Health Savings Accounts and High-Deductible Health Plans: A Primer

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Introduction

Health Savings Accounts (HSAs) were signed into law as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and became available on January 1, 2004. While not yet widespread, participation in HSAs surpassed 1 million people in 2005, and continued growth is expected in coming years.[1] HSAs shift a greater portion of healthcare costs onto patients and therefore save employers money, while treating HSA funds – contributions, earnings, and distributions – on a tax-advantaged basis. It is not yet clear whether widespread participation in HSAs will have any beneficial effects on the American health care system.

The Basics

What is a Health Savings Account?

Overview

An HSA is an account funded by an employee and/or an employer that can be used for qualified medical expenses. HSAs essentially represent a triple tax subsidy for health care. First, all contributions to the HSA are tax-free. Employer contributions to an HSA do not count as taxable income to the employee. Employee contributions are tax-free if made through a salary reduction plan – meaning that a certain amount of an employee's gross salary is withheld and invested through the HSA – and tax-deductible if made outside a salary reduction plan.[2]

Second, HSA funds, including any money made through investing HSA funds, accumulate tax-free. An HSA is similar to an IRA in that both are owned by the employee and funds can be invested in the same options with the same limitations. IRA funds, however, do not accumulate tax-free.

Finally, HSA distributions (withdrawal of funds from the account) for health care expenses are tax-free. Before an individual turns 65, HSA distributions for anything other than qualified medical expenses are subject to a 10% tax penalty in addition to income tax. After age 65 or disability, HSA funds can be withdrawn and used for non-medical expenses without penalty, although these distributions are still subject to income taxes.[2]

High-Deductible Health Plan

In order to qualify for an HSA, an individual must first be enrolled in a high-deductible health plan (HDHP); that is, every HSA is associated with a HDHP.[3] Due to their higher deductibles, HDHPs have lower premiums than conventional comprehensive, low-deductible plans. The minimal deductibles for HDHPs are $1,000 for individuals and $2,000 for families, although most HDHPs have deductibles that are much higher. Once a person pays the deductible, remaining medical expenses are mostly paid by the insurance plan. However, many plans do not cover all remaining medical expenses and instead impose cost-sharing after the deductible is met. For example, with "co-insurance" cost-sharing, plans require a person to pay a certain percentage of remaining medical expenses after reaching the deductible.

With HDHP's, there is a maximum amount that an individual or family can pay for out-of-pocket costs, which include deductibles, co-pays, and co-insurance for in-network providers.[3] In 2005, the maximum annual out-of-pocket limit was $5,100 for individuals and $10,200 for families.

By definition, HDHPs usually do not cover "first-dollar" medical expenses; that is, patients must pay medical expenses until the deductible is reached before their insurance coverage begins. Distributions from an HSA for qualified medical expenses covered by the HDHP, along with prescription drug costs, count towards the HDHP deductible. Preventive care *may* be covered under an HDHP with or without a co-pay, in which case the costs of preventive care do not count towards the deductible.[3]

Maximum Contribution to HSA

By law, the maximum total contribution to an HSA from all sources per year is generally limited to either the full amount of the HDHP deductible or a pre-set amount set by the government, whichever is less (for 2005, this amount was $2,650 for individuals and $5,250 for families). Individuals 55 and older are allowed to make additional "catch-up contributions", which are amounts in excess of the maximum annual contribution, in order to increase the amount in their HSA as they approach retirement. In 2005, the maximum catch-up contribution was $600, and this amount will increase by $100 each year to $1000 in 2009 and beyond. Once individuals are enrolled in Medicare, they may no longer make contributions to their HSA. They may, however, still use funds from their account.[3]

Eligibility Restrictions

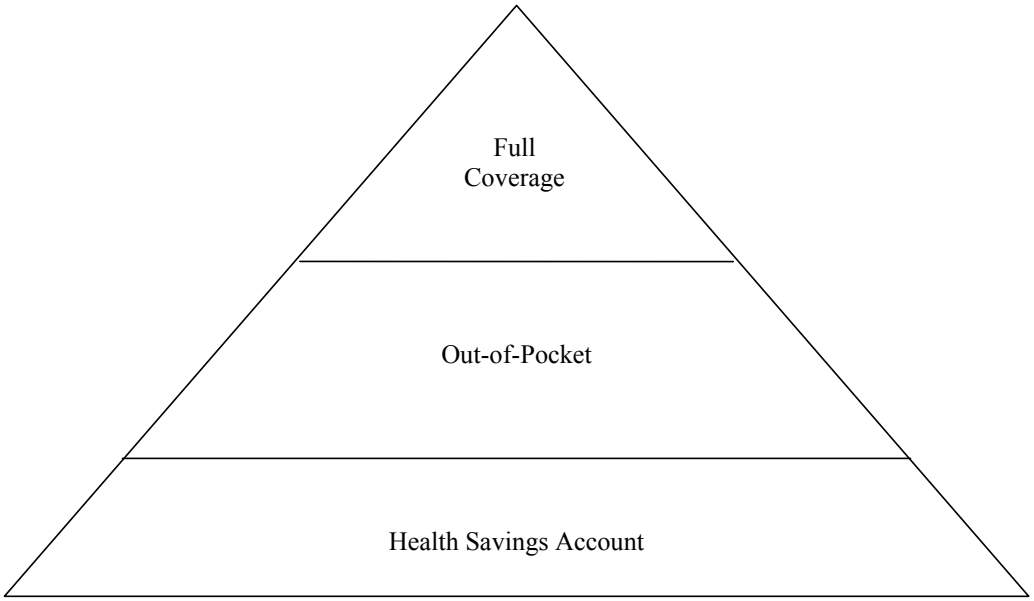
Individuals are disqualified from opening HSAs if they are over age 65; if they are already enrolled in a low-deductible insurance plan, Flexible Spending Account, or Health Reimbursement Account; if they can be claimed as a dependent on someone else's tax return; or if they receive benefits from Medicare, Medicaid, or other such programs.[2]

