

Cover Missouri Project: Report 10

High-Deductible Health Plans
with Health Savings Accounts:
Emerging Evidence and
Outstanding Issues



About MFH

Established in 2000, the Missouri Foundation for Health is dedicated to its mission of empowering the people of the communities we serve to achieve equal access to quality health services that promote prevention and encourage healthy behaviors. In support of its mission, the Foundation undertakes policy research to educate the public and decision makers on effective health policies that will result in long-term, positive health system change in the state of Missouri. Formulating sound health policies advances the Foundation's efforts to increase access to high quality, cost-effective preventive and curative care, especially for the uninsured, underinsured, and underserved in our service region of 84 Missouri counties and the City of St. Louis.

The Missouri Foundation for Health does not take responsibility for any analysis, errors, or omissions of fact found in this report.

Cover Missouri Project

Preface

In an effort to inform the discussion regarding practical policy options to expand health care coverage for the uninsured in Missouri, the Missouri Foundation for Health (MFH) has established the Cover Missouri Project. Under this project, MFH has engaged The Urban Institute to produce a series of papers which considers strengths and weaknesses of the current health care system in Missouri and explores options for decreasing the number of uninsured. MFH offers these studies as a means to further understand and ultimately improve access to health care coverage.

Missouri currently faces considerable challenges related to creating an equitable and comprehensive system of health care for all Missourians. In 2005, between 635,000 and 707,000 Missouri residents were without health insurance. In addition, eligibility cuts and cost-sharing changes to Missouri's Medicaid program made in 2005 increased the number of uninsured. Ultimately, these changes may shift Missouri from being one of the 12 states with the lowest uninsurance rates to being among the 12 states with the highest rates of uninsurance.

Research broadly documents the serious health and financial consequences associated with being uninsured. The uninsured live sicker and die younger than those with insurance. They forego preventive care and seek health care at more advanced stages of disease. Society then bears these costs through lower productivity, increased rates of communicable diseases, and higher insurance premiums. Those without health insurance often must choose between visiting a doctor and paying for other essentials.

This paper, "High-Deductible Health Plans with Health Savings Accounts," stands as the 10th in the series emerging under the Cover Missouri Project. Data presented in this paper suggests that the combination of high-deductible health plans and Health Savings Accounts represent an important trend in health care coverage. The purpose of this study is to discuss how these plans are likely to affect health care costs, risk segmentation, and overall levels of health insurance coverage.

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About The Urban Institute

The Urban Institute is a nonprofit nonpartisan policy research and educational organization established to examine the social, economic, and governance problems facing the nation. It provides information and analysis to public and private decision makers to help them address these challenges and strives to raise citizen understanding of the issues and tradeoffs in policy making. The Urban Institute works to promote sound social policy and public debate on national priorities through gathering and analyzing data, conducting policy research, evaluating programs and services, and educating all Americans. More information about The Urban Institute may be found at www.urban.org.

High-Deductible Health Plans with Health Savings Accounts: Emerging Evidence and Outstanding Issues

by Lisa Clemans-Cope, PhD, Fredric Blavin, BA, and Genevieve M. Kenney, PhD

Expanding Health Savings Accounts (HSAs) is a central objective of President George H. W. Bush's proposed health policy reforms.¹ As part of his 2006 State of Union address, the President outlined numerous policy changes intended to increase enrollment in HSAs by making them more attractive to consumers and employers. HSAs, used in conjunction with high-deductible health plans (HDHPs), are part of a grouping of health insurance products commonly referred to as "consumer-driven health plans" (CDHPs). CDHPs are designed to increase the sensitivity of individual consumers to the costs of medical services.

CDHPs typically include a high-deductible health insurance product and may be coupled with an account, such as health reimbursement accounts or HSAs. These accounts allow individuals and/or their employers to make tax-preferred contributions toward medical care not covered by the HDHP. The high

deductibles are intended to make consumers think carefully about their need for care prior to using services, since the initial spending prior to meeting the deductible would come out of either the consumer's own pocket or out of their HSA. The accounts allow employers and/or consumers to pay for out-of-pocket medical expenses on a tax-preferred basis. Consumers not spending the full yearly allotment in their accounts can build up their balances over time, accumulating resources for future medical needs. Funds contributed to HSAs are owned by the individual, similar to an Individual Retirement Account (IRA). Health reimbursement accounts provide tax-preferred funds for medical needs just as HSAs do, but unlike HSAs, funds not paid out are retained by the employer.

HDHPs tend to have significantly lower premiums than more comprehensive insurance plans.² These lower premiums derive from two cost-saving techniques. First, they cover fewer of the medical dollars spent, since individuals must pay a larger amount of their medical needs before the actual insurance protection begins. Second, high-deductible plans tend to attract and, therefore, cover less costly healthy individuals. Because health insurance premiums are determined in relations to the expected health care risk of those enrolling, a plan with a healthier population would have lower premiums than one with a sicker population.

