

HSAs and High-Deductible Health Plans: A Primer

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ALLIANCE FOR
HEALTH REFORM

Consumer-directed health care is the newest name given to a handful of strategies—some innovative, some recycled—that seek to marshal the power of consumers making cost-conscious choices to constrain rising U.S. health care spending. The leading edge of the consumer-directed movement is a new generation of tax-advantaged accounts known as health savings accounts (HSAs) that are linked to high-deductible health plans (HDHPs).

Simply stated, HSAs require an individual to use his or her own money (or money set aside by an employer for the individual's use) to pay for medical expenses up to a fairly substantial deductible. At that point, traditional insurance coverage begins.

Such plans are less costly per covered person than many traditional insurance policies. For 2006, the deductible is a minimum of \$1,050 for self-only coverage or \$2,100 for family coverage—quite a bit higher than for most health insurance. Thus, insurers aren't required to pay claims below those amounts. And theoretically, employees using their own money will be more aware of prices and will be more likely to “shop around” for care—saving dollars for both themselves and their employer.

Consumer-directed plans are new enough that reliable national data on the number of participants are only beginning to become available. The most recent count, by America's Health Insurance Plans (AHIP), shows that almost 3.2 million people were covered by HSAs linked to high-deductible health plans in January 2006. This is a growth of 2.7 million people since September 2004, or more than 600 percent. (See graph, “Growth of HSA/HDHP Enrollment.”)

A consensus is emerging that con-

sumer-directed plans eventually will become a major health care coverage option among large employers. The AHIP study noted that the percentage of HSA enrollees in large groups increased by 10 fold between 2004 and 2006—from 3 percent of all enrolled in such plans to 33 percent. The share of all HSAs sold in the small-group market has also increased—from 18 percent of all enrolled in 2004 to 25 percent in 2006.

Soaring Costs as the Mother of Invention

HSAs are attracting attention primarily because of their potential to curb years of escalating employer health care costs. On average, premiums for employer-sponsored health plans rose anywhere from 6.1 percent to 9.2 percent in 2005, depending on the survey being cited. This was the sixth straight year in which premiums grew at more than double the pace of prices overall or workers' earnings. Employers saw premiums go up steeply in 2001 (10.9 percent), 2002 (12.9 percent), 2003 (13.9 percent) and 2004 (11.2 percent).

Employers, the source of coverage for 161.7 million non-elderly people in 2004, have used a variety of means to reduce their health care costs. According to Paul Ginsburg, president of the Center for Studying Health System Change, employers “bought down” the price of health insurance by reducing benefits and increasing cost-sharing for workers, notably by increasing plan deductibles and copayments. The result, he concluded, was that the average premium would have been 2 to 3 percent higher in 2002, 2003 and 2004 without the “buy-down.”

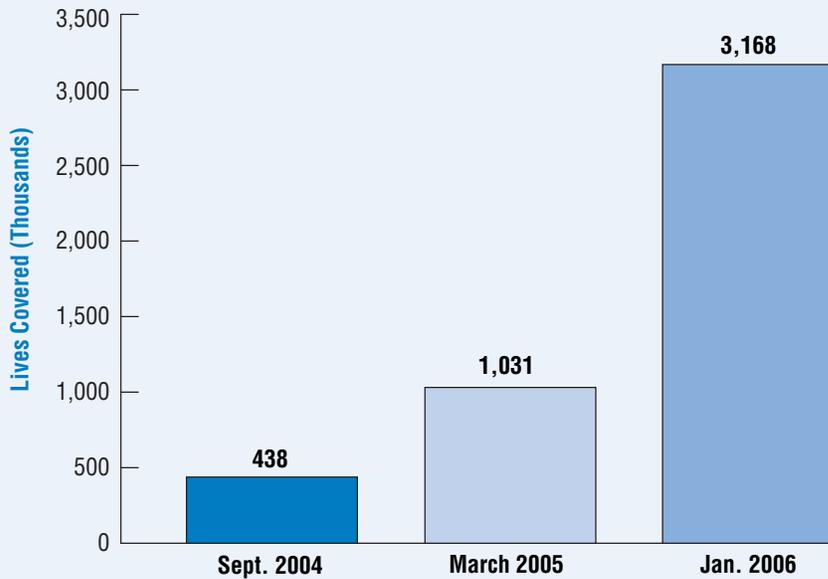
But the continued rapid growth in premiums has prompted employers to seek

