

## MARKET WATCH

**Comparing The Assets Of Uninsured Households To Cost Sharing Under High-Deductible Health Plans**

Households with few assets cannot handle the cost-sharing requirements of many high-deductible health plan options.

by Paul D. Jacobs and Gary Claxton

**ABSTRACT:** Financial assets are relevant when one is assessing whether high-deductible plans, which require greater up-front cost sharing, are worthwhile for the uninsured. We show that uninsured households have less financial assets compared to the insured; at lower income levels, their net financial assets may even be negative. Although lower premiums may increase the ability of the uninsured to buy some coverage, high out-of-pocket liability may leave families exposed to costs that they cannot meet. Paying premiums for a policy that exposes the uninsured to unaffordable medical bills may be viewed as an uneconomical use of their limited assets. [*Health Affairs* 27, no. 3 (2008): w214–w221 (published online 15 April 2008; 10.1377/hlthaff.27.3.w214)]

ONE IN EVERY SIX Americans under age sixty-five—46.5 million people—did not have health insurance at some point in 2006. About 80 percent of them were in families earning less than three times the federal poverty level.<sup>1</sup> Some have suggested that health insurance policies with relatively high out-of-pocket costs for care, a popular example being high-deductible health plans (HDHPs), may provide an affordable coverage option for some of this population.<sup>2</sup> Others have proposed subsidizing the premiums for low-income people who cannot afford even the relatively low premiums associated with such policies. For example, President George W. Bush proposed in his fiscal year 2007 budget that refundable tax credits be made available to low-income families who purchase HDHPs that meet the statutory requirements

permitting a person to open a health savings account (HSA).<sup>3</sup> During the Republican presidential primaries, candidate Mitt Romney announced his support for HDHPs and advocated tax breaks for premiums to encourage wider adoption.<sup>4</sup>

Although the premiums for HDHPs are more affordable than those for more comprehensive policies, HDHPs also expose enrollees to thousands of dollars in annual financial risk. This raises the question of whether lower-income families can afford to pay the relatively high cost sharing required by these policies if a serious illness arises. Understandably, people without sufficient resources to absorb the potential cost sharing under HDHPs might not view them as providing meaningful financial protection or access to higher-cost medical services. Consideration of the appropriateness

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of HDHPs for lower-income uninsured families should include some assessment of their ability to use the policies effectively if poor health arises.

One factor relevant to this question is whether the uninsured can fund the cost sharing under HDHPs with their accumulated assets. The out-of-pocket expenses under HDHPs can be thousands of dollars; for example, as discussed below, the average maximum out-of-pocket amount under HSA-qualified nongroup insurance policies in 2004 was almost \$4,800, and federal law permits out-of-pocket limits of more than double that amount.<sup>5</sup> It is reasonable to assume that many families, particularly those with lower incomes, would find it difficult to fund these amounts out of their current income and would likely need to look to savings or other assets to pay these large costs.

Others have looked at the relationship of family assets and the demand for health insurance.<sup>6</sup> This paper focuses more narrowly on the assets of the uninsured compared with those of the insured and how they relate to HDHP cost sharing. Specifically, we consider how many uninsured households had sufficient financial assets in 2004 to cover the deductible and other out-of-pocket expenses associated with HSA-qualified HDHPs.

### Study Data And Methods

For this study, we used the 2004 Survey of Consumer Finances (SCF)—a triennial, nationally representative household survey conducted by the Federal Reserve Board. Because the 2004 SCF is the most recent available, we used this as the basis of our findings, and we compared assets to the legally defined HSA cost-sharing limits for 2004.<sup>7</sup>

We present the distributions of financial assets for insured and uninsured households at 300 percent of poverty (in 2004, this was \$29,481 for a single nonelderly adult and \$57,471 for a family with two adults and two

children). We used this as a cut-off because of its use in other policy initiatives to cover the uninsured, including in Massachusetts (300 percent of poverty) and as proposed in California (300 percent of poverty for children and 250 percent for parents and caretakers).<sup>8</sup> Those below this threshold are more likely than those above it to lack sufficient disposable income to accumulate financial assets, and thus to afford higher deductibles and perhaps to find insurance itself worthwhile.

