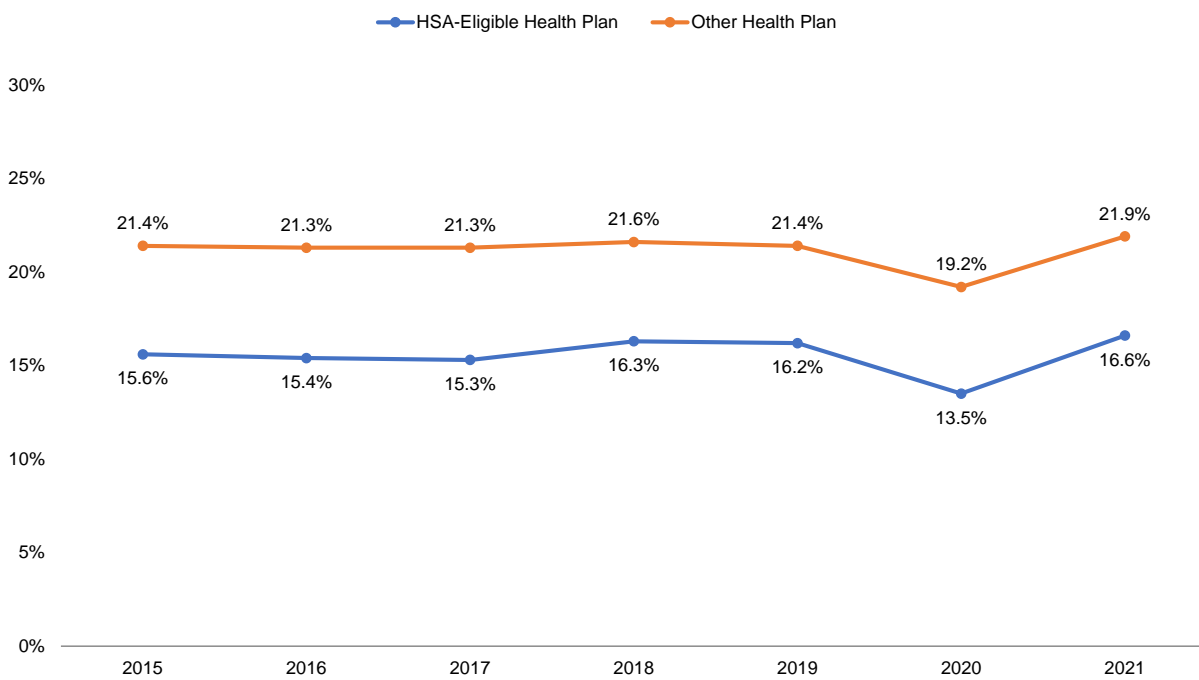
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.



Yet, we cannot conclude that the IRS notice was responsible for the higher increase in enrollment in HSA-eligible health plans among enrollees with the relevant health conditions. In the three-year period prior to the release of the IRS notice, the percentage of plan enrollees with a health condition impacted by the IRS notice was already trending up, and it was trending faster in HSA-eligible health plans (4 percent) than in other health plans (1 percent). So, it is possible that the trend between 2018 and 2021 would have occurred in the absence of IRS notice, as enrollment was already trending in this direction.

