

**Health Savings Accounts and High Deductible
Health Insurance Plans:
Implications for those with High Medical Costs,
the Low-Income, and the Uninsured**

Statement of

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Mr. Chairman, Mr. Camp, and distinguished Members of the Subcommittee: Thank you for inviting me to share my views on Health Savings Accounts (HSAs) and their implications for cost containment and the distribution of health care financing burdens. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

In brief, my main points are the following:

- The related issues of a large and growing number of uninsured Americans and the escalating cost of medical care create problems of limited access to necessary medical care for millions of Americans, financial hardship for many households, and severe budgetary pressures on the public health care safety net as well as on federal and state government. However, HSAs are not the solutions to these pressing national concerns.
- HSAs provide additional subsidies to the people most likely to purchase health insurance even in the absence of no subsidy at all—those with high incomes. As income and marginal tax rates increase, the value of the tax exemption associated with contributions to HSAs and the interest, dividends, and capital gains earned on HSA balances grows as well. Because most of the uninsured have low incomes and get little or no value from tax exemptions, the subsidies are very poorly targeted for expanding coverage.
- Because of the highly skewed nature of health care spending—the highest-spending 10 percent of the population accounts for 70 percent of total health expenditures—cost containment strategies that do not deal substantially with the high users of health care services will not have a significant effect on overall spending. The cost saving potential of HSAs is on spending before the deductible is reached, and most of health care spending occurs by high users of services, after the deductibles are reached. This significantly limits the ability of HSAs to lower systemwide health care spending.
- To the extent that high-deductible plans raise costs for higher-cost users, their use of medical services may fall. But there are no provisions to help these patients choose the services most important to their health, so reductions in care could lead to expensive, catastrophic health consequences in the long run. Moreover, patients' ability to compare health care providers on the basis of cost and quality is extremely limited. As a consequence, high-deductible plans and HSAs have a limited ability to make patients better value shoppers.
- Because high-deductible plans with or without HSAs place greater financial burdens on frequent users of medical care than do comprehensive policies (policies with lower out-of-pocket maximums and possibly broader sets of covered benefits), they tend to attract healthier enrollees. This selection can raise costs for the less healthy. The higher-cost insured population remaining in comprehensive coverage will tend to see their premiums rise as the healthy peel off into high-deductible/HSA plans. Unless the costs of these high users of care are spread more broadly by manipulating premiums across plan types or through regulation or subsidization, this dynamic will make coverage less

affordable for those with the greatest medical needs.

- Despite lower premiums compared with comprehensive plans, high-deductible/HSA plans have so far failed to attract many low-income uninsured individuals and families. In addition to the fact that they get little tax benefit, they often do not have assets to cover the high deductibles—and have decided that they are better off remaining uninsured. The “one size fits all” high-deductible policy under the HSA legislation is flawed since, for example, a \$2,200 deductible could be financially ruinous for a low-income family, while the same deductible could have virtually no cost-containment impact for a high-income family.
- Roughly half of those with HSA-compatible, high-deductible policies do not open HSAs (GAO 2008), despite the tax advantages of doing so. Two-thirds of employers offering single coverage through high-deductible/HSA combinations report making no contribution to the HSAs of their workers (Kaiser Family Foundation/Health Research and Education Trust 2007). As a consequence, low-income or high health-care-need workers with no choice of coverage but a high-deductible/HSA plan are likely to be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy, since employers are not, by and large, offsetting these higher deductibles with cash contributions to HSAs. Presented with the option of making varying contributions to HSAs as a function of worker income or health status, employers are highly unlikely to do so.
- At present, the legal use of HSAs is far more tax favored than is any other health or retirement account. Contributions, earnings, and withdrawals for HSAs can be tax free, if spending is health related. However, there is no mechanism in place, other than being subjected to a general tax audit, to verify that spending out of HSA balances is actually being done for medical purposes. Medical Flexible Spending Accounts (FSAs), a much more widely used tax-advantaged account for paying out-of-pocket medical costs, do have verification mechanisms in place that add very little to the costs of the plans. H.R. 5917 would prevent the illegal use of HSAs as a general tool of tax evasion.