We limited our sample to those households headed by a person ages 18–64, resulting in a final data set of 18,194 observations. Households with two or more members were designated as uninsured if a minimum of two people in the household were not insured. Households with one member were designated as uninsured if that person was uninsured. Results comparing assets to HSA-qualified

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HDHP cost-sharing levels are shown separately for households with one uninsured member and for households with two or more uninsured members, regardless of household size. Dividing the data this way permits a more accurate comparison between the assets of uninsured households and the relevant (that is, single versus family) HSA-qualified HDHP limits.

■ **Categorizing assets.** Households can hold different types of assets, which vary in their degree of liquidity (the ease with which they can be converted to cash). Because medical expenses require relatively immediate payment, the calculations below focus on financial assets instead of more illiquid assets such as cars and houses. We constructed three definitions of *financial assets*: liquid, gross, and net. These definitions provide a picture of total available assets (liquid and gross financial assets) and also give some idea of overall household financial wealth (net financial assets). Our definitions are analogous to those that others have used in research on wealth.<sup>9</sup>

We defined *liquid assets* as the sum of funds available in checking and saving accounts, money market accounts, certificates of deposit, and savings bonds. *Gross financial assets* included all liquid assets as well as the value of equity in stocks, corporate/municipal bonds, and mutual funds. *Net financial assets* are defined as gross assets minus the amount of unsecured debt, which is defined as any debt not backed by collateral (such as credit card debt, educational loans, and installment plans for consumer products or automobiles).

To account for the possibility that families may have debt that is paid for via reasonable installment plans, we also discuss how our results were affected by constructing a net financial asset measure that excluded installment debt.<sup>10</sup> This alternative measure of net financial assets included our broad measure of gross financial assets less credit card debt (instead of also subtracting installment payments to produce a net financial asset figure).

■ **HSA cost-sharing requirements.** There is no standard definition of an *HDHP*, and health insurers generally have wide discretion in determining cost sharing under the policies they offer. We focused on a popular variant of *HDHPs*—ones that meet the legal qualifications for an enrollee to establish an *HSA*. An *HSA* is a tax-preferred financial product that holds deposited funds for the payment of out-of-pocket medical costs incurred by those covered through *HDHPs*.

*HSAs* were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act (*MMA*) of 2003, which permits a person to establish an *HSA* if he or she is covered by a “qualified health plan.” Such a plan has a deductible (as of 2007) of at least \$1,100 for single coverage and \$2,200 for family coverage, and meets other requirements.<sup>11</sup> *HSA*-qualified *HDHPs* can have other cost sharing, such as coinsurance, after the deductible is reached, but as of 2007, they must limit cost sharing for covered, in-network services to \$5,500 for single coverage and \$11,000 for family coverage. People who establish *HSAs* may make or receive contributions to their *HSAs* of up to \$2,850 if they have single coverage or up

to \$5,650 for family coverage. *HSA* account holders can use these funds to pay for cost sharing under their *HDHP* or for other health care costs.

While the *MMA* established minimum deductible and maximum out-of-pocket amounts, policies sold in the marketplace tend to have higher deductibles and lower out-of-pocket maximum amounts than the law specifies. One survey of nongroup policies found that the average deductibles for *HSA*-qualified and medical savings account (*MSA*)-qualified plans in 2004 were \$2,364 for single coverage and \$4,653 for family coverage.<sup>12</sup>

We compared the asset holdings of uninsured households in the 2004 *SCF* to three different cost-sharing levels associated with *HSA*-qualified *HDHPs* in 2004. The first was the minimum deductible that would qualify an *HDHP* to be *HSA*-eligible: \$1,000 for single coverage and \$2,000 for family coverage. The second set of limits considered were the average *HSA* deductibles reported above (\$2,364 for single coverage and \$4,653 for family coverage).<sup>13</sup> The third limit we considered was the maximum out-of-pocket expense an individual (\$5,000) or family (\$10,000) could incur under an *HSA*-qualified *HDHP*. Out-of-pocket maximum limits are the largest amount that individuals or families would have had to pay toward covered benefits (in network). These nongroup market cut-offs are probably the best point of reference for considering the potential cost sharing for uninsured families under *HSA*-qualified *HDHPs*, because most of the uninsured in working families are not eligible for employer health benefits.<sup>14</sup>

## Study Results

■ **Assets by insurance status and income.** The results below indicate a sizable gap between the financial assets held by insured households versus those with uninsured members. The median level of gross financial assets for insured households was \$5,500 in 2004, whereas the median for uninsured households was about nine times lower: \$600. The typical insured household in the middle of the distribution had \$4,000 in liquid assets, which was

more than seven times the level of liquid assets for uninsured households (\$510). The impact of consumer debt on the net financial position of these households was noticeable. Median net financial assets were positive (\$30) only for insured households; most uninsured households had zero net financial worth (median of \$0).