Fast Facts

- ▲ The two main types of consumer-directed health plans are health savings accounts (HSAs) and health reimbursement arrangements (HRAs).
- ▲ Almost 3.2 million people were covered by HSAs linked to high-deductible health plans in January 2006.
- ▲ Proponents of consumer-directed plans say the plans cause individuals to make smarter, more cost-conscious health care purchasing decisions while allowing employers to save money on health coverage premiums.
- ▲ Opponents of consumer-directed plans say the plans won't do much to lower overall health care costs and will discourage some individuals from seeking care when they need it.
- ▲ President Bush proposes expanding HSAs by offering tax incentives to individuals and to employers.

This issue brief, prepared by the Alliance for Health Reform with support from the Robert Wood Johnson Foundation, examines “consumer-directed” health plans, and includes selected material from an Alliance/Foundation Capitol Hill briefing on the subject.

Growth of HSA/HDHP Enrollment from Sept. 2004 to Jan. 2006



SOURCE: America's Health Insurance Plans (2006). (www.ahip.org/content/default.aspx?docid=15302)

new ways to control their health care costs. Unlike the 1990s, when employers focused on enrolling employees in managed care plans that restricted the use of services, and seeking discounts from providers, their latest strategies aim to curb demand for health care services and improve the value of health spending by making employees more sensitive to both price and quality. Consumer-directed health plans are emerging as important components of this strategy, particularly among the largest employers.

The Evolution of HSAs

Created by the Medicare Modernization Act of 2003, health savings accounts evolved from earlier tax-preferred accounts that, through various mechanisms, allow payment of health care expenses.

The earliest predecessors to HSAs were medical saving accounts (MSAs), which first appeared when some states changed their tax laws to favor the accounts.

The next type of consumer-directed approach to develop was health reimbursement arrangements, or HRAs. Unlike medical savings accounts, HRAs are not restricted to employees of small firms only. Like MSAs, the funds in an employee's account are available for qualifying medical expenses until those funds are used up. Unused funds are rolled over at the end of the year. If the employee changes jobs, the HRA does not follow the employee to the new job. An employer's contributions to an HRA are tax deductible, like con-

tributions to other health insurance. (For more on the difference between HSAs and HRAs, go to www.allhealth.org/issue_briefs_HSAs.asp.)

There appears to be greater interest in HSAs than in either MSAs or HRAs, as employers seek to reduce costs and the Bush Administration advocates them as part of a broad-based campaign to establish what is being called an "ownership society."

HSAs offer certain advantages over the other accounts. For example, HSAs are available to the self-employed, as well as to employees of firms.

Unlike HRAs, HSAs are also fully portable; they are owned by the individual, who can take them from one company to another. HSA interest accruals are tax-free, as are withdrawals for IRS-eligible, or "qualified," health care expenses. Those who are unemployed can use HSA funds to purchase health coverage in the individual insurance market, or to pay COBRA premiums for up to 18 months to maintain the employer-sponsored coverage they had under a former job.

Supporters' Arguments

Proponents of consumer-directed health care call it a revolutionary movement. They say that consumer-directed principles will transform relatively passive, cost-insulated health care users into informed and active shoppers.

Supporters of such plans say they represent a portable, attractive health insurance alternative for self-employed and uninsured individuals, as well as for employees of firms of all sizes. Proponents say if consumer-directed plans become more popular, they may produce a cost-consciousness among both consumers and providers.

The Heritage Foundation says HSAs give consumers "a new choice in coverage design, greater control of their health care spending, and the ability to own their own health care plans." HSAs also help employers, Heritage says, by giving them "the ability to make the transition from a defined benefit system, with open-ended costs, to a defined contribution system in which health care spending can be better managed."