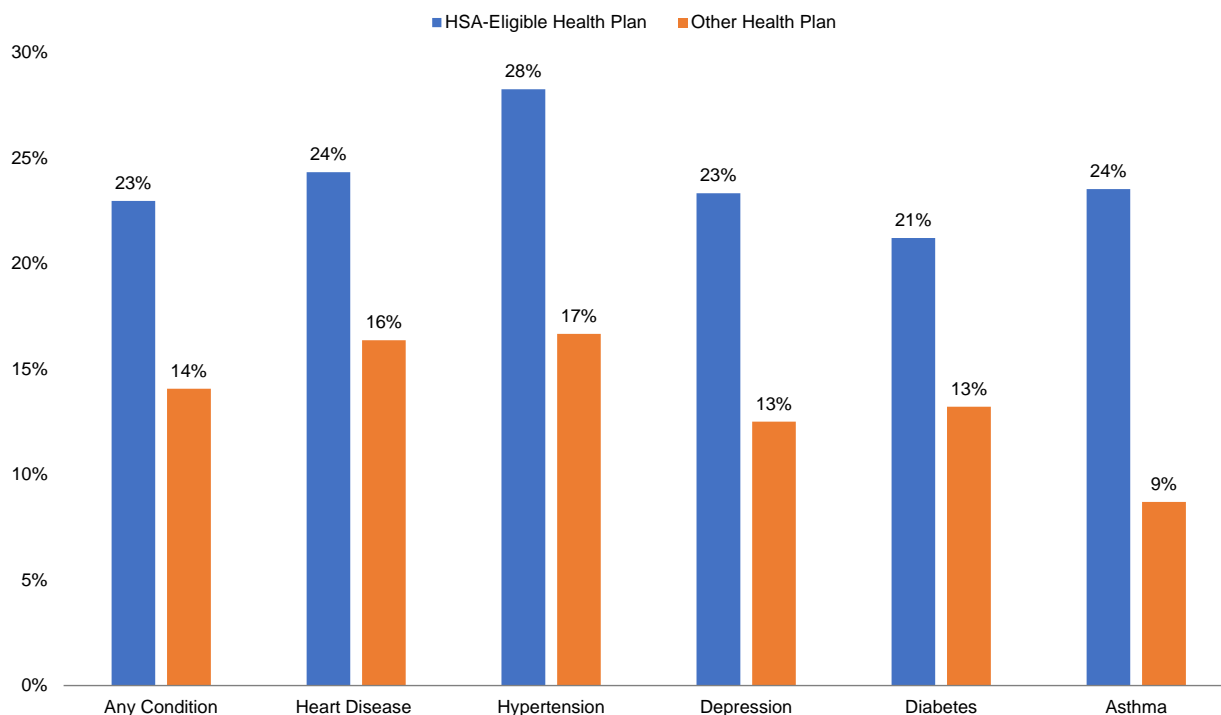
It is possible that the COVID-19 pandemic impacted the changes in enrollment between 2018 and 2021. In our methodology, health conditions were determined using claims data. Because use of health care services fell in 2020 as a result of the COVID-19 pandemic, we saw fewer enrollees with health conditions in 2020 (Figure 4). This was an artificial change, only occurring due to the fact that use of health care services had fallen. When use of health care rebounded in 2021, the percentage of plan members with relevant health conditions increased commensurately. Because of pent-up demand, it is possible that some plan members were still unable to get health care services in 2021, which would have had the effect of lowering the number of enrollees with health conditions. And we do not know if this affected HSA-eligible health plan enrollees more or less than it affected other health plan enrollees. However, we did find that the percentage change in enrollees with various health conditions was higher in HSA-eligible health plans between 2020 and 2021 than in other types of health plans (Figure 5).

**Figure 4**  
**Percentage of Plan Enrollees With Health Condition, by Plan Type, 2015-2021: HSA Enrollees Less Healthy, Other Enrollees More Healthy**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 5  
**Percentage Change in Enrollees With Health Condition, by Type of Health Plan, 2020–2021**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