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At this point in time, it is too early to gauge the full effects of HDHPs linked to HSAs. Relative to traditional health insurance plans, CDHPs, such as HDHPs with HSAs, change incentives in a number of different ways.³ Some have argued that they will make consumers more cost-conscious when making personal health care choices. The resulting awareness will decrease health care spending, particularly on discretionary services.⁴ Others contend that the plans will do little to slow health care spending growth. Because they simply shift health care spending burdens onto those who are sick. It has been noted that HDHPs linked to HSAs provide new pre-tax investment benefits to higher-income families.⁵ In addition, it is not known what effect these plans will have on rates of health insurance coverage. Some have argued that the presence of plans available for lower premiums might reduce uninsurance rates.⁶ Others have argued that selection of lower risk individuals into high-deductible plans could raise premiums for plans covering those individuals with greater health risks, thereby increasing the number of uninsured.⁷

HDHPs combined with HSAs represent a continuation of a decade-long trend toward greater cost-sharing in health insurance plans. HSAs were established in 2003 under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Under that law, consumers selecting HDHPs can establish a completely portable and tax-free HSA. Individuals owning HSAs must be covered by a health plan with annual deductibles of not less than \$1,050 for single coverage or \$2,100 for family coverage.⁸ Under current law, employer contributions to HSAs are not subject to personal income taxes or employment taxes.

In order to extend the tax advantages of employer-sponsored insurance (ESI) to individually purchased HSA-qualifying plans,

the President proposed, as part of the 2007 budget, a tax deduction for 100 percent of the premium costs associated with an individually purchased high-deductible insurance policy attached to an HSA, and a refundable tax credit equal to 15.3 percent of the premium, as an offset to the payroll tax.⁹

Plans that couple HSAs with HDHPs may provide preventative medical benefits and coverage before the deductible is met. In order not to discourage individuals from receiving necessary care, MMA, in accordance with IRS guidelines, states that certain preventive services can be covered in full and do not have to be subject to the deductible.¹⁰ These services include periodic health evaluations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity/weight loss programs, and certain screening services. In addition, annual out-of-pocket costs for deductibles and other medical expenses may not exceed \$5,250 for single coverage or \$10,500 for family coverage. These amounts are indexed to the rate of inflation.

Both individuals and employers are allowed to make tax-exempted contributions to HSAs. In 2005, the maximum annual contribution amounts were \$2,700 for single coverage and \$5,450 for family coverage. The President proposed increasing these annual limits, potentially setting them as high \$5,250 for individuals and \$10,500 for families.¹¹ This would nearly double the yearly tax-exempt contributions permitted to an HSA. In order to encourage savings for health expenses after retirement, individuals who are age 55 or older are allowed to make additional catch-up contributions. However, no contributions can be made by an individual enrolled in Medicare. In 2005, catch-up contributions were limited to \$600. The limit increases by \$100 each year until 2009 and remains at \$1,000 thereafter. If more money is deposited

in an HSA than is allowed under law, the excess amount is subject to a yearly 6 percent excise tax penalty until it is withdrawn.¹² Any money left in the account at the end of the year automatically rolls over and is available for future out-of-pocket health care costs.

As currently configured, HSAs represent an attractive investment vehicle for high-income families. Both contributions and withdrawals to HSAs are exempt from federal income taxes if used for qualified medical expenses.¹³ This tax treatment is unique in that it is more generous than the tax treatment of other investment options, such as traditional IRAs that tax withdrawals or Roth IRAs that tax contributions.¹⁴ The tax subsidy associated with HSAs can be more than 50 percent higher than the tax subsidy associated with traditional retirement accounts.¹⁵ Therefore, higher income individuals who have reached the annual contribution limits for their traditional retirement accounts have substantial incentives to use HSAs to shield greater portions of their incomes from taxes. Additionally, the tax benefits of HSAs do not phase out at a specific income level, so wealthy individuals with income exceeding the criteria for participation in a traditional IRA can use HSAs as tax-free investment vehicles. Moreover, since an HSA can be used for non-health expenses without penalty once an individual reaches age 65, it essentially functions as an IRA. The President's proposals, which roughly double the maximum contributions allowed, would make HSAs an attractive investment for high-income families.

HSAs were not permissible until Congress changed federal tax policy by extending the same tax benefits enjoyed by comprehensive ESI to health plans

combining HDHPs with HSAs. Prior to 1996, the insurance market, especially the employer group market, was dominated by plans with relatively low deductibles and coinsurance. Health benefits received as an employee fringe benefit were exempt from federal income and payroll taxes, but individual out-of-pocket spending on health care was tax deductible only to the extent that total health expenses in a year exceeded 7.5 percent of adjusted gross income.¹⁶ In 1996, Congress established a favorable federal tax status for medical savings accounts – a precursor to today's HSAs – available as an option to a narrow segment of workers (the self-employed and workers of employers with 50 or fewer employees) and to Medicare beneficiaries.