Qualified Medical Expenses

Qualified medical expenses that can be paid for using HSA funds include most medical care and services, dental and vision care, and over-the-counter drugs. While HSA funds generally may not be used to pay for medical insurance premiums, exceptions include health plan coverage while receiving unemployment benefits, continuation health coverage when changing employers, qualified long-term care insurance, and Medicare premiums and out-of-pocket expenses for certain parts of Medicare.[3]

Examples

The following diagram conceptually illustrates how HSA/HDHP plans work. If a person incurs medical costs, he or she first pays for these costs from their HSA. Once the HSA funds are depleted, the person begins to pay out-of-pocket for health care costs (deductibles, co-payments, or co-insurance beyond the deductible). Once the maximum out-of-pocket spending limit is surpassed, the HDHP covers all costs. The difference between HSA/HDHP and traditional insurance plans is that in the latter, the deductible is much lower, premiums tend to be somewhat higher, and there is no HSA.



As a more concrete example, illustrate how HDHP's and HSAs work, consider a 30-year old man named Bill who has an annual income of $50,000. Bill enrolls in a high-deductible health plan with a $100 monthly premium, a $1,000 deductible, a 20% co-insurance rate for expenses beyond the deductible, and a maximum out-of-pocket spending limit of $5,100. Bill also opens a health savings account and initially deposits $1,000 into the HSA.

Within a month, he breaks his leg while playing basketball with friends. His initial medical bills (emergency room, X-rays, cast) cost $1,000. Since the deductible on his HDHP is $1,000, he must pay this amount himself, and he withdraws the $1,000 from his HSA tax-free to do so.

On each of his three follow-up visits to the doctor, Bill is charged a $25 co-pay. He also goes to physical therapy eight times after his cast is removed, and he is charged a $20 co-pay for each visit. Finally, Bill is charged a $10 co-pay per month for his prescription pain medication. The total amount of out-of-pocket costs (co-pays and deductibles) in the year after his injury is $1,355:

HDHP deductible/HSA contribution		$1,000
Follow-up visit co-pays	$25 * 3 =	$ 75
Physical therapy	$20 * 8 =	$ 160
Prescription drugs	$10 * 12 =	$ 120
TOTAL		$1,355

The maximum amount that Bill is allowed to pay out-of-pocket per year is $5,100. In this example, Bill did not incur enough costs to surpass the $5,100 level, so he pays $1,355 out-of-pocket. Added to the $1200 in premiums (12 months x $100/month), the total amount Bill pays for health care in the year after his injury is $2,555.

Suppose now that Bill's initial medical bills for breaking his leg were much higher. For example, imagine that Bill is hospitalized for a compound fracture that requires surgery and that the initial medical bill is $16,000 instead of $1,000. Bill would pay the first $1,000 of the hospital bill to meet the deductible, using funds from his HSA (as he did in the previous example). Since his co-insurance rate is 20%, his HDHP would cover 80% of the remaining $15,000 ($12,000) and Bill would be responsible for $3,000. Assuming that Bill incurred the same costs as above for follow-up visits, physical therapy, and prescription drugs, Bill's total out-of-pocket costs (co-pays and deductibles) would be $4,355:

HDHP deductible/HSA contribution		$1,000
Follow-up co-pays	$25 * 3 =	$ 75
Physical therapy	$20 * 8 =	$ 160
Prescription drugs	$10 * 12 =	$ 120
Co-insurance for hospital		$3,000
TOTAL		$4,355

Again, Bill does not incur enough costs to surpass the $5,100 level, so he pays $4,355 out-of-pocket. Added to the $1200 in premiums (12 months x $100/month), the total amount Bill pays for health care in the year after his injury in this example is $5,555.