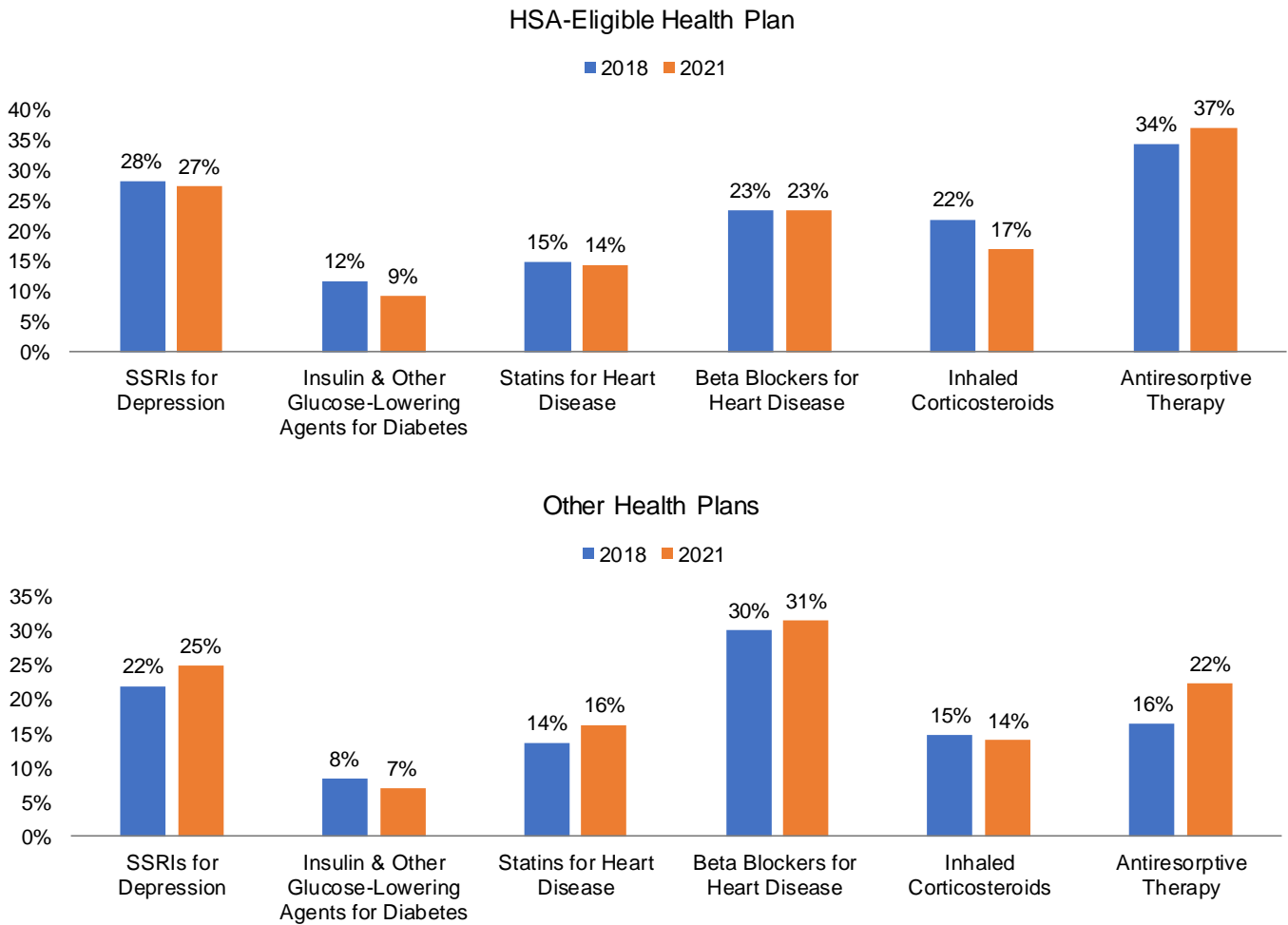
## Cost Sharing

We examined eight of the 14 services in the IRS notice to see if and how cost sharing was affected by the notice. Overall, total cost sharing as a percentage of total spending for each of the services examined was mostly constant between 2018 and 2021. This is not a surprising finding. In the 2021 EBRI survey of employers, we found that the majority of employers were replacing deductibles with copayments or coinsurance as a result of the IRS notice. However, there is a slightly different picture with respect to type of health plan. Among HSA-eligible health plan enrollees, cost sharing as a percentage of total spending fell for SSRIs, insulin and other glucose-lowering agents, statins, and inhaled corticosteroids (Figure 6). Cost sharing was unchanged for beta blockers and increased for antiresorptive therapy. In contrast, among other health plan type enrollees, cost sharing as a percentage of total spending increased for SSRIs, statins, beta blockers, and antiresorptive therapy, and it fell for insulin and other glucose-lowering agents and inhaled corticosteroids.

When examining the composition of cost sharing, we find that it shifted from deductibles to copayments and coinsurance for enrollees in HSA-eligible health plans. Among HSA-eligible health plan enrollees, the percentage of cost sharing paid through deductibles fell for SSRIs, insulin and other glucose-lowering agents, statins, beta blockers, and inhaled corticosteroids (Figure 7). Cost sharing was unchanged for antiresorptive therapy. We did not find the same shift among other health plan enrollees (Figure 8).