Those medical savings accounts laid the foundation for HSAs, but never generated much interest among consumers because the contributions did not carry over from one year to the next. Interest among insurers was low due to federal requirements related to benefit design.¹⁷ However, with the return of double-digit increases in private insurance premiums in 2001, policies with higher deductibles, greater cost-sharing, and lower premiums began to attract attention from employers seeking to limit health benefit costs.¹⁸

Employers have used flexible spending accounts, authorized under Section 125 of the Internal Revenue Code, as a part of the Revenue Act of 1978 to reduce employee health care costs and soften the impact of benefit reductions.¹⁹ These accounts allow employees to use pre-tax dollars to pay for health care services not covered by health insurance. Unlike HSAs, flexible spending accounts do not need to be combined with HDHPs and any dollars remaining in the accounts at the end of the plan year are forfeited to the employer.

Trends in Health Savings Accounts

While no definitive data source exists to provide a comprehensive picture of how much of the population is covered by HDHPs with HSAs, available data suggests that HDHPs linked to HSAs constitute a small, but fast-growing, segment of the health insurance market.²⁰ *The New York Times* reported that more than 2 million people had signed up for HDHPs by the start of 2006, with less than half contributing money toward an associated HSA.²¹ According to American's Health Insurance Plans (AHIP), a national association representing 1,300 member companies providing health insurance coverage to more than 200 million workers, enrollment in HSAs linked to HDHPs increased by 135 percent from September 2004 (438,000 enrollees) to March 2005 (1,031,000 enrollees). The AHIP data suggest that as of March 2005, HSAs were more popular, at least among their members, in the individual market rather than in the group market, though this data may understate enrollment in HSAs among workers in the group market. Among AHIP enrollees, 54 percent had coverage in the individual market, 39 percent had coverage in the group market, and 7 percent had coverage in an unknown market.²²

The Employer Health Benefits Survey provides more insight on the growth of high-deductible policies and HSAs among employers. The survey, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust and compiled by Dun and Bradstreet, reports findings from a telephone survey of 2,995 randomly selected public and private non-federal employers.²³ In 2003, only 5 percent of firms offering health benefits offered employees HDHPs. This share increased to

10 percent in 2004 and to 20 percent in 2005. These employers were also asked if HDHPs permit their employees to establish HSAs (referred to as an "HSA-qualified HDHP"). Among all the firm offering health benefits in 2005, 2.3 percent offered an HSA-qualified HDHP. In firms offering these plans, approximately 15 percent of workers participate (covering approximately 810,000 workers); the participation rate in larger firms of 1,000 or more workers is significantly lower (3%).

The Employer Health Benefits Survey also provides information on specific features of HSA-qualified HDHPs. Comparing HSA-qualified HDHPs with health plans overall, the average premium costs for both single and family coverage in HSA-qualified HDHPs are lower (\$2,700 and \$7,909, respectively) than the average premiums for single and family coverage overall (\$4,024 and \$10,880, respectively).²⁴ On average, workers receive HSA contributions from their employers of \$553 for single coverage and \$1,185 for family coverage. Although, 35 percent of firms offering these plans (which is equivalent to 37 percent of the workers in such plans) make no contribution to their employees' HSAs. Workers with HSAs have average deductibles of \$1,901 for single coverage and \$4,070 for family coverage, and their average maximum out-of-pocket liability is \$2,551 for single coverage and \$4,661 for family coverage. Finally, only 30 percent of workers covered by HSA-qualified HDHPs are in a plan covering some preventive benefits before the deductible is met.²⁵ To our knowledge, there is no national data reflecting the level of coinsurance applied to expenses between the deductible and the out-of-pocket maximums for HDHPs.

The percentage of employers offering HSA-qualified HDHPs is expected to increase over the next several years, especially among large employers (200 or more workers). According to the 2005 Employer Health Benefits Survey, 2 percent of all firms not offering HSA-qualified HDHPs report that they are “very likely” to offer this option within the next year; another 25 percent report that they are “somewhat likely” to do so in the future. Large firms expressed greater interest in these plans than firms overall. Seven percent of large firms not currently offering HSA-qualified HDHPs report that they are

“very likely” to offer such plans in the next year. This is consistent with results from the 2005 National Survey of Employer-Sponsored Health Plans conducted by Mercer, which found that 11 percent of employers intend to offer CDHPs in 2006 and 13 percent of employers intend to offer CDHPs in 2007. This compares to only 2 percent that offered such plans in 2005. Even higher percentages of the largest employers (20,000 or more employees) intend to offer CDHPs, with rates expected to rise to 29 percent in 2006 and 31 percent in 2007, from 22 percent in 2005.