Joseph Antos of the American Enterprise Institute notes that by not covering "first dollar" health expenses, consumer-directed plans help avoid consumer overuse of health care services.

To make smart choices under a consumer-directed plan, however, consumers must be offered information to help them make purchasing decisions. Ideally, plans make intensive use of the internet to give members information about health care providers, prices and quality. Some plans offer consumer education and health care

“coaching” programs aimed at helping members with financial and clinical strategies. Proponents such as former House Speaker Newt Gingrich note that this sort of information is necessary for consumers if the plans are to help lower costs.

Critics’ Arguments

Some skeptics, such as Uwe Reinhardt of Princeton, argue that these news plans rarely provide information that workers would need to make better health care decisions—information about both prices and clinical abilities of physicians and hospitals. Indeed, a 2005 study concluded that the first generation of HSA products typically does not provide consumer-friendly cost and quality information.

Some analysts also worry that consumer-directed plans may fail to meet consumers’ health care needs and therefore place additional financial burdens on those with chronic health conditions and could cause some consumers to delay or forgo needed care. That could trigger a response similar to the backlash against HMO gate-keeping in the late 1990s and early 2000s. Delaying care, or forgoing it altogether, can lead to more serious illness.

Karen Davis and colleagues at The Commonwealth Fund found 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 by not visiting a doctor or clinic. By contrast, 21 percent of adults with no deductible report one of these four access problems.

Questions are also raised about how effective the plans will be in controlling costs, given the widely uneven spending patterns of health care users.

Once households hit the deductible for their high-deductible health plan, they face little additional incentive to economize. In 2004, non-elderly people with health insurance who spent less than the minimum MSA deductible accounted for less than 6 percent of total medical spending by singles and 4 percent of families’ medical expenditures.

Critics of the consumer-directed plans also argue that current comprehensive coverage for many workers could be threatened if premiums for plans not linked to HSAs begin rising rapidly in response to a migration of healthier workers to cheaper high-deductible plans.

HSA Changes Coming?

As the debate continues between proponents and

skeptics, President Bush renewed his support for expanded use of HSAs in his 2006 State of the Union message.

The president vowed to “strengthen health savings accounts—making sure individuals and small business employees can buy insurance with the same advantages that people working for big businesses now get.” He went on to say, “We will do more to make this coverage portable, so workers can switch jobs without having to worry about losing their health insurance.”

The 2007 White House budget proposal offers specifics. (See box, “President Bush’s Plan to Promote Health Savings Accounts.”)

Some supporters of HSAs are asking Congress to rework the law to allow first-dollar coverage of prescription drugs, particularly those maintenance drugs needed by people with chronic conditions, regardless of the deductible.

But the White House’s Roy Ramthun told a March 2006 Alliance briefing audience that other HSA backers on Capitol Hill wanted consumers to be aware of the high cost of prescriptions.

Forecasting HSAs’ Impact

Enrollment in consumer-directed plans is growing, but it remains to be seen whether they will become

President Bush’s Plan to Promote Health Savings Accounts, February 2006

As part of his FY 2007 budget request to Congress, President Bush proposed a number of changes in current law to make HSAs more attractive to individuals and employers. Among them:

- ▲ Provide an income tax credit for contributions to an HSA, equal to the amount of payroll taxes paid on those contributions.
- ▲ Exclude from taxable income the amount of premiums paid for an HSA-qualified insurance plan purchased in the individual market, and provide an income tax credit equal to the payroll taxes paid on the premium amounts.
- ▲ Raise the amount individuals and employers may contribute to an HSA to an amount equal to that of the out-of-pocket maximum defined by the HSA-qualified plan. Currently, contributions are only allowed up to the amount of the deductible.
- ▲ Allow employers to make larger contributions to HSAs of chronically ill employees than to the accounts of employees with no chronic illnesses
- ▲ Provide advanceable tax credits for low income individuals and families when an HSA-qualified insurance is purchased. The amount of the credits would be up to \$1,000 for a single adult, \$2,000 for two adults and \$3,000 for a family, up to 90% of the plan premiums.
- ▲ Provide \$500 million per year to encourage up to 10 states to test innovative methods for covering their chronically ill residents. For example, states could fund risk-adjusted premium subsidy programs or use the funds to provide HSA accounts to state high-risk pool enrollees.