Next we compared the uninsured below 300 percent of poverty to those above this threshold. Eighty percent of uninsured households in the SCF sample were below 300 percent of poverty.<sup>15</sup>

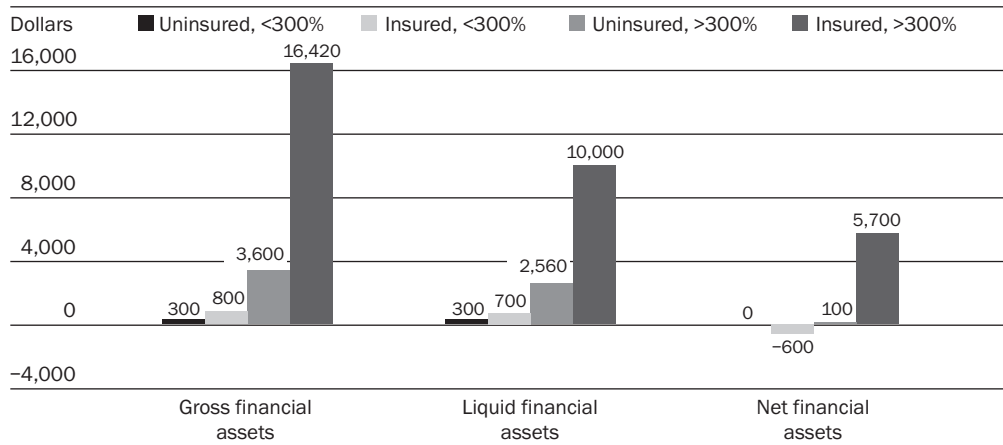
The results confirm that uninsured households below 300 percent of poverty had meager asset levels, especially when compared with the insured. Exhibit 1 shows the median value of assets held by households for the three financial asset categories. Even though the size of the assets of those above three times the poverty level far exceeds the size of the assets of those below this cut-off, differences were still apparent within these categories by insurance status.<sup>16</sup> Uninsured households below 300 percent of poverty had about half the median asset holdings for both gross and liquid assets than their insured counterparts. Net financial assets were low for both groups below 300 percent of poverty, although the median uninsured household had relatively more (\$0)

than those of the insured (-\$600) in 2004. Differences in asset holdings at higher incomes were also evident. The median insured household above 300 percent of poverty had gross assets that were more than four times the level of assets held by the corresponding uninsured household (\$16,420 versus \$3,600) and liquid assets that were almost four times those of the uninsured (\$10,000 versus \$2,560).

Exhibit 2 extends the discussion by looking more closely at the distribution of assets for uninsured households below 300 percent of poverty. Gross and liquid assets were roughly similar across the distribution, ranging from \$0 (gross and liquid) at the twenty-fifth percentile to \$2,000 (gross) and \$1,500 (liquid) at the seventy-fifth percentile. One-fourth of uninsured households below three times the poverty level had net financial assets less than or equal to -\$6,600, and half of all households in this category had net financial assets less than or equal to zero.

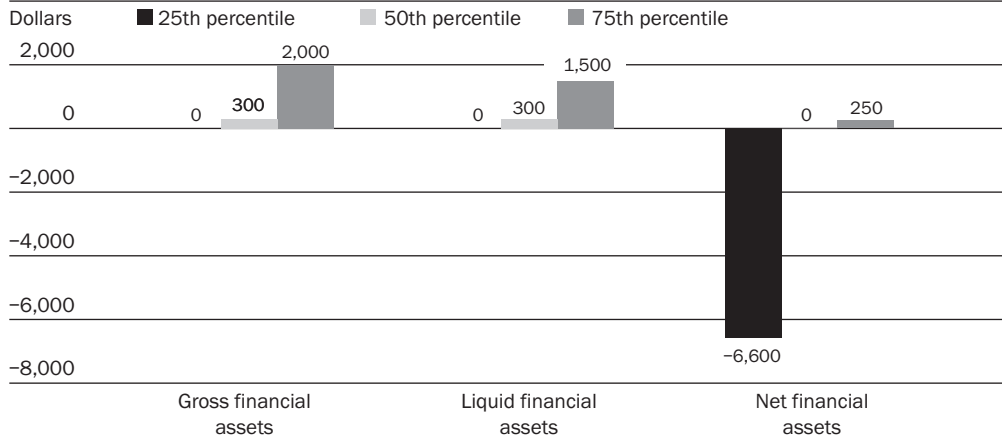
■ **Assets compared to HSA cost-sharing limits.** Exhibit 3 shows the percentage of households with one uninsured member and assets greater than each of the three HSA out-of-pocket requirements. Roughly half of these households had gross or liquid assets sufficient to cover the minimum HSA deductible