Potential Impacts on Costs and Service Use

Proponents of HDHPs linked to HSAs argue that these arrangements will reduce health care spending and unnecessary medical services by providing consumers with incentives to prudently use health care services.²⁶ Under these plans, incentives to eliminate unnecessary service use or to seek out lower prices for care operate primarily for spending below the deductible, which is not where most health care spending occurs. Thus, it is not clear how much of an impact HDHPs will have on aggregate spending and service use, let alone on the rate of spending growth over time.²⁷ It is generally expected that plans with higher deductibles will lead to lower levels of spending.²⁸ This expectation is based on findings from the RAND Health Insurance Experiment.²⁹ Conducted between 1974 and 1982, the RAND study showed that spending was lower when consumers were faced with higher cost-sharing in the form of higher deductibles. For example, study participants in the large-deductible plan (that had a 95 percent coinsurance rate)

used 25 to 30 percent fewer services than those in the free care plan.³⁰ Numerous attempts have been made to simulate the effects of a broad adoption of high-deductible plans based on the RAND findings. These studies put the range of potential cost-savings between 4 and 15 percent.³¹

However, the presence of a savings account combined with a high-deductible plan may mitigate the cost-savings because consumers have already set those funds aside and could spend them tax-free on health care. The incentives to limit spending below the deductible and thus accrue balances under their savings accounts may differ depending on whether a consumer has a health reimbursement account or an HSA. Consumers do not own health reimbursement accounts and cannot take these accounts with them should they change employers, which may make them reluctant to accumulate large balances. Researchers have estimated that combining HDHPs

with HSAs would yield an aggregate savings of between 2 and 7 percent.³²

HSA-qualified HDHPs would have to dominate a large share of the market in order to generate systemwide savings. It is expected that plans will negotiate discounted prices with physicians and hospitals, and that these discounts would be passed on to enrollees when purchasing services below the deductible. Larger market shares are likely to assist plans in negotiating for discounts, since patient volume is likely to influence the magnitude of the discounts offered. However, HDHPs linked to HSAs comprise only a small share (approximately 1% to 2%) of the total health insurance market at this time. Additionally, if these plans attract mainly younger, healthier enrollees, there would be even lower savings than indicated here.³³ Because health care spending is heavily concentrated among a small share of the population with high health care needs,³⁴ a product that attracts a largely healthy, low-spending enrollee population will not significantly affect national health spending.

However, even if a large share of the population were to enroll in HSA-qualified HDHPs, their ability to significantly affect aggregate health spending is limited due to the distribution of health care spending relative to the deductible.³⁵ The distribution of health care expenditures is highly skewed: the highest spending 10 percent of the population accounts for about 70 percent of total expenditures in the country, while the lowest spending 50 percent accounts for only 3 percent of expenditures.³⁶ As a consequence, most health care costs are associated with spending exceeding the high deductibles associated with HSA-qualified HDHPs. Blumberg and Burman estimated that 79 percent of all spending occurs above the minimum HSA-qualified HDHP

deductible and more than 95 percent of all spending (including spending above and below the deductible) was incurred by those whose spending exceeded these deductibles.³⁷ Making significant inroads into spending would require achieving spending reductions among the chronically ill, who incur the majority of costs. However, early evidence from insurance companies shows no significant changes in utilization of HSA-qualified HDHPs among this type of enrollee.³⁸

Preliminary empirical evidence indicates that the effects of HSAs on health care spending and service use are ambiguous. An Aetna study of first-year adopters of a HDHP with HSAs found that people enrolled in a CDHP called HealthFund had lower costs relative to PPO enrollees.³⁹ Aetna also found that compared to their prior-year utilization, people enrolled in HealthFund had fewer inpatient and emergency room admissions, but an increased number of specialist visits.⁴⁰

A study, by Parente et al., of a large employer that offered an HMO and PPO in 2000-2002 and introduced a CDHP in 2001 found that the CDHP was associated with increased health spending relative to the HMO and with lower spending relative to the PPO.⁴¹ Physician visits and pharmaceutical use and costs were lower in the CDHP group when compared to both other groups, but emergency admission rates and total physician expenditures for CDHP enrollees were significantly higher than for enrollees in the HMO and PPO plans.⁴² This study also indicates that the majority of CDHP enrollees included in the study had spending levels that exceeded the deductible. Approximately 57 percent of enrollees exceeded the deductible and only 29 percent had money left in their HSAs by the second year.⁴³ Finally, a 2000 study by

Solank et al. found that cost-sharing through higher deductibles had negative effects on preventive counseling, Pap tests, and mammography examinations.⁴⁴ The estimated effects on blood pressure screening were inconclusive.⁴⁵

Of particular concern is whether reductions in use of services for CDHP enrollees result from elimination of necessary or health-enhancing care as opposed to unnecessary services. Several surveys indicate that individuals with CDHPs are more likely to miss necessary care than those enrolled in traditional health plans. Data from the Employee Benefit Research Institute (EBRI) - Commonwealth Fund Consumerism in Health Care Survey shows that individuals with CDHPs were significantly more likely to avoid, skip, or delay health care because of costs than those with more comprehensive health insurance. These behaviors were particularly acute for those with chronic health problems and/or incomes below \$50,000.⁴⁶ About 35 percent of individuals in CHDPs and 31 percent of those with HDHPs reported delaying or avoiding care, compared with 17 percent of those in comprehensive health plans.⁴⁷