Finally, suppose that Bill had suffered a compound fracture of his leg and incurred complications during his surgery. In this scenario, his initial medical bills are $41,000 instead of $16,000. Bill would pay the $1,000 deductible using his HSA and would then be responsible for 20% of the remaining $41,000, or $8,000. Assume that Bill incurred the same costs as above for follow-up visits, physical therapy, and prescription drugs. If Bill's HDHP had no maximum out-of-pocket spending limit, Bill's total out-of-pocket costs (co-pays and deductibles) would be $9,355:

HDHP deductible/HSA contribution		$1,000
Follow-up co-pays	$25 * 3 =	$ 75
Physical therapy	$20 * 8 =	$ 160
Prescription drugs	$10 * 12 =	$ 120
Co-insurance for hospital		$8,000
TOTAL		$9,355

However, Bill's plan does have a $5,100 maximum out-of-pocket spending limit. As such, he would not pay $9,355 out-of-pocket but rather only $5,100; his HDHP would pick up the difference ($9,355 – $5,100 = $4,255). Added to the $1200 in premiums (12 months x $100/month), the total amount Bill pays for health care in the year after his injury in this example is $6,300.

What is the difference between a Flexible Spending Account (FSA), a Health Reimbursement Account (HRA), and a Health Savings Account?

There are two forms of Flexible Spending Accounts (FSAs). A Health Care FSA (HCFSA) pays for qualified medical expenses not covered or reimbursed by a health insurance plan. A Dependent Care FSA (DCFSA) pays for eligible childcare or adult dependent care expenses necessary for the employee or his/her spouse to work, look for work, or attend school full-time. Employees deposit pre-tax dollars into the FSA, often through a salary reduction plan. Employers also may contribute money to an employee's FSA. The maximum amount that can be deposited each year is $4,000 for healthcare expenses or $5,000 for dependent care expenses. Funds must be used within each plan year, and any

funds left over at the end of the year are forfeited by the employee. This is usually referred to as the "use-it-or-lose-it" rule. A person may have both types of FSAs but must fund each separately.[4]

Health reimbursement accounts (HRAs) are similar to HSAs, but the major difference is that the HRA is owned by the employer, not the employee. Employers deposit money into HRA's that employees can use to pay for qualified medical expenses. When account funds are depleted, the employee pays for the remaining medical expenses out of his/her own pocket. Employees do not pay taxes on their employer's contributions to an HRA. Employers who fund HRAs do so instead of offering traditional comprehensive insurance; in doing so, employers become responsible for a set amount of health care per employee every year, instead of rising premiums for health insurance per employee every year. Unlike FSA's, unused funds are rolled over at the end of the year, but unlike HSAs, the HRA remains with the employer who originally funded it (HRAs are not portable between employers).[5]

The following graph summarizes the differences between FSAs, HRAs, and HSAs. Note that FSA's and HRA's are not automatically associated with an HDHP, as HSAs are (e.g. HSAs require concurrent health insurance coverage).

	Flexible Spending Account	**Health Reimbursement Account**	**Health Savings Account**
Concurrent health insurance coverage required	No	No	Yes
Contributor	Employee	Employer	Variable
Qualified medical expenses	Unreimbursed medical expenses	Unreimbursed medical expenses	Unreimbursed medical expenses Qualified insurance premiums
Unused funds rolled over to following year	No	Yes	Yes
Portable between employers	No	No	Yes
Funds may be invested	No	No	Yes

What are the benefits of the Health Savings Account/High Deductible Health Plan combination?

There are several purported benefits of HSAs and HDHPs. First of all, a healthy person who does not seek frequent care, and who therefore does not spend much on care, will save money by paying lower premiums for his insurance and only using his HSA funds when absolutely necessary. As a reward for "rationing by choice," patients can profit by investing unused HSA funds, which can then grow tax-free.[6] In effect, this arrangement offers an incentive to not over-utilize health care services because costs are paid out of the patient's own bank account.[7]

In addition, HSA/HDHP plans offer some advantages over traditional comprehensive health plans. In general, HSA/HDHP plans cover more services than traditional plans, including vision, dental, and alternative therapies such as acupuncture. These plans also offer patients greater choice of providers.

Moreover, the HSA is owned by the employee and is portable between employers, thus avoiding gaps in coverage that might otherwise have only been bridged by health insurance coverage under COBRA, a program that allows for temporary continuation of health insurance coverage after an employee stops working for an employer.

Since patients pay for a greater share of health care costs, some believe that patients will be more likely to demand high quality service. Empowered as a consumer, the patient will make inquiries regarding the price of care, the quality of a particular hospital or provider (e.g. safety or performance records), and the evidence base for pursuing a particular route of treatment over another. He or she will refuse care if it is not essential enough to justify the expense, or alternatively seek out higher quality or less costly care.[6,7]

What are the drawbacks of the Health Savings Account/High Deductible Health Plan Combination?