**EXHIBIT 1**  
**Median Household Financial Assets By Federal Poverty Level (Above And Below 300 Percent Of Poverty) And Insurance Status, 2004**



**SOURCE:** Authors' analysis of data from the 2004 Survey of Consumer Finances.

**EXHIBIT 2**  
**Distribution Of Household Financial Assets Of Uninsured Households Below 300 Percent Of The Federal Poverty Level, 2004**



**SOURCE:** Authors' analysis of data from the 2004 Survey of Consumer Finances.

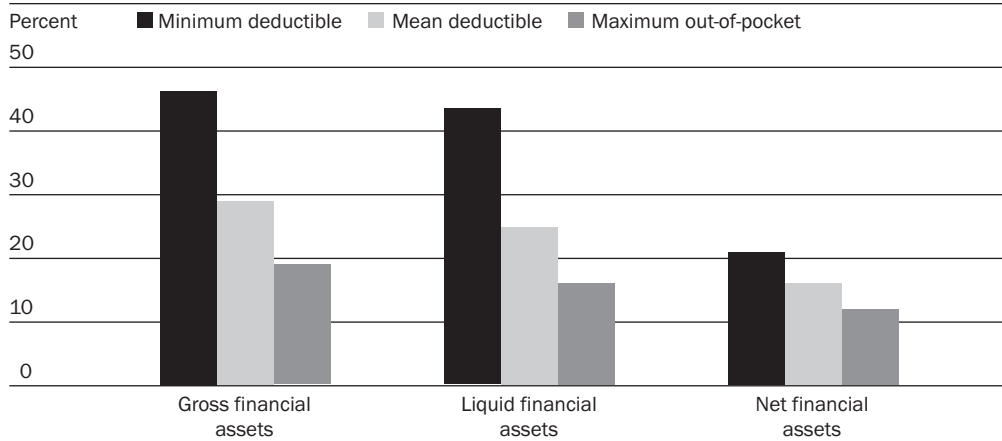
(\$1,000). Fewer than one in three had sufficient gross or liquid assets to cover the higher average HSA deductible level (\$2,364), and the percentages fell to less than one in four for the HSA maximum out-of-pocket limit (\$5,000).

When one examines net financial assets, one sees that debt had a meaningful impact on the wealth of uninsured households. For example, only 21 percent of households with one

uninsured member had sufficient assets to cover the minimum HSA deductible when their unsecured debts were included.

Exhibit 4 presents the results using our three categories of assets for households with two or more uninsured members. The patterns in Exhibit 4 are similar to those in Exhibit 3, although the percentages for households with two uninsured members are lower across the

**EXHIBIT 3**  
**Among Households With One Uninsured Member, Percentage With Enough Assets To Fund Single-Person Cost-Sharing Levels For A Health Savings Account (HSA), 2004**

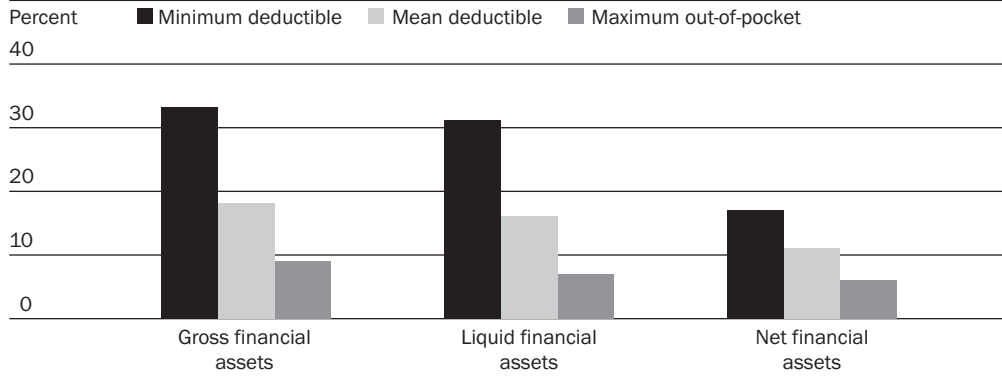


**SOURCE:** Authors' analysis of data from the 2004 Survey of Consumer Finances.

**NOTE:** Minimum HSA deductible: \$1,000; mean HSA deductible: \$2,364; maximum out-of-pocket: \$5,000.

**EXHIBIT 4**

**Among Households With Two Or More Uninsured Members, Percentage With Enough Assets To Fund Family Cost-Sharing Levels For A Health Savings Account (HSA), 2004**