Likewise, another study finds that 38 percent of adults with deductibles of \$1,000

or more reported at least one of four cost-related access problems: not filling a prescription; not getting needed specialist care; skipping a recommended test or follow-up; or having a medical problem but not visiting a doctor or clinic.⁴⁸ This same study found that these access problems were amplified for low-income and sick adults. Of particular concern is the impact of these new plans on preventive services (such as child care, checkups, and prescription drugs for chronic conditions). Early evidence suggests that the majority of plans do not cover preventive services before the deductible is met.⁴⁹

Some researchers have argued that HDHPs linked to HSAs alone will not constrain spending growth over time and that overall cost containment can be achieved only by a combination of greater cost-sharing and modern managed care mechanisms working in tandem to control spending above the deductible and the out-of-pocket maximums.⁵⁰ In addition, several studies suggest that growth in spending can be attributed to technological innovation. There is little evidence indicating that greater cost-sharing can slow the adoption of new technology.⁵¹

Potential Impacts on Risk Segmentation in Health Insurance Markets

The rationale for combining people with different health care risks into the same health insurance risk pool is that it allows health care spending burdens to be spread more evenly across the population. The principle of collective health insurance, which has been the dominant paradigm for

decades in the employer market, is that the majority of enrollees in a health insurance plan are in good health and use fewer covered benefits in a given year than the population average, which allows their premium payments to subsidize health care for those enrollees who have higher

expenditures in that year.⁵² This principle contrasts fundamentally with the logic underlying an increasing practice in the health insurance industry: categorizing individuals according to health risk and marketing separate health plans to each risk class. Incentives to expand enrollment in HSA-qualified HDHPs accelerate this trend.

The consequence of the proliferation of HDHPs is that health care expenses associated with high-cost medical cases in the United States are being shifted to the individual.⁵³ As the costs of medical care are spread less broadly, financial burdens for seriously ill individuals can increase dramatically. Recent literature describing the large share of personal bankruptcies attributable to medical expenses shows that these shifts can have significant negative effects on the financial stability of families with high-cost members.⁵⁴

Risk segmentation, implemented through medical underwriting techniques, has been particularly prominent in private non-group health insurance markets. The approach assures the profitability of each plan. The emergence of HSA-qualifying plans will likely produce further non-group product differentiation because of the tax benefits that are offered. For example, those who are healthy and have higher incomes may find HSAs attractive as an investment vehicle and appreciate the lower premiums, but not be concerned by having more limited health care benefits.

The effects of HSA-qualifying plans on risk segmentation in the ESI (“group”) market are complex. Early simulations of plan choices confirm the theoretical hypothesis that CDHPs with HDHPs have the potential for exacerbating risk selection based on health status.⁵⁵ Some proponents of HSAs argue that if employers offer

HDHPs, healthy consumers who were previously uninsured because of high premium rates, may now choose to purchase coverage, thus lowering the average risk level in the employer pool.⁵⁶ Others suggest that even some very unhealthy individuals⁵⁷ may achieve modest savings in premiums and out-of-pocket expenses through a high-deductible plan.⁵⁸ However, whether HDHPs can generate out-of-pocket savings for some high-cost individuals is speculative, requiring that increases in out-of-pocket spending levels are more than offset by decreases in premium payments. Although Buntin et al. assert that an accompanying savings account, such as an HSA, would allow these high-cost individuals to save more by paying these medical expenses via pre-tax income, HDHPs with or without HSAs are most attractive to healthy individuals.⁵⁹

While coverage rates may increase for some healthy individuals who choose HDHPs, these individuals will be induced to purchase insurance only if the plan offers a low premium. Members of such a plan would include those with low expected health expenditures, implying that continued and increased segmentation of risk would be required to keep premiums down so as to attract these price-sensitive, healthy individuals. The result would be a greater segmentation of the ESI market by health status (e.g., attracting healthy individuals to one plan and leaving less healthy individuals in a separate, more comprehensive health plan).⁶⁰

If new high-deductible plans in the group market provide coverage only to previously uninsured individuals, the risk pool of the comprehensive plan would experience little impact. However, lower-cost individuals previously purchasing comprehensive low-deductible plans would have a financial

incentive to shift to HDHPs. Premiums in the comprehensive plan would increase to cover the higher average expenses of the remaining, less healthy population. These premium increases would drive more healthy people to the high-deductible policies, further pushing up premiums for comprehensive low-deductible insurance.⁶¹

In addition to attracting healthier risks into employer-sponsored HSA-qualifying plans, the tax advantages of HSAs may also attract higher-income families. The tax subsidy is greatest for those in the highest marginal tax bracket and is of little value for those who do not owe income taxes. For example, a \$5,150 HSA contribution would generate a tax reduction of \$1,802 per year to a household in the top income tax bracket.⁶² This level of savings would be less than half as much for a moderate-income family, and the lowest income families, who pay no income taxes, may benefit only from avoiding payroll taxes.⁶³