While HSAs and HDHPs discourage unnecessary utilization of health care, one of their biggest problems is that they also discourage necessary utilization of health care. Basic concerns about costs are likely to cause some patients enrolled in HDHPs to skip necessary tests, treatments, or follow-up even when medically necessary.[8] Furthermore, there is a potential that patients in general – including the chronically-ill – might see the earnings potential of HSA funds as a financial incentive not to seek necessary health care services, preventive or otherwise. While some HDHPs might cover preventive care before the deductible is fulfilled, this is not necessarily universal and could even decrease in frequency as more individuals needing preventive care switch into such plans.

HSAs appeal mainly to younger, healthier, richer patients who do not incur many health care costs and who can afford paying the deductible. In contrast, many low-income patients will not be able to afford paying the deductible or to deposit money into an HSA.[8] In addition, even if an individual has sufficient funds available to contribute to an HSA, there is always a risk that those funds will diminish through poor investment decisions. Since out-of-pocket spending on health care increases with the number of chronic conditions, the increased cost-sharing burden of HSA/HDHP's will discourage chronically ill patients from enrolling in these plans.[9]

A prevalent argument against HSAs relates to the potential for a premium "death spiral", in which premiums would skyrocket for enrollees in traditional comprehensive health plans. Such a situation would be caused by the tendency for younger, healthier patients to enroll in HSAs, leaving older and chronically-ill patients behind in traditional plans.[10] Premiums for conventional insurance would therefore be higher due both to more comprehensive coverage and to the greater risk involved in covering a sicker population of enrollees.[11] Such a pattern would likely continue, with rising premiums causing more patients to abandon traditional plans.[8] Moreover, as premiums for traditional plans become prohibitively expensive, more employers might stop sponsoring such comprehensive plans, choosing instead to only offer HDHPs, or even stop offering health insurance altogether.[8]

The populations benefited by the tax advantages of Health Savings Accounts will vary by income level. The triple tax advantages of HSAs – tax-deductible contributions, tax-free earnings, and tax-free withdrawals[3] – are more likely to favor higher-income individuals who are already able to afford insurance, since the value of a tax deduction is greatest for individuals in the highest tax bracket.[14] In some cases, the triple tax subsidy may cause the cost of health care for highly-taxed, high-income populations to be *less* than the cost of health care for less-taxed low-income populations.

There have been proposals to offer tax credits for individuals to cover premiums for HDHPs, but these proposals are controversial. One study by the Kaiser Family Foundation found that a tax credit would favor the young and healthy. This study also found that it would only increase the number of insured under age 65 by 1 million, while simultaneously causing 1 million people to lose employer-based health insurance coverage because employers would drop health care coverage, knowing that their workers would ba "taken care of" with the tax credit.[15]

Discussion

Since the creation of health savings accounts in late 2003, there has been abundant debate about the benefits and risks of mass enrollment of patients into high-deductible health plans and investment of health care dollars through HSAs. Although both proponents and critics claim to be working towards greater access to health insurance coverage for the uninsured[16,17], they tend to advocate for opposing approaches. On the side favoring health savings accounts are groups such as the Galen Institute, the American Medical Association[7], the National Center for Policy Analysis[6], the Cato Institute, the Heritage Foundation[18], and insurance companies such as Aetna[19], Definity Health[20], and Destiny Health[21]. These groups tend to promote consumer-driven health care as a tool for reducing utilization and costs through cost-sharing, increasing competition in a market-driven health care delivery system, maximizing the potential of profit for the consumer, and improving patients' choice regarding their care.[6] At the other end of the spectrum, critics of health savings accounts include the Center on Budget and Policy Priorities, Physicians for a National Health Program[22], the Universal Health Care Action Network[23], and Consumers Union.[24] These groups tend to advocate for comprehensive changes to the American healthcare system, such as a national health insurance program that is administered mainly through the federal or state governments.

Risk Pools, Adverse Selection and Risk Segmentation

The traditional idea behind risk pools in the group (employer-based) insurance market is that the larger the risk pool, the lower the premium paid for each enrollee. All employees pay the same premium for the same plan, and they are all included in the same risk pool. Having more people enrolled in a plan (and therefore part of the pool) dilutes the cost to everyone when one enrollee incurs an adverse health event that requires extensive health care service. Older employees are more likely than the young to utilize the healthcare services that they are paying for, but young employees benefit by knowing that they will have access to health care if they need it.

In contrast, the lower premiums of HDHPs and investment potential of HSAs are more likely to appeal to healthier workers, thereby siphoning off enrollees from traditional large-group health plans. This is called "adverse selection." Under this scenario, the risk pool in the traditional plan would become progressively smaller, sicker, and costlier to insure.