Background

Between 2000 and 2006, employer-based health insurance premiums grew by 86 percent, compared with 20 percent for worker earnings and 18 percent for overall inflation (Kaiser Family Foundation and Health Research and Educational Trust 2006). By 2006, the number of uninsured had increased to 18 percent of the total nonelderly population in the United States, and a third of the nonelderly population with incomes below 200 percent of the federal poverty level were uninsured (Holahan and Cook 2007). Health Savings Accounts have been one approach some policymakers have embraced to addressing these dual and growing problems.

While high-deductible plans have been available in the nongroup market for many years, the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) included provisions to provide a generous tax incentive for certain individuals to seek out high-deductible health insurance policies with particular characteristics. In 2008, the minimum annual deductibles for these policies are \$1,100 for single and \$2,200 for family policies.

Annual out-of-pocket maximums for these plans are capped at \$5,600 for single policies and \$11,200 for family policies, with the limits applying only to the types of services included in the coverage of the plan.

Individuals (and families) buying these policies either through their employers or independently in the private nongroup insurance market can make tax-deductible contributions into an HSA. Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax free, and are not taxed as long as they are used to cover medical costs. Contributions can be made by employers, individuals, or both. In 2006, Congress removed the requirement that annual deposits into HSAs be capped at the level of the plan's deductible, and instead provided a fixed statutory limit for annual contributions. In 2008, these limits are \$2,900 for single policies and \$5,800 for family policies.

HSAs were intended to encourage more cost-conscious spending by placing more of the health care financing burden on the users of services, as opposed to having them incorporated in the shared financing inherent in insurance coverage.

What Makes HSAs Attractive?

As a consequence of the structure of the tax subsidy and the shift of health care spending to out-of-pocket costs, these accounts are most attractive to high-income people and those with low expected health care expenses. The tax subsidy provided for HSA participants is greatest for those in the highest marginal tax bracket and is of little or no value to those who do not owe income tax. Clemans-Cope (forthcoming) demonstrated that 70 percent of the nonelderly uninsured have family incomes below 200 percent of the federal poverty level, and that only 16 percent of uninsured adults fall into the 20 percent or greater marginal tax bracket. A \$5,800 HSA contribution, the maximum permitted under the law, would generate a tax reduction of \$2,030 to a household in the top income tax bracket. The value of the tax benefit would be less than half as much for a moderate-income family. And it would be worth much less if the family could not afford to contribute very much into the account. For those whose incomes are so low that they have no income tax liability, the subsidy is worth nothing. However, HSA contributions made by an employer, as opposed to by an individual, will decrease even a low-income worker's payroll tax liability, resulting in a modest tax savings.

Higher-income individuals are also better able to cover the costs of a high deductible, should significant medical expenses be incurred. Jacobs and Claxton (2008) showed that uninsured households have substantially lower assets than do the insured. As a consequence, high-deductible policies are unlikely to provide the uninsured with sufficient financial access to medical care in the event of illness or injury.

Additionally, those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free that they can use for a broad array of health-related expenses that are not reimbursable by insurance (e.g., non-prescription medications, eyeglasses, cosmetic surgery). Those without substantial health care needs may also be attracted to HSAs because they can be effectively used as an additional IRA, with no penalty applied if the funds are spent for non-health-related purposes after age 65. Young, healthy individuals may even choose to use employer contributions to their HSAs for current

non-health-related expenses, after paying a 10 percent penalty and income taxes on the funds—a perk unavailable to those enrolled in traditional comprehensive insurance plans.

These expectations have been borne out in the enrollment experience of HSAs (United States General Accountability Office [US GAO] 2008). The GAO analysis found that the average adjusted gross income of HSA participants was about \$139,000 in 2005, compared with \$57,000 for all other tax filers. They also found that average contributions to HSAs were more than double the average withdrawals, suggesting that either HSA participants were not high users of medical services or they used these accounts purely as investment vehicles—or both.