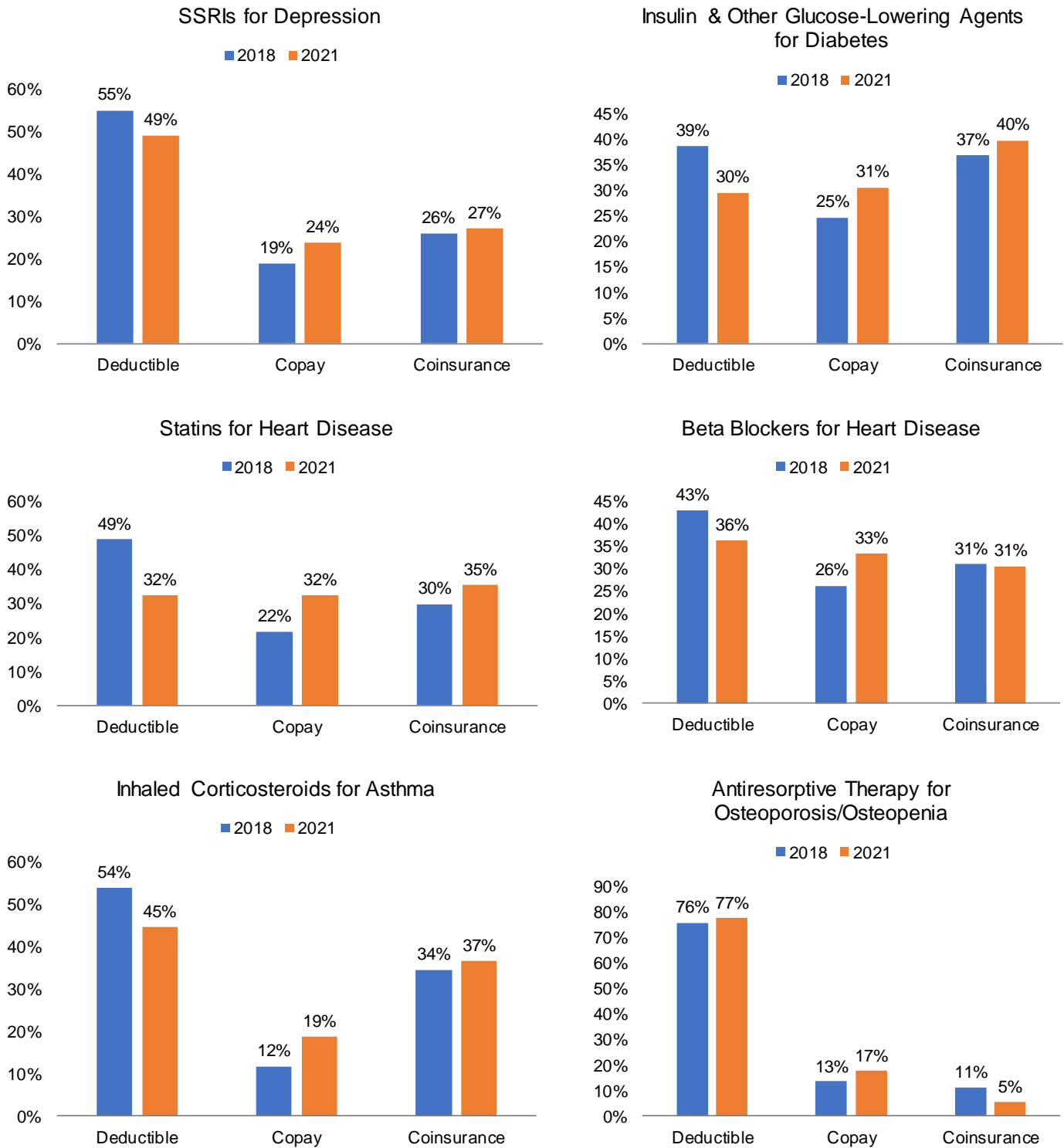
Another way to look at the impact of IRS notice on cost sharing is to examine the percentage of enrollees paying anything toward their deductible by type of service. We find that among HSA-eligible health plan enrollees, the percentage paying anything toward the deductible for the eight services examined fell for six of those services between 2018 and 2021; it increased for one (antiresorptive therapy) and remained constant for another (retinopathy screenings) (Figure 9). When the percentage of enrollees paying a deductible fell, it fell between 3 percent and 30 percent. In contrast, among other plan enrollees, the change in the percentage of enrollees paying a deductible was mostly unchanged between 2018 and 2021.

Figure 6  
**Cost Sharing as a Percentage of Total Spending, by Type of Health Plan**