**SOURCE:** Authors' analysis of data from the 2004 Survey of Consumer Finances.

**NOTE:** Minimum HSA deductible: \$2,000; mean HSA deductible: \$4,653; maximum out-of-pocket: \$10,000.

board than those for households with one uninsured member. Households with more than one uninsured member were less likely than those with only one uninsured member to have enough assets to meet the corresponding HSA limit. Only about one in five had sufficient liquid or gross assets to meet the average deductible threshold, and only one in fourteen to one in eleven had sufficient liquid or gross assets, respectively, to meet the out-of-pocket maximum threshold we used.

We examined whether the low levels of net financial assets shown above are sensitive to ignoring installment debt, which may be more manageable for some families. After paying their credit card balances, 16–31 percent of households with one uninsured member, and 8–26 percent of households with more than one uninsured member, would have enough financial assets to cover the maximum out-of-pocket payment and the minimum HSA deductible, respectively. Removing installment debt did not seem to affect our overall findings.

**Discussion And Policy Implications**

Regardless of insurance status, we found striking differences in asset levels by poverty level among families, which highlights the role of income and household size in building an asset base. The results above also show differences between the financial assets held by in-

sured households versus those of households with uninsured members. Many uninsured households did not have sufficient gross financial assets to pay the cost sharing that may be imposed under HSA-qualified HDHPs. For households with one uninsured member, less than half had sufficient gross financial assets to meet the minimum HSA-related deductible, only about one-third could meet the average deductible reported for nongroup plans, and less than one-fourth could meet the maximum out-of-pocket limit permitted by law. The percentages for households with two or more uninsured members and with gross financial assets greater than the relevant family benchmarks were even lower.

■ **Study limitations.** There are reasons why these comparisons may overestimate or underestimate family out-of-pocket liability under HSA-qualified HDHPs. Because our analysis used data from 2004, changes in asset levels relative to changes in cost-sharing limits for HSAs since that time would change the analysis above. Our estimates may exaggerate liability because families covered by HSA-qualified HDHPs may receive a contribution from their employer to an HSA, reducing their out-of-pocket exposure. Uninsured working families whose employers offer HSA contributions, regardless of whether the employer di-

rectly offers the policy, would generally experience lower out-of-pocket liability; thus, our estimates may overstate the cost sharing these families would face.

Another reason why these comparisons may underestimate family liability is that some HSA-qualified HDHPs, particularly in those in the nongroup market, may leave families exposed to additional out-of-pocket liability. The study cited above by America's Health Insurance Plans (AHIP) found that only a small percentage of HSA- and MSA-qualified nongroup plans provided coverage for routine maternity care (normal labor and delivery) and that 8–12 percent excluded coverage for mental health or substance abuse services, or both.<sup>17</sup> Such exclusions are not rare in the nongroup market in general and are relevant

to measuring out-of-pocket liability for households that may rely on this type of coverage.

■ **Relevance to policy.** These findings raise important questions about the appropriateness of insurance policies with significant out-of-pocket liability as vehicles for covering a substantial share of uninsured households. Even if premiums are made more affordable, many uninsured households do not have a sufficient financial cushion to absorb the potential out-of-pocket liability that can arise under these policies. In particular, low-income (under 300 percent of poverty) uninsured households, with median gross financial assets of \$300 in 2004, would seem to be a poor match for policies with large cost-sharing exposure. For such families with little cash flow and high levels of debt, the onset of a chronic condition or a serious illness would merely add to their already poor financial condition. Of course, even coverage with high cost sharing would greatly reduce these households' out-of-pocket exposure relative to remaining uninsured. From the family vantage point, however, paying even a subsidized premium for a policy that can leave the family with sizable medical bills that they cannot afford might not seem

like a wise use of their limited funds. These families may rationally choose not to participate in "affordable" insurance options that do not have meaningful limits on their out-of-pocket exposure.