Evidence exists that adverse selection occurred even among traditional types of comprehensive plans. For example, research done in the late-1990s on California's Health Insurance Plan Cooperative showed that, given the choice between an HMO and a PPO – the latter of which tended to cover more services – persons with higher health costs preferred PPOs. As a result, premiums for PPOs necessarily increased, and some PPOs withdrew from the cooperative due to the higher costs.[25] The effects of adverse selection in this case were somewhat limited by other health care reforms that had been instituted around the same time, which increased guaranteed and renewable coverage and limited the extent to which insurers could exclude coverage for pre-existing conditions.[23] Unfortunately, such

restrictions on insurers are not currently in place to limit the potential effect of adverse selection on people who stay in comprehensive plans instead of HSA/HDHP plans.

Rather than address the potential for adverse selection to occur, proponents of HSAs deny that such consumer-directed plans tend to attract younger and healthier enrollees.[6] For example, during a 2004 hearing regarding health savings accounts before the U.S. Senate Special Committee on Aging, Robert Goodman, President of the National Center for Policy Analysis, and Ronald Williams, President of Aetna, referred to an Aetna HealthFund study[26] as evidence that, in terms of age and family status, enrollees in consumer-directed plans such as health savings accounts actually tend to be similar to the general population.

However, the relevant dimensions to compare are not age and family status, but rather enrollee health status and utilization of health care. In a study by Humana, Inc., adverse selection did in fact occur when high-deductible health plans were offered alongside traditional HMOs and PPOs.[9] Significantly, the analysis included demographic data, data on prior claims, and data on use of health care services. Basing the analysis on demographic data such as age revealed similar levels of risk between both populations, which is consistent with the Aetna HealthFund study. However, basing the analysis on prior claims and health care utilization revealed that enrollees in the HSA/HDHP plans were healthier than those remaining in the traditional plans, supporting the idea that the chronically ill are less likely to enroll in HSA/HDHP plans. Whether or not adverse selection occurs therefore seems to depend on which factor – demographics, self-reports of health status, or prior claims data – is used to measure risk.[9]

It is interesting to note that while proponents of health savings accounts deny that HSAs attract younger, healthier, and wealthier individuals, some employers considering sponsoring such accounts actually are told that this is what they can reasonably expect. For example, the website HSAfinder.com offers answers to frequently asked questions, and in response to the question "Who is best suited to an HSA account?" offers the reply:

> Generally, the program will be better received if the worker base is: young adult (over 21 but under age 30), predominantly single, and/or responsible for their own insurance needs, highly paid (over $50,000) on the strength of its tax-advantaged possibilities. […] If the worker base is paid low wages (under $23,000) they will have very little enthusiasm. These employees may find it hard to set aside anything for savings, especially if they have family to support.[27]

The common sense assumption, even by employers, is that HSAs are not as appealing to employees who are less likely to be able to afford them.

The Chronically Ill

One population that deserves particular attention when discussing HSAs is patients with chronic conditions. There are two potential problems with offering HSAs and HDHPs as the only insurance option to this group of patients. First, under such plans, chronically ill patients would have a financial incentive not to seek necessary care. This will result in poorer health and higher overall health care costs; indeed, studies have shown that better management of chronic conditions, such as glycemic control in Type 2 Diabetes, results in decreased costs and utilization of health care services later on.[28] Second, since treatment can be more of a necessity than a choice for patients with chronic conditions, those patients may not actually change their spending on medical expenses, thereby defeating the

purpose of cost-sharing. It follows, then, that by giving chronically ill patients an incentive to avoid seeking medical care, HSA/HDHPs will not decrease costs but may actually increase costs, as there would be a higher chance that these patients would incur an emergent (and therefore expensive) need for health care services..

The Educated Consumer

A prominent argument of HSA proponents is that, when paying out of their own pockets and when given the appropriate tools and information, patients will educate themselves and pursue the best value in healthcare, or the highest quality care for the least cost. According to John Goodman of the National Center for Policy Analysis, "These are people who when they spend a dollar are going to insist on a dollar's worth of value."[30] In support of this notion, Aetna reports that enrollees in their health plans request more information about health care costs and quality.[17]

The ability of patients to analyze the cost-benefit ratio of seeking care depends on a number of factors. One important factor is whether the information regarding the costs, effectiveness, and quality of care is accessible to those patients. In terms of information on cost, few patients or providers know the cost of health care, and information regarding procedure prices is either not disclosed or not readily available to patients or physicians.[31] In terms of information on effectiveness, the usefulness of treatments or the exact causes of diseases may not be clear even to physicians because of imperfect or unclear evidence bases. Furthermore, for a variety of reasons, the facts that are known about treatment efficacy are not always imparted to consumers.[32]

In terms of information on quality, it is not clear that physicians and hospitals will want information about performance and safety records to become widely known. For example, currently, physicians and hospitals are hesitant to disclose information regarding medical errors for fear of litigation. To combat this, Congress recently passed the Patient Safety and Quality Improvement Act[33], which gives legal protection to physicians who voluntarily provide information about medical errors.[34] As another example, pay-for-performance measures, or rewarding physicians financially for higher-quality care, are being met with mixed reactions in the private insurance market, in part because of resistance by physicians to scrutiny of their performance records.[35]