Despite the concerns regarding the potential effects of risk selection on the health insurance market, little rigorous empirical evidence is available to describe selection into HDHPs and HSA-qualifying plans. A few studies describe individuals choosing high-deductible plans. One recent unpublished survey of approximately 2,000 enrollees in a large firm's ESI plan shows that individuals choosing the high-deductible CDHP plan had higher levels of education, fewer chronic illnesses, and better overall health than either low-deductible CDHP enrollees or PPO enrollees.⁶⁴ A study conducted by the General Accounting Office (GAO) of the Federal Employees Health Benefits Program (FEHBP) found that HDHP enrollees were younger and earned higher federal salaries than other FEHBP enrollees.⁶⁵

Empirical evidence concerning individuals with HSAs is particularly limited and data collection lacks transparency, which has led to uncertain conclusions. One recent review by Park and Greenstein evaluates the currently available evidence.⁶⁶ Only one survey of enrollment data, the August 2005 Blue Cross and Blue Shield (BCBS) Association Survey, collected information on health status of individuals participating in HSA-qualifying HDHPs.⁶⁷ Individuals in these plans reported having similar health statuses as group and non-group enrollees in all other plans. However, it has been observed that because these data pool group and non-group enrollees, the health status of the enrollees in the non-group market may cancel significant differences within the group market.⁶⁸ In the non-group market, less healthy individuals are unlikely to receive offers of health insurance. Income information and actual HSA enrollment was not available from the BCBS survey report, so conclusions cannot be drawn regarding the effects of income on selection into HSA-qualifying plans or HSAs in general.

A few surveys indicate that the majority of individuals purchasing HSAs in the non-group market have moderate to high incomes.⁶⁹ Information available about individuals purchasing HSAs through eHealthInsurance (a licensed agency providing health insurance to individuals and small businesses) shows that 58 percent of individuals purchasing HSAs in the non-group market report incomes exceeding \$50,000 and 22 percent report incomes exceeding \$100,000.⁷⁰ Data from individuals purchasing non-group coverage through Assurant Health are consistent with these findings, indicating that nearly three-quarters of those with HSAs had incomes exceeding \$50,000.⁷¹

Potential Effects on Uninsurance Rates

To date, few published studies estimate the coverage impacts of HSAs and HSA-qualifying health insurance policies. National data reflecting health insurance coverage and costs in 2004 – the first year that HSAs became available – are just now being released. However, a small number of studies using historical coverage and cost data provide clues as to the potential impact of HSAs on the rate of uninsurance and the distribution of coverage.

Glied and Remler examine how many currently uninsured people might be induced to buy HSA-qualifying health insurance plans in the group and non-group markets under the existing HSA legislation.⁷² The authors conclude that the introduction of HSAs is likely to increase the number of insured by between 0.3 percent and just under 2 percent of the number of currently uninsured adults. They show that HSAs are unlikely to be an important contributor to the expansion of health coverage among the uninsured. Glied and Remler base these conclusions on the fact that most uninsured individuals have low incomes and would not benefit substantially from HSAs tax benefits. Additionally, these individuals continue to face financial barriers to enrollment, even for HDHPs.

Feldman et al. simulate the take-up of HSA contracts in the group and non-group markets.⁷³ The authors use data collected primarily before the introduction of HSAs to predict take-up of HSAs under current legislation. They predict a take-up rate of 9 percent in the non-group market among the restricted population of adults with neither public insurance nor an offer of health insurance from an employer. The HSA take-up rate in the group market among those with an employer offer of coverage was estimated to

be only 1 percent. In their assessment of the effect of the Bush administration's proposal to offer a refundable income-related tax credit for the premium of an HSA-qualifying health insurance plan, the authors predict that the administration's tax credit proposal would double HSA take-up rates, reducing the number of uninsured individuals by 2.9 million.⁷⁴ This relatively large estimated impact may derive in part from a number of assumptions that underlie the simulations. First, the authors assume that all non-group market individuals applying for an HSA-qualifying HDHP would not be denied coverage, which contradicts evidence from numerous sources.⁷⁵ Second, the authors caution that group estimates should be viewed as an upper limit due to assumptions related to estimates of HDHP coverage in the group market.

In contrast to the Feldman et al. study, Gruber conducted simulations showing a significantly smaller impact of the Bush administration's tax credit proposals for the premiums related to HSA-qualified HDHPs on the number of uninsured.⁷⁶ Gruber estimates that income-related tax credits will result in a reduction of 1 million individuals covered by ESI, and an increase of 2.4 million individuals covered in the non-group market. These changes result in a net reduction of 1.4 million in the number of uninsured.