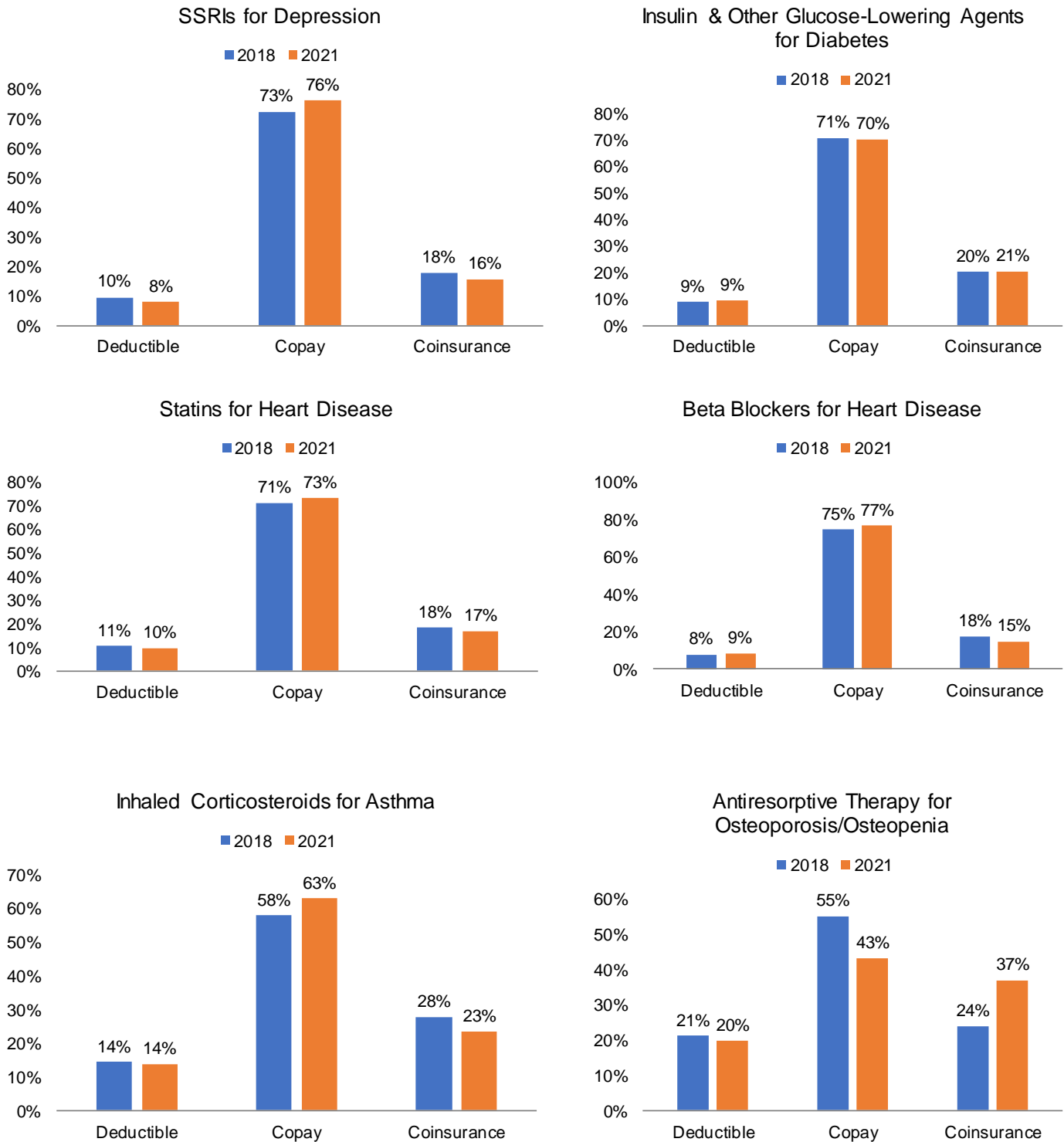
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 7  
**Cost Sharing by Type of Health Care Service, Among HSA-Eligible Health Plan Enrollees**



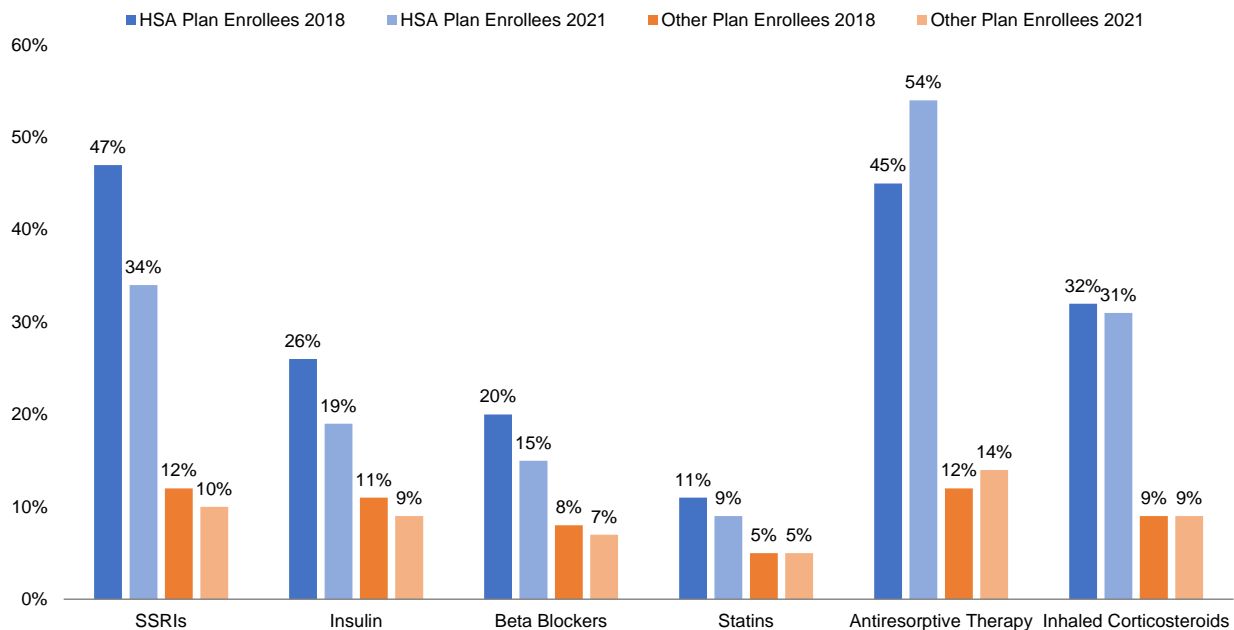
Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 8  
**Cost Sharing by Type of Health Care Service, Among Other Health Plan Enrollees**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