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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Alliance for Health Reform
1444 I Street, NW, Ste 910
Washington, D.C. 20005
Phone 202/789-2300
Fax 202/789-2233
www.allhealth.org

the plans of choice for American employers.

A December 2005 study of consumer-directed health care provides ammunition for both sides in the ongoing debate. The study, by the Employee Benefit Research Institute and The Commonwealth Fund, found that just 30 percent of high-deductible plan enrollees said they would stay with their current plan if they had an opportunity to switch.

On the other hand, the study also found that people in consumer-directed plans and high-deductible plans were significantly more likely to say that the terms of their health plans “made them consider costs” when deciding on treatment options

Asked what the future holds for consumer-directed health care, Tom Miller, senior health economist for the Congressional Joint Economic Committee, advises people to “chill out a little bit about this and ride the wave. ... There are a lot of interesting things that could be done and will be done, but they're going to come in stumbling starts, trial and errors. Some folks will win, some people will lose,” he said, referring to insurers providing consumer-directed plans. “That's called competition, innovation, and we ought to try it in health care.”

(For the sources used in this publication, click on the title of this issue brief at www.allhealth.org under “Publications.”)

Expert Sources

▲ Joe Antos , <i>American Enterprise Institute</i>	202/862-5938
▲ Katherine Baicker , <i>Council of Economic Advisors</i>	202/395-5084
▲ Frank McArdle , <i>Hewitt Associates</i>	202/331-1155
▲ Gary Claxton , <i>Kaiser Family Foundation</i>	202/347-5270
▲ David Colby , <i>Robert Wood Johnson Foundation</i>	609/627-5754
▲ Karen Davis , <i>The Commonwealth Fund</i>	212/606-3825
▲ Paul Fronstin , <i>Employee Benefit Research Institute</i>	202/775-6352
▲ Jon R. Gabel , <i>Center for Studying Health System Change</i>	202/484-5269
▲ Paul Ginsburg , <i>Center for Studying Health System Change</i>	202/484-4699
▲ John Goodman , <i>National Center for Policy Analysis</i>	972/386-6272
▲ Jonathan Gruber , <i>Massachusetts Institute of Technology</i>	617/253-8892
▲ Karen Ignagni , <i>AHIP</i>	202/778-3203
▲ Tom Miller , <i>Joint Economic Committee (Congress)</i>	202/224-3915
▲ Tony Miller , <i>Definity Health</i>	952/277-5533
▲ Edwin Park , <i>Center on Budget and Policy Priorities</i>	202/408-1080
▲ Dan Perrin , <i>The HSA Coalition</i>	202/271-3959
▲ Roy Ramthun , <i>National Economic Council</i>	202/456-5333
▲ Uwe Reinhardt , <i>Princeton University</i>	609/258-4781
▲ Greg Scandlen , <i>Consumers for Health Care Choices</i>	301/606-7364
▲ Janet Trautwein , <i>National Association of Health Underwriters</i>	703/276-3806
▲ Reed Tuckson , <i>UnitedHealth Group</i>	952/936-1253
▲ Grace-Marie Turner , <i>Galen Institute</i>	703/299-8900

Websites

▲ Alliance for Health Reform	www.allhealth.org
▲ American Association of Health Plans	www.aahp.org
▲ California HealthCare Foundation	www.chcf.org
▲ Center for Studying Health System Change	www.hschange.org
▲ Center for Consumer Driven Health Care	www.galen.org/ccdhc.asp?1
▲ Center on Budget and Policy Priorities	www.cbpp.org
▲ The Commonwealth Fund	www.cmwf.org
▲ Consumers for Health Care Choices	www.chcchoices.org
▲ Employee Benefit Research Institute	www.ebri.org
▲ Health Research and Educational Trust	www.hret.org
▲ Kaiser Family Foundation	www.kff.org
▲ The Robert Wood Johnson Foundation	www.rwjf.org
▲ U.S. Bureau of Labor Statistics	www.bls.gov/data/

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