The low asset levels shown here pose a challenge for policymakers and others trying to make coverage more affordable for the uninsured. Higher cost sharing reduces the premium burden, but the resulting products might not provide adequate financial protection

for lower-income families with high medical needs. Those interested in cost-conscious approaches for increasing coverage may need to look beyond the current high-deductible approach and consider options that vary cost sharing with family means. Such products might be more popular if they were tailored

to the financial circumstances of lower-income families who often lack financial assets.

**“Low-income  
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#### NOTES

1. Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, October 2007, <http://www.kff.org/uninsured/upload/7451-03.pdf> (accessed 4 January 2008).
2. See, for example, D. Hunter, "Health Savings Accounts: The News Keeps Getting Better," Heritage Foundation WebMemo no. 833, 6 September 2005, <http://www.heritage.org/Research/HealthCare/wm833.cfm> (accessed 16 August 2007).
3. Office of the President of the United States, "State of the Union: Affordable and Accessible Health Care," 31 January 2006, <http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html> (accessed 29 August 2007).
4. Reuters, "Romney Wants Tax Breaks to Expand U.S. Health Cover," 24 August 2007, <http://www.reuters.com/article/email/idUSN2434181020070824> (accessed 29 August 2007).
5. T.F. Wildsmith, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," America's Health Insurance Plans, August 2005, Table 12, p. 16, [http://www.ahipresearch.org/pdfs/Individual\\_Insurance\\_Survey\\_](http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_)

- Report8-26-2005.pdf (accessed 4 June 2007); and Department of the Treasury, Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans," Pub. no. 969, 2005, <http://www.irs.gov/pub/irs-pdf/p969.pdf> (accessed 4 June 2007)
6. For example, see J.S. Banthin, W. Encinosa, and D.M. Bernard, "Affordability of Health Insurance: Do Assets and Net Wealth Explain the Demand for Health Insurance Better Than Income?" Paper presented at the Inaugural Conference of the American Society of Health Economists, Madison, Wisconsin, 4 June 2006, [http://www.allacademic.com/meta/p93337\\_index.html](http://www.allacademic.com/meta/p93337_index.html) (accessed 17 August 2007).
  7. Appendix 1 describes the SCF in greater detail and includes further explanation of the methods used to obtain these estimates. It is available online at <http://content.healthaffairs.org/cgi/content/full/hlthaff.27.3.w214/DC2>.
  8. Kaiser Commission on Medicaid and the Uninsured, "Massachusetts Health Care Reform Plan," Fact Sheet, April 2006, <http://www.kff.org/uninsured/7494.cfm> (accessed 4 June 2007); and California HealthCare Foundation, "FAQ about ABX1 1 (Núñez/Perata)," 18 December 2007, <http://www.calhealthreform.org/content/view/63> (accessed 10 January 2008).
  9. See, for example, J. Gruber, "The Wealth of the Unemployed," *Industrial and Labor Relations Review* 55, no. 1 (2001): 79–94; and M. Starr-McCluer, "Health Insurance and Precautionary Savings," *American Economic Review* 86, no. 1 (1996): 285–295.
  10. For our rationale behind showing net assets without installment debt, see Appendix 1, as in Note 7.
  11. For example, HSA-qualified HDHPs may cover preventive care, but not other services, before the plan deductible is met. Department of the Treasury, Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans."
  12. T.F. Wildsmith, "Individual Health Insurance," Table 9, p. 13. MSAs are interest-earning tax-deductible health spending arrangements similar in structure to HSAs. However, they are reserved for the self-employed or employees of small firms and their family members, and they have different deductible levels and maximum out-of-pocket cost sharing than HSAs have.
  13. *Ibid.*
  14. Only about 13 percent of the full-year uninsured lived in a family where at least one family member worked full time and was offered insurance in 2003. Authors' calculations of data from the 2003 Medical Expenditure Panel Survey, produced by the Agency for Healthcare Research and Quality (AHRQ).
  15. In Appendix 2, we also show the results for the uninsured at a finer level of detail (that is, below 200 percent, 200–400 percent, and above 400 percent of poverty). Appendix 2 is available online, as in Note 7.
  16. This difference would likely increase if the insured population were limited to the privately insured. Since the SCF is a household survey, dividing the population across three insurance categories complicates the decision to categorize households with both private and public coverage.
  17. Wildsmith, "Individual Health Insurance."