Figure 9  
**Percentage of Plan Enrollees Paying Deductible for Health Care Service, by Type of Health Plan**



Source: Employee Benefit Research Institute estimates based on administrative enrollment and claims data.

## Discussion

Our analysis confirms the findings from the 2021 EBRI survey of employers. Cost sharing for services affected by the IRS notice shifted from deductibles to copayments and coinsurance among enrollees in HSA-eligible health plans. In other health plans, we did not see the shift in cost sharing. However, overall cost sharing for services affected by the IRS notice was mostly unchanged. This is not a surprise, as the majority of employers interviewed in 2021 reported that they did not eliminate cost sharing when they added pre-deductible coverage. Instead, they substituted copayments and coinsurance for deductibles. While enrollees may not spend less money overall on health care services, the impact of changing the composition of cost sharing may change use of health care services and improve patient outcomes. Spreading out cost sharing over the course of the year instead of requiring patients to pay a large amount at the beginning of the year may result in higher use of high-valued services early in the year, which could prevent complications due to nonadherence of treatment regimens.

The fact that we do not see a change in enrollment patterns as a result of the IRS notice is not surprising. As mentioned above, this may be due to the reduction in use of health care services due to the COVID-19 pandemic, which in turn affected our ability to identify enrollees with heart disease, hypertension, depression, diabetes, asthma, osteoporosis/osteopenia, liver disease, and bleeding disorders. It may also be due to other factors. Many employers expanded pre-deductible coverage for the first time in 2021. It may take time for enrollees with the above health care conditions to get comfortable choosing a new health plan, and these medium-run effects can be identified once the 2022 data are made available. Similarly, they may not be aware of the change in plan design, despite employers' best efforts to inform enrollees of a plan design change that is considered an improvement in benefits. In fact, EBRI research indicates that 63 percent of enrollees with an HSA-eligible health plan spend less than 30 minutes choosing a health plan.<sup>8</sup> Furthermore, the employers themselves may or may not have done a good job educating their employees about the change.

The fact that employers moved toward covering services on a pre-deductible basis once they were allowed to comes at a critical period of time. When the ACA passed in 2010, it included provisions requiring that employers and health plans cover certain preventive services in full. These include services such as screenings for cancer and other health

conditions, vaccinations, and birth control. Plan sponsors have been prohibited from imposing any form of cost sharing (i.e., deductibles, copayments, or coinsurance) on participants receiving these services.

On September 7, 2022, Judge Reed O'Connor of the U.S. District Court for the Northern District of Texas found a key part of the preventive service provision unconstitutional. Specifically, the decision on *Braidwood Management Inc. v. Becerra* refers to the part of the ACA that requires coverage of preventive services without cost sharing to which the U.S. Preventive Services Task Force (USPTF) — a group the Agency for Healthcare Research and Quality has been authorized by the U.S. Congress to convene since 1998 — assigns a rating of “A” or “B”.