The tools that are currently available to provide information on cost, effectiveness, and quality are mostly on the Internet. However, lower-income and less well-educated patients are less likely to have access to the Internet. According to the Current Population Survey in August 2000 by the U.S. Census Bureau, only 19% of households with incomes below $25,000 had at-home Internet access, compared to 79% of households with incomes of $75,000 or more. In addition, a mere 46% of adults with only a high school diploma had access to a computer at home, compared to 78% percent of adults with a bachelor's degree or more.[36] Since income and education play a role in access to computers and the Internet and, therefore, access to consumer tools for quality and cost information, such tools – and health savings accounts themselves – do not appear to be actually designed with the intent of benefiting lower-income, less well-educated patients. Indeed, lack of access to the Internet precludes lower-income patients from making informed decisions about how to spend the money in their HSAs. Furthermore, the benefit either to immigrants, many of whom speak little to no English, can only be minimal at best.

Even if there were perfect information available, it is not at all clear that even well-educated and high-income patients would want to spend their limited time shopping around for health care services. Those who do choose to shop around for health care services are more likely to have an easier time

doing so if there is a large number of providers available in their geographic area. As was shown by the experience of the California's Health Insurance Plan Cooperative, cost-conscious decision making tends to be more effective in urban areas than rural areas due to the higher density of providers and plans in the former.[23] Patients in areas with few providers and hospitals do not have the option of shopping around, as their choices are limited.

Effects on the Physician-Patient Relationship

It has been asserted by Goodman, as well as by Dr. Edward Langston of the American Medical Association, that health savings accounts will strengthen the patient-physician relationship. They argue that physicians will act in the best interest of their patient not only medically, but also economically. They also argue that since money to pay for procedures will come from the patient's own bank account, wasteful spending will decline. Langston states:

> When spending comes from the patient's personal HSA, patients and their physicians have a strong incentive to balance the costs of medical procedures against the potential favorable impact on health.[7]

Meanwhile, Goodman argues that "[Physicians] must become economic agents as well – helping patients minimize the cost of high quality care. Patients will make better choices if they can rely on doctors who put their medical and economic interests first."[6]

However, it is difficult to predict absolutely that physicians will embrace the additional responsibility of being "economic agents" for patients. Not only will this take time, but it may also encourage physicians to provide the cheapest care, instead of the best care. Furthermore, the overt transformation of the patient into a consumer through HSA/HDHP plans may itself transform the physician-patient relationship into a seller-buyer relationship. Finally, some cost-conscious patients may start to question everything that they are prescribed, which may serve to undermine the trust for their physician that is so vital to good patient care.

The idea of eliminating wasteful spending by asking both the patient and the physician to weigh the cost of care versus the chance of favorable outcomes also ignores the key issue of patient compliance. Currently, the relative lack of financial barriers for the well-insured allows them to obtain the care that they need. However, HDHP's erect an obstacle to obtaining this care. If patients constantly ignore their physician's advice because they do not judge the n a case where the physician believed a treatment to be medically necessary despite the cost and the patient did not consider the cost-benefit ratio low enough to warrant spending money, the patient-physician relationship would suffer.

Coverage for the Working Uninsured

Proponents of HDHPs believe that they can help alleviate the problem of uninsurance in the United States because HDHPs tend to have lower premiums. As John Snow, Secretary of the Treasury, pointed out, "more people can afford high deductible insurance than insurance that is not high deductible."[15] However, such thinking assumes that giving the uninsured low-quality, non-comprehensive insurance plans is an acceptable solution to the problem of uninsurance. At best, HSAs merely shift the problem of uninsurance to one of underinsurance, especially for patients who cannot afford to make significant contributions to their HSAs. At worst, as mentioned above, HSAs may actually increase the number of uninsured by setting off the death spiral of premiums in traditional health insurance plans.

Another argument put forth by proponents of HDHPs is that the savings employers realize from the lower premiums of HDHPs will be passed along to workers. For example, Dr. Langston of the AMA has claimed that the lower premiums of HDHPs will allow employers to contribute more money to HSAs.[7] However, there is no guarantee that employers will use those savings for that purpose. In fact, a recent survey of employer health benefits showed that one in three employers offering HDHPs did not contribute to their employees' HSAs.[34]

Many of the working uninsured choose not to participate in employer-sponsored insurance because rising premiums for traditional comprehensive plans have prompted employers to shift more of the cost of insurance to their employees.[37] In 2004, the employee contribution towards health insurance premiums increased by 10%, while workers' wages only increased by 2.2%.[38,39] In effect, employers have an incentive to shift the cost of health insurance onto employees to save money.[40] Given this, it seems unlikely that employers will spontaneously offer to give additional money to employees for their HSAs.