Gruber compares the income-related tax credit proposal to the Bush administration's 2006 proposal calling for tax deductibility of the premiums related to individually purchased HSA-qualified HDHPs along with a "payroll offset" tax credit equal to 15.3 percent of the premium.⁷⁷ Gruber finds that compared to the tax credit proposal, the non-group premium deductibility proposal significantly erodes the

number of individuals covered by ESI due to the introduction of a non-group option with an equal subsidy. Gruber projects that the number of small employers offering health insurance would decrease. Also, overall only half of individuals losing ESI would take up insurance elsewhere. As a result, the net effect of the non-group premium deductibility proposal is a projected increase of 1.5 million in the number of uninsured individuals. Gruber estimates that both the tax credit and non-group premium deductibility proposals together would reduce the number of uninsured by just 600,000.

Gruber's study shows that proposals more likely to maximize total coverage are structured so that those least likely to purchase coverage (i.e., the low-income) would receive the greatest tax benefit, while those likely to purchase coverage even in the absence of a subsidy (i.e., the high-income) would receive little or no subsidy. The tax advantages associated with current HSAs, as well as new tax subsidy proposals such as those for premium deductibility, work in precisely the opposite direction.

Effects on the Non-Group Health Insurance Market

Individually purchased health insurance in the non-group market has become a focus of attention among those researching the effects of HSAs, since the uninsured are primarily low-income individuals without access to ESI. In fact, approximately 80 percent of uninsured workers do not have access to an offer of ESI, either through their own employer or through the employer of a family member.⁷⁸ The non-group market covers a small share of the population, approximately 5 percent nationally in 2000-2001; however, some studies suggest that HSAs could expand this market considerably.⁷⁹

The effect of HSAs on the non-group market

is likely to be driven by how individuals view the tax advantages of HSAs. Since HSA contributions are tax exempt, the tax advantages accrue to individuals choosing non-group HSA-qualifying plans. However, the tax advantages are reduced relative to those with employer-sponsored HSA-qualifying plans, since the latter benefit from exemptions of both payroll taxes and income taxes on any premium contribution from employers.

Both Feldman et al. and Gruber predict substantial increases in the non-group market as a result of increased take-up of new HSA-qualifying plans and the proposals for increased tax incentives.^{80,81} Gruber estimates that the tax credit proposal would produce a net increase of 3.8 million individuals covered in the non-group market (2.4 million previously uninsured; 900,000 previously insured through the group market; and 500,000 previously insured by Medicaid) and that the non-group deductibility proposal would produce a net increase of 6 million individuals covered in the non-group market (2.4 million previously uninsured; 3.3 million previously insured through the group market; and 300,000 previously insured by Medicaid).

Glied and Remler suggest that HSA-qualifying plans in the non-group market would likely be attractive to unhealthy individuals who usually reach or exceed out-of-pocket maximums.⁸² Glied and Remler contend that increased take-up of non-group insurance among those in poor health would result in premium increases, particularly since non-group risk pools are quite small and cannot spread risk efficiently. Also, because those in better health would move to lower deductible plans. However, this phenomenon is likely to be limited by two features of the non-group market. First, higher premiums can be charged for a given plan to unhealthy individuals. Therefore, these non-group carriers can segment unhealthy enrollees without moving

them into different plans. Second, tight medical underwriting practices are nearly ubiquitous in the non-group market, except in a small number of states that prohibit these practices. Research has shown that underwriting practices limit the availability of non-group coverage offers for those with chronic conditions, even those affected by mild conditions, such as hay fever.⁸³ Since few states have guaranteed issue laws that would allow those in poor health to have open access to the non-group market, it is likely that HSA-qualifying plans in the non-group market will be limited to healthy individuals, particularly those in high-income families who can take advantage of the tax preferential treatment of HSAs.⁸⁴

Effects on the Group Market

HSAs and HSA-qualifying HDHPs may have a more fundamental impact on the group market. Because the introduction of tax advantages for an HSA-qualifying plan purchased in either the group or non-group market could create a major discontinuity in the set of choices available to those in the group market, many researchers have predicted significant impacts on the distribution of coverage and benefit structures of ESI.

Some individuals, who were uninsured despite having an offer of group coverage, may be induced to take up the newly offered employer-sponsored HSA-qualifying plan due to the tax advantages and lower premiums. However, many analysts suggest that the impacts of these plans will be to affect the choices of those previously covered by ESI. These analysts forecast a slow erosion of ESI coverage, including a shift from low-deductible policies toward high-deductible policies.⁸⁵ Gruber estimates that further reductions in the tax advantages of ESI, particularly if implemented through non-group premium deductibility of HSA-

qualified HDHP premiums, would cause group coverage to drop significantly, particularly for employees of small firms.⁸⁶

Among large employers who offer multiple plans, the concentration of high-risk individuals in one plan and low-risk individuals in another plan could escalate premiums in the high-risk plan. Some analysts predict this will bring about significant changes in the benefits that are offered and that the introduction of HSA-qualifying plans as a choice for employees may precipitate “the disappearance of generous plans, even if these plans had been operating efficiently.”⁸⁷