If this court decision is upheld, employers and health plans could impose some form of cost sharing for these preventive services. Yet, employers may continue to provide these services at no cost to members for at least a few reasons, including:

1. Employers may not want to cut benefits during a time when unemployment is low and recruitment and retention of workers is of concern.
2. Employers may continue to offer coverage for these services in full if they believe that incentivizing their use reduces aggregate health spending in the long term.
3. There is precedent for covering these services without cost sharing in the absence of the ACA mandate. When health reimbursement arrangements (HRAs) were introduced in the early 2000s, some employers provided first-dollar coverage for preventive services (Fronstin 2002). Comparable generous coverage was implemented when HSA-eligible health plans were introduced (Fronstin, Sepulveda, and Roebuck 2013). And of course, the 2021 EBRI survey mentioned above found that when the IRS allowed employers and health plans to cover certain preventive services outside HSA-eligible health plan deductibles, about three-quarters of them chose to do so, often without cost sharing (Fronstin and Fendrick 2021).<sup>9</sup>

Two recent surveys find support among employers for the continuation of providing preventive services without cost sharing. A 2022 EBRI survey found that 80 percent of HR decision makers said they would continue to cover preventive services in full.<sup>10</sup> Similarly, a 2023 survey found that 72 percent of employers expect to continue providing coverage for all preventive services without cost sharing.<sup>11</sup>

Nearly 20 years after passage of the MMA, only one-quarter of smaller employers and one-half of larger employers offer an HSA-eligible health plan.<sup>12</sup> Employers may be holding back from adopting HSA-eligible health plans because of evidence that they may be associated with a reduction in appropriate preventive care and medication adherence (Agrawal, Mazurenko, and Menachemi 2017). The savings or medical cost offsets from providing incentives to get preventive care are often difficult to quantify. Yet employers often invest in such care in the absence of evidence. Because of constraints around preventive care and HSA-eligible health plans, employers appear to have moved toward higher deductibles in PPOs, while some have adopted HRA plans instead, possibly with flexible spending accounts (FSAs). The IRS notice may not only cause employers offering HSA-eligible health plans to adopt pre-deductible coverage, but also might result in more employers offering such plans.

Yet, while employers could incentivize the use of preventive services in non-HSA plans, not all employers have done so. The IRS notice may move such employers toward changing their plan design to incentivize the use of preventive services for several reasons. First, they may do so because the IRS notice has legitimized it. Second, as health plans make it easier to offer preventive services on a pre-deductible basis in HSA plans, it becomes just as easy for employers to adopt the strategy in other types of health plans.

## **Congressional Efforts to Further Expand Pre-Deductible Coverage**

Building on the momentum of Executive Order 13877 and IRS Notice 2019-45, Sens. John Thune (R-SD) and Tom Carper (D-DE) introduced the Chronic Disease Management Act of 2019 in the Senate (S. 1948), followed by the introduction of the companion bill in the House of Representatives (H.R. 3709) by Reps. Earl Blumenauer (D-OR) and Tom Reed (R-NY). This bipartisan, bicameral legislation would provide HSA-eligible health plans additional flexibility to provide coverage for services that manage chronic conditions prior to meeting the plan deductible. The bill was reintroduced in the Senate in January 2020 (S. 3200), April 2021 (S. 1424), and March 2023 (S. 655) and in the House of Representatives in May 2021 (HR. 3563), building on the IRS guidance and previous versions to further increase pre-deductible coverage for chronic disease management.

## **Conclusion**

In response to IRS Notice 2019-45, three-quarters of large employers and health plans offering HSA-eligible health plans expanded pre-deductible coverage for medications and services that prevent the exacerbation of chronic conditions (Fronstin and Fendrick 2021). The impact on premiums of expanding pre-deductible coverage for 14 services in HSA-eligible health plans as allowed in IRS Notice 2019-45 is small (Fronstin, Roebuck, and Fendrick 2022). Further expanding pre-deductible coverage to 116 drug classes that are used mostly for chronic disease medication management also has a small impact on premiums (Fronstin, Roebuck, and Fendrick 2022).

Our analysis confirms the findings from the 2021 EBRI survey of employers. Cost sharing for services affected by the IRS notice shifted from deductibles to copayments and coinsurance among enrollees in HSA-eligible health plans. In other health plans, we did not see the shift in cost sharing. Employers would add additional services if allowed by the IRS, according to EBRI's survey results. And there is bipartisan, bicameral legislation that has been introduced in the U.S. Congress that would provide additional flexibility to extend pre-deductible coverage to services that manage chronic conditions. Employers and policymakers have an appetite for more flexible plan designs or "smarter" deductibles, because rising health care spending has created serious fiscal challenges.

Smarter deductibles accommodating services preventing the exacerbation of chronic conditions might be a natural evolution of health plans. Value-based reimbursement promotes the delivery of evidence-based, high-quality care that encourages use of — rather than creating barriers to — high-value services. Interventions that improve patient-centered outcomes while maintaining affordability may be found in the form of a clinically nuanced HSA-eligible health plan that better meets workers' clinical and financial needs.