The incentive structure and the findings strongly indicate that HSAs and their associated tax subsidies are health care spending vehicles that are poorly targeted to the population most in need—the low-income and those with above average medical needs.

The Cost Containment Implications of the Health Care Spending Distribution

The distribution of health care spending is highly skewed, meaning a small percentage of the population accounts for a large share of total health care spending. The top 10 percent of health care spenders spend 70 percent of health care dollars, while the bottom 50 percent of spenders account for only 3 percent of those dollars (Berk and Monheit 2001). As a consequence, significantly decreasing health care spending will require substantially lowering the spending associated with high users of medical services, ideally, while not decreasing quality of care. However, the high-deductible/HSA plan approach is not well designed for lowering the spending of the high-cost population in a manner that does not negatively affect their health.

Cost savings can be manifest through two mechanisms: a decline in the amount of services per episode of care due to an increase in marginal price, or through a decline in the number of episodes of care due to an increase in the average price. For those who are generally healthy and would not have annual spending that exceeded the high deductibles associated with HSA compatible plans, the increased marginal price of out-of-pocket medical care could have some impact on their use (Newhouse 1993, 2004). Incentives to curtail unnecessary services are strongest for these individuals. However, our analysis of the Medical Expenditure Panel Survey – Household Component showed that only 3 percent of total health care spending is attributable to those who spend below the minimum required deductibles. Consequently, there is little room for systemwide cost savings among this population since their spending accounts for so little of the overall expenditures.

For those who are unhealthy and who, with comprehensive insurance coverage, would spend above these higher deductibles, a number of scenarios are possible. Those who do not face significantly higher out-of-pocket maximums relative to their previous plan would not have any additional cost containment incentives. Those who face significantly higher out-of-pocket maximums under the new high-deductible/HSA plans would face a higher average price of medical care, and could reduce their spending as a consequence. However, research has demonstrated that the reductions in their spending would occur as a consequence of their reducing the number of episodes of their care, as opposed to reducing the cost of an episode once initiated (Newhouse 1993, 2004). In other words, they would decide not to initiate a contact with a medical professional for financial reasons, with potentially serious consequences

for their health and for the long-term costs of their care. Two studies (Fronstin and Collins 2005; Davis et al. 2005) have found that HSA participants were more likely to report missed or delayed health services and not filling prescriptions due to cost. These problems were greater for those with lower incomes or worse health.

Paradoxically, high-cost individuals are not likely to curtail unnecessary services before reaching the high deductible, as might be desired. That is because the lion's share (80 percent) of health care spending for high-cost users of care is attributable to their spending that is incurred once those higher deductible levels are surpassed (Clemans-Cope forthcoming). Since most of the current system's spending results from high-cost users spending above the HSA-compatible deductible levels, the cost-saving incentives can only affect a small segment of total health care dollars. That is unless the increased cost sharing is so much higher as to strongly dissuade the unhealthy from seeking much of the services that they would use under other circumstances. The health consequences of the latter could be extraordinarily grave, and the long-term cost consequences of allowing conditions to worsen substantially before care is sought may offset the cost saving from decreasing their early care.

While a number of studies have found that modest one-time savings of between 4 to 15 percent might be anticipated from conversion to high-deductible/HSA plans, they do not imply that such a change would have a significant impact on the rate of growth of medical spending. This is because medical spending growth is driven largely by the increased use of, and intensity of, technologies and services for people with high health care needs (Newhouse 2004). So while increased cost sharing can be used to lower the frequency of health care provider visits, it does not lower the costs per episode once an episode of care occurs.

Other, more promising avenues exist for achieving significant cost savings in our health care system. These include, among others,

- coordinated approaches to evaluation of cost-effectiveness and efficacy of new and existing technologies/procedures/medications combined with new regulatory and pricing strategies to target resources to the most cost-effective options;
- increasing the use of preventive care and chronic-care or high-cost case management strategies;
- payment reform and development of purchasing strategies that promote the consistent delivery of care in the most efficient and appropriate setting;
- administrative cost-saving strategies, including development of effective information technology infrastructure.