In contrast, the introduction of HSA-qualifying plans may produce pronounced coverage changes among individuals in small firms, especially for those in poor health. Healthy workers may reject coverage offers made by small firms, and instead shift their coverage to an HSA-qualifying plan in the non-group market despite the fact that non-group policies include higher administrative charges and do not include any premium subsidy from the employer. Group premiums for those individuals left behind – some of whom cannot obtain offers in the non-group market due to their health problems – may then increase unsustainably, leading to decreases in both offer and take-up rates in smaller firms.⁸⁸ If tax deductions are extended to premiums purchased in the non-group market, healthy workers with relatively high marginal tax rates would have even greater incentives to shift coverage to the non-group market – accelerating risk segmentation and leading to a spiral of premium escalation within the small-group market.⁸⁹ Eventually, employers are likely to scale down or drop the low-deductible option altogether, leaving some unhealthy individuals underinsured or uninsured, bearing a greater burden for their own health expenses and vulnerable to potentially large financial risk.⁹⁰

Conclusion

HSAs combined with HDHPs continue an ongoing trend away from traditional insurance, which has historically emphasized spreading health care spending burdens across the population. While it is too early to gauge the impact of HSAs and HDHPs, we do know that while HSAs constitute a small part of the health insurance market, they constitute a fast-growing segment and that the number of employers offering HSA plans is expected to continue to grow over the next several years. Should the President's proposals pass, it is likely that HSA policies will grow at an even faster rate.

Given recent experience, definitive answers to a number of key questions regarding the impact of HSAs is lacking. However, the best available evidence suggests the following about the likely impacts of HSA plans combined with HDHPs:

- HSA-qualifying HDHPs offer more incentives to avoid spending above the deductible compared to traditional insurance plans. Because such a large share of health care spending is concentrated above the deductible, these plans will have only a small effect on aggregate health care spending.
- As currently configured, these plans include out-of-pocket maximums and do not expose consumers to higher cost-sharing levels above the deductible compared to traditional health insurance coverage.
- To the extent that they lead to greater reliance on the non-group market, administrative costs will likely rise.
- With their lower premiums and higher deductibles, HSA-qualifying HDHPs are likely to lead to greater risk segmentation and benefit those who are

healthy, shifting health care spending burdens onto those who are sick.

- To the extent that greater risk segmentation occurs, it could make it even more difficult for individuals with high health care needs to obtain coverage since they are likely to face higher premiums and fewer ESI offers, particularly of more comprehensive policies.
- It is unlikely that the presence of HSA-qualifying HDHPs will reduce uninsurance rates to any significant degree. Moreover, it is possible that they will disrupt ESI coverage sufficiently to raise uninsurance rates. Because the uninsured are concentrated in low-income households who cannot meet the cost-sharing requirements in these plans and do not benefit from the tax advantages because they are in low tax brackets, HSA-qualifying plans are unlikely to attract many who would otherwise be uninsured.
- The proliferation of HSAs would likely reduce federal tax revenues while providing investment benefits to higher-income families. The tax treatment of HSAs, which is more generous than that of other investment options such as IRAs, presents an extremely attractive and lucrative investment vehicle, particularly for wealthy individuals in higher tax brackets. The individuals who stand to gain the most from the tax treatment of HSAs currently have very high rates of health insurance coverage.

Some have argued that achieving real cost-savings will hinge on building in more managed-care case management techniques for those with chronic illnesses and for others with very high health care needs.⁹¹ Moreover, should only a minority of these plans cover preventive services, as available data suggest, it

is likely that consumers in these plans will forgo such services, which could lead to future increases in health care costs. Analysts are also skeptical that HSAs will slow rates of spending growth over time.

In addition, concerns have arisen about whether these plans may engender more bad debt and increased rates of bankruptcy due to the higher out-of-pocket spending burdens, particularly among low-income families with sick individuals. There is also concern that providers may experience more problems collecting payments directly from consumers than they would have encountered when billing plans, which in turn would generate greater uncompensated care burdens for providers.⁹² Indeed, this issue has risen to the level where audio conferences are being offered to providers on effective collection practices.⁹³

While this paper has focused on how HSAs and HDHPs might function in the private health insurance market, some states are contemplating using them in their Medicaid

programs in an effort to curb soaring costs. Proponents of such plans believe that competition among health plans will slow the growth of spending and provide better care for Medicaid recipients.⁹⁴ Critics contend that higher administrative costs and imprecise adjustment for individual health care risks associated with such approaches will drive low-income individuals into plans with significantly higher out-of-pocket costs than they face in today's Medicaid program. In turn, the costs would impose significant financial barriers on access to needed medical care for those with low incomes.⁹⁵

In closing, it is unlikely that HSAs and HDHPs will solve the nation's twin health care problems of rising health care costs and high uninsurance levels, and it is likely that they will introduce new problems by increasing the level of risk segmentation in the health insurance market. Ultimately, other policy changes are called for in order to achieve the nation's cost-containment and insurance coverage objectives.

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