The Purpose of Health Insurance

The struggle between traditional insurance and HDHPs represents a significant philosophical debate about the purpose of health insurance. Proponents of HDHPs believe that the purpose of health insurance is to protect against catastrophic costs, just as other forms of insurance do. For example, Secretary Snow has referred to HSAs and HDHPs as "real insurance," likening such plans to auto or home insurance.[15] In the same way that auto insurance does not cover oil changes, muffler replacements, and other routine maintenance, many HDHP proponents believe that health insurance should not cover routine medical care, physical exams, and other non-catastrophic costs.

The opposing philosophy is that the purpose of health insurance is to promote health by removing financial barriers to health care. According to this line of thought, it is both morally and economically imperative to maximize health by including comprehensive benefits in health insurance. In addition, to argue that health insurance should serve the same purpose as auto insurance is to treat health as an equivalently important entity as automobiles. However, as Robert Greenstein of the Center on Budget and Policy Priorities put it: "…You can live without a muffler, and you can live without a washing machine, but you cannot live without health care, and what is what we are talking about. That is why [HDHPs are] such a bad idea."[41] It is morally acceptable to allow auto insurance to only cover catastrophic costs, because people do not die if they cannot afford an oil change for their car. On the other hand, 18,000 people die prematurely each year because of a lack of health insurance. The considerations in designing health insurance should therefore be different from the considerations in designing other types of insurance.

Individualism vs. Community

The other major philosophical issue raised with HSAs and HDHPs is that of the individual good vs. the societal good. The model of health insurance propagated by HSAs is one of individual ownership of health insurance – the idea that health insurance should be designed only to maximize the individual good. As discussed above, HSAs break up insurance risk pools by attracting younger, healthier patients. When this happens, the subsidization of the costs of older, sicker patients does not occur, and such patients are then left to to fend for themselves against skyrocketing premium. While individuals who are younger and healthier may benefit individually from HSAs, society as a whole suffers from the resulting inequities in health insurance.

In contrast, the social model of health insurance, which is espoused by every other industrialized country in the world, represents the idea that health care is a societal good. In this model, it is

everyone's responsibility to insure that people have few financial barriers to health care, which means that the healthy must subsidize the sick. This is not an altruistic enterprise; indeed, in exchange for paying more in premiusm than they use in benefits, the healthy also obtain security against high health care costs healthy should they need it.

Traditional health insurance in America leans more towards the latter model, and the advent of HSAs/HDHPs represents an attempt to move towards the individual ownership model. In a greater political context, HSAs/HDHPs actually represent one major piece of a larger attempt to move all of America towards an ownership society; the recent attempts to privatize Social Security represent another piece.

Early Experience with HSAs

An October 2005 study conducted by the Commonwealth Fund and Employee Benefit Research Institute was one of the first to reveal initial trends in consumer behavior and attitudes in response to the growth of HSAs and HDHPs. The findings were consistent with many of the arguments against the spread of these plans. First, although people enrolled in consumer-driven health plans (those combining high-deductible health plans and health savings accounts) or high-deductible health plans alone were more likely to consider cost when deciding whether to seek medical care or buy medication, they were also more likely to go without care. Second, out-of-pocket costs – measured as percentage of income spent on out-of-pocket costs and premiums – were higher for those in consumer-driven health plans and high-deductible health plans than for those in comprehensive health plans. Third, people in consumer-driven and high-deductible health plans – especially those with chronic conditions or incomes less than $50,000 – were more likely to avoid health care due to costs than those in comprehensive plans. Fourth, the study found that cost and quality information about providers was not provided by many health plans.

Finally, and most importantly, the study found that only 42 percent of people in consumer-driven health plans and 33 percent in high-deductible health plans were extremely or very satisfied with their plan, versus 63 percent of those in comprehensive health plans. Given these findings, it seems unlikely that consumer-driven health care will solve America's health insurance problems.[42]

What is AMSA's Policy?

The American Medical Student Association's official position on health savings accounts is that they "establish tax-exempt investment accounts which primarily benefit older and wealthier individuals, discourage preventive care, discriminate against less-healthy individuals, serve little benefit for low-income or uninsured individuals, and reduce affordable, low-deductible health insurance coverage."[43]

The current trend towards HDHPs and HSA will cause America to be even less insured that it was before. In a time when there are 45 million uninsured people and millions more who are underinsured, AMSA believes that what society needs is more insurance, not less.

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[1] Center for Policy and Research, America's Health Insurance Plans. "Number of HSA Plans Exceeded One Million in March 2005." 2005.
[2] United States Department of the Treasury. "All About HSAs" Presentation. May 17, 2005.
[3] United States Department of the Treasury. "Health Savings Accounts" Brochure. April 2005. http://www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa_tri-fold_brochure.pdf. Accessed June 13, 2005.
[4] Flexible Spending Account Program for Federal Employees (FSA Feds). "Frequently Asked Questions: What are FSAs?" https://www.fsafeds.com/fsafeds/faq.asp#g1. Accessed July 7, 2005.