While many of these avenues require significant upfront investment in infrastructure, research, analysis, or experimentation, they are substantially more likely to yield systemwide savings without compromising access to and quality of care for the high-need population.

Implications of HSAs for the High Medical Need Population

The most significant premium savings accruing to high-deductible/HSA plan enrollees likely occurs by altering the mix of individuals who purchase coverage of different types. By providing incentives for healthy individuals and groups to purchase HSA-compatible plans, insurance risk pools can be further segmented by health status. The average medical costs of those purchasing the HSA plans will be substantially lower if the high-risk population is left in

more traditional comprehensive plans. As the average cost of those in the comprehensive plans increases, so does the premium associated with the coverage. In the extreme risk segmentation circumstance, premiums for comprehensive coverage may increase so much that maintaining that type of coverage is no longer financially viable.

Such a circumstance can be avoided in the employment context if both high-deductible and comprehensive options are offered and employers set premiums for each plan independent of the health care risk of those enrolling in each. In other words, premiums for the high-deductible/HSA plan could be set such that they are lower than the comprehensive plan, but only due to the difference in actuarial value across the plans, not due to the differential health care risk of those enrolling in each plan. In essence, each plan's premium would be set as if all employees were enrolled in each plan. Then, a portion of premium collections for the high-deductible/HSA plan could be transferred to the comprehensive plan to subsidize premiums for that higher-cost group. In the nongroup market context, however, the transfer of financial support from the healthy to the less healthy will only occur through regulation or through direct government subsidization.

Without some type of intervention, by government or employers to spread health care risk more broadly, the practical effect of high-deductible/HSA plans is that the most vulnerable populations (the sick and low-income) are left bearing a greater burden of their health expenses. The extent to which this is a preferred societal outcome should be explicitly debated, as it is the primary impact of a move toward high-deductible/HSA plans.

The Ability of Patients to Be Good Value Shoppers

Theoretically, placing a greater share of the health care financing burden on the individual users of health care should create incentives for greater price/quality comparisons and more cost effective medical decisions. However, the ability of the patients to engage in such comparison shopping is extremely limited in the current private insurance context. As Ginsburg (2007) describes, effective comparison of services on price occur only in the context of non-emergency care, services that are not complex, bundled prices for services, consistent quality across providers, and only after an appropriate diagnosis has been made. Situations that meet such criteria eliminate a great deal of the medical care within the system. In addition, confidentiality agreements between providers and insurers prevent the providers from being able to give patients actual prices, as opposed to ranges that are generally not useful for comparison purposes. Traditionally, patients have relied upon their insurers to guide their provider decisions by choosing an efficient provider network on their behalf.

Enforcement of HSA Legal Requirements

As noted earlier, spending by those under 65 years of age out of HSA accounts is tax advantaged only if that spending is for medical purposes. If HSA funds are used for nonmedical purposes, a nonelderly individual would be required to pay taxes on the withdrawal in addition to a 10 percent penalty. However, currently, there is no administrative mechanism in place to verify that spending from HSAs is in fact being used for medical purposes. Unless an individual HSA participant is subjected to an IRS audit, there are no checks on the type of spending being done. Given that any individual's likelihood of an audit is very low, this lack of verification creates an easy mechanism for evading taxes. This problem is amplified by the

increase in allowable annual contributions to HSAs and the fact that such contributions can now exceed the associated insurance plan's annual deductible.

Flexible spending accounts (FSAs) are employment-related accounts that allow users to deposit pretax dollars into accounts that can then be drawn down during the year to pay for medical expenses. The permissible medical expenses are defined broadly, including out-of-pocket costs for care that is or is not part of the account-holder's insurance policy, just like HSAs. There are a number of differences between FSAs and HSAs (e.g., unused FSA balances are forfeited at the end of the year, they do not earn income, and they do not require health insurance plan participation), but the only relevant difference for this discussion is that withdrawals from FSAs are verified by the account administrators to be medical-related expenses that comply with the FSA law. This is precisely the type of verification that should be required of HSA withdrawals, and would be under H.R. 5917.