## Appendix

Appendix Figure 1 Statutory HSA Limits, 2004–2023							
	Minimum Deductible		Maximum Contribution		Maximum Out-of-Pocket Limit		Per-Person Catch-up Contribution Limit
	Individual	Family	Individual	Family	Individual	Family	
2004	\$1,000	\$2,000	\$2,600	\$5,150	\$5,000	\$10,000	\$500
2005	1,000	2,000	2,600	5,150	5,000	10,000	600
2006	1,050	2,100	2,700	5,450	5,250	10,500	700
2007	1,100	2,200	2,850	5,650	5,500	11,000	800
2008	1,100	2,200	2,900	5,800	5,600	11,200	900
2009	1,150	2,300	3,000	5,950	5,800	11,600	1,000
2010	1,200	2,400	3,050	6,150	5,950	11,900	1,000
2011	1,200	2,400	3,050	6,150	5,950	11,900	1,000
2012	1,200	2,400	3,100	6,250	6,050	12,100	1,000
2013	1,250	2,500	3,250	6,450	6,250	12,500	1,000
2014	1,250	2,500	3,300	6,550	6,350	12,700	1,000
2015	1,300	2,600	3,350	6,650	6,450	12,900	1,000
2016	1,300	2,600	3,350	6,750	6,550	13,100	1,000
2017	1,300	2,600	3,400	6,750	6,550	13,100	1,000
2018	1,350	2,700	3,450	6,900	6,650	13,300	1,000
2019	1,350	2,700	3,500	7,000	6,750	13,500	1,000
2020	1,400	2,800	3,550	7,100	6,900	13,800	1,000
2021	1,400	2,800	3,600	7,200	7,000	14,000	1,000
2022	1,400	2,800	3,650	7,300	7,050	14,100	1,000
2023	1,500	3,000	3,850	7,750	7,500	15,000	1,000

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## Endnotes

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<sup>1</sup> In 2021, 60.1 percent of individuals with health coverage through a private-sector establishment were in a plan with a deductible that met the deductible requirements to be HSA eligible. However, we do not know how many of these enrollees were in an HSA-eligible health plan. Some were enrolled in a health plan with a health reimbursement arrangement (HRA). Others were in health plans that met the deductible requirement but may have not met other requirements, such as the restriction on preventive services.

<sup>2</sup> See <https://www.irs.gov/pub/irs-drop/n-19-45.pdf>.

<sup>3</sup> See [https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP\\_HDHP-Survey.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP_HDHP-Survey.pdf).

<sup>4</sup> See [https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP\\_HDHP-Survey.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP_HDHP-Survey.pdf).

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<sup>5</sup> See Kaiser Family Foundation (2015) and Internal Revenue Service (2013).

<sup>6</sup> See <https://www.irs.gov/pub/irs-drop/n-04-50.pdf>.

<sup>7</sup> See the literature reviews in Bundorf (2012) and Agrawal, Mazurenko, and Menachemi (2017) as well as research in Brot-Goldberg, Chandra, Handel, and Kolstad (2017); Chandra, Gruber, and McKnight (2010); Chernew et al. (2008); Collins, Rasmussen, Beutel, and Doty (2015); Fronstin and Roebuck (2019); Fronstin and Roebuck (2013); Fronstin and Roebuck (2020); Fronstin and Roebuck (2014); Fronstin and Roebuck (2016); Fronstin, Sepúlveda, and Roebuck (2013); Fronstin, Sepúlveda, and Roebuck (2013); Fronstin, Roebuck, Buxbaum, and Fendrick (2020); Goldman, Joyce, and Zheng (2007); Trivedi, Moloo, and Mor (2010); Wharam et al. (2017); and Wharam et al. (2018).

<sup>8</sup> See <https://www.ebri.org/docs/default-source/fast-facts/ff-455-cehcshealth-2mar23.pdf>.

<sup>9</sup> Also see [https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP\\_HDHP-Survey.pdf](https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP_HDHP-Survey.pdf) and <https://www.irs.gov/pub/irs-drop/n-19-45.pdf>.

<sup>10</sup> See <https://www.ebri.org/docs/default-source/fast-facts/ff-445-pssurvey-27oct22.pdf>.

<sup>11</sup> See <https://www.nationalalliancehealth.org/news/immunization-remains-critical/>.

<sup>12</sup> See Figure 8.3 in <https://www.kff.org/report-section/ehbs-2022-section-8-high-deductible-health-plans-with-savings-option/>.