The insurance industry complains that imposing such verification on HSAs would eliminate their cost saving potential by imposing new and onerous administrative costs. However, the administrative costs of FSAs, which would be directly comparable with that of HSAs for this purpose, are actually very low. In fact, overall FSA administrative costs, which include payment of claims (a function which HSAs already perform and is included in their current administrative costs) as well as verification of the appropriateness of claims, are about \$5.25 per member per month (\$63 per member per year).¹ However, much of the administrative tasks associated with FSAs are not applicable to HSAs, and the cost of adding adjudication of claims to the HSAs would be about \$2 per member per month according to the third party administrator of such plans that we contacted. If an additional cost of \$24 per member would substantially reduce or eliminate the cost savings associated with HSAs, as some contend, then that is clear evidence that there is currently little to no cost savings associated with participating in those plans today.

Such an increment to administrative costs associated with these plans is clearly a very small price to pay to ensure that the law is being complied with and individuals are not using HSAs merely as a personal tax dodge.

Conclusion

HSAs are a highly tax-advantaged savings vehicle that is most attractive to people with high incomes and those with low expected use of health care services. As such, they are unlikely to significantly decrease the number of uninsured, who often have low incomes and neither benefit significantly from the tax advantages nor have the assets necessary to cover the large deductibles associated with the plans. Their ability to reduce systemwide spending is also very limited. The plans have the potential to increase segmentation of health care risk in private insurance markets, unless employers set premiums to offset the healthier selection into the plans or government subsidizes the higher costs associated with the remaining comprehensive coverage market.

¹ From personal communication with third party administrators providing administrative services for FSAs and consumer-directed health plans.

To date, HSAs have been less popular than their advocates envisioned, making up only about 2 percent of the health insurance market (US GAO 2008). Thus, their negative ramifications on populations with high medical needs have probably been limited. However, efforts to expand enrollment in these plans through further tax incentives, for example, could place growing financial burdens on those least able to absorb them, leading to increasing effective barriers to medical care for the low income and the sick and potentially increasing the net number of uninsured.

References

Berk, Marc and Alan Monheit. 2001. "The Concentration of Health Expenditures Revisited," *Health Affairs*, 20:204-213.

Clemans-Cope, Lisa. Forthcoming. "Short- and Long-term Effects of Health Savings Accounts." Working paper prepared for The Urban Institute – Brookings Institution Tax Policy Center.

Davis, K., Doty, M. M. and Ho, A. 2005. "How High Is Too High? Implications of High-Deductible Health Plans." The Commonwealth Fund, April.

Fronstin, Paul and S. R. Collins. 2005. "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute and the Commonwealth Fund, December.

Ginsburg, Paul B. 2007. "Shopping For Price In Medical Care." *Health Affairs*, March/April; 26(2): w208-w216.

Holahan, John and Allison Cook. 2007. "Health Insurance Coverage in America: 2006 Data Update." Henry J. Kaiser Family Foundation.
http://www.kff.org/uninsured/upload/2006_DATA%20UPDATE.pdf, accessed May 12, 2008

Jacobs, Paul D. and Gary Claxton. 2008. "Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans." *Health Affairs*. web exclusive, April 15 2008, pp. w214-w221.

Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Survey of Employer-Sponsored Health Benefits, 2006. See <http://www.kff.org/insurance/ehbs-archives.cfm>.

Henry J. Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Survey of Employer-Sponsored Health Benefits, 2007. See <http://www.kff.org/insurance/ehbs-archives.cfm>.

Newhouse, J. P., 2004. "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs* Volume 23(6): 107-113.

Newhouse, J. P. and the Insurance Experiment Group. 1993. *Free for All? Lessons from the Rand Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

United States Government Accountability Office (US GAO). 2008. Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes. April 1. GAO-08-474R.