[5] Saleem, H.T. "Health Spending Accounts." United States Department of Labor, Bureau of Labor Statistics. Originally posted October 29, 2003. Revision posted December 19, 2003. www.bls.gov/opub/cwc/cm20031022ar01p1.htm. Accessed July 7, 2005.
[6] Goodman, J.C. President, National Center for Policy Analysis. Statement on Health Savings Accounts. Testimony Before the U.S. Senate Special Committee on Aging. May 19, 2004.
[7] Langston, E.L. Trustee, American Medical Association. Statement to the Special Committee on Aging, United States Senate, Re: "Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future?" May 19, 2004.
[8] Simantov, E., Schoen, C., Bruegman, S. "Market Failure? Individual Insurance Markets For Older Americans." *Health Affairs*. Vol 20:4. July/August 2001.
[9] Hwang, W., Weller, W., Ireys, H., Anderson, G. "Out-Of-Pocket Medical Spending For Care Of Chronic Conditions." *Health Affairs*. Vol 20: 6. November/December 2001.
[10] Greenstein, Robert. Executive Director, Center on Budget and Policy Priorities. Hearing on "Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future?" before the Senate Special Committee on Aging. May 19, 2004.
[11] Tollen, L., Ross, M., Poor, S. "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana, Inc." *Health Services Research* 39 (4, Part II): 1167-1187.
[14] Greenstein, R. Transcript of statement to the Senate Special Committee on Aging. May 19, 2004.
[15] Gruber, J. "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals." Henry J. Kaiser Family Foundation. March 2004.
[16] Scandlen, G. "Health Savings Accounts." *Health Issues*. Galen Institute. December 17, 2003.
[17] Statement of Hon. John W. Snow, Secretary, U.S. Department of the Treasury, Washington, DC, before the U.S. Senate Special Committee on Aging. May 19, 2004.
[18] Galen Institute. "Consensus Group: Participants." www.galen.org/conpart.asp. Accessed June 15, 2005.
[19] Williams, Ronald. "Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future." Testimony Before the Special Committee on Aging of the U.S. Senate. May 19, 2004. See also http://www.aetna.com/public_policy_issues/health_savings_accounts.htm.
[20] Definity Health Corporation. "Galen Institute Briefing on Consumer Choice Health Care." February 11, 2004.
[21] Destiny Health Corporation. "Debunking the Myths of Consumer-Driven Healthcare." Destiny Health Presentation to Galen Institute. February 11, 2004.
[22] Physicians for a National Health Program. "Gail Shearer's JEC Testimony on 'Consumer-Driven' Healthcare." February 26, 2004. http://www.pnhp.org/news/2004/february/gail_shearers_jec_te.php. Accessed August 3, 2005.
[23] Universal Health Care Action Network. "The Dangers of 'Consumer-Driven' Health Care Are Many." February 25, 2004. http://65.61.27.230/files/issues/consumerdrivenhc.html. Accessed June 15, 2005.
[24] Shearer, Gail. Director, Health Policy Analysis, Consumers Union. Testimony Before the Joint Economic Committee On Impact of 'Consumer-Driven' Healthcare on Consumers. February 25, 2004.
[25] Buchmeuller, T.C. "Managed Competition in California's Small-Group Insurance Market." *Health Affairs*. Vol 16:2. March/April 1997. 218-228.
[26] Aetna HealthFund study. Aetna press release, February 16, 2004. www.aetna.com.
[27] "Frequently Asked Questions about HSAs." http://www.hsafinder.com/faq.shtml. Updated 11/30/04. Accessed August 4, 2005.
[28] Wagner, E.H., et al. "Effect of Improved Glycemic Control on Health Care Costs and Utilization." JAMA. January 10, 2001. Vol 285:2. 182-189.
[30] Transcript of statement of John C. Goodman, PhD, President, National Center for Policy Analysis, Dallas, TX, before the U.S. Senate Special Committee on Aging. May 19, 2004.
[31] Davis, K. Consumer-Directed Health Care: Will It Improve Health System Performance? *HSR: Health Services Research* 39:4, Part II. August 2004. 1228.
[32] McNeill, D. "Do Consumer-Directed Health Benefits Favor The Young And Healthy?" *Health Affairs*. Vol 23:1. January/February 2004. 186-193.
[33] Freking, K. "Bill for Reporting Medical Errors Cleared." *Washington Post*. July 27, 2005. http://www.washingtonpost.com/wp-dyn/content/article/2005/07/27/AR2005072701714.html. Accessed August 6, 2005.
[34] S. 544. Bill Summary & Status for the 109th Congress. http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN00544:@@@D&summ2=m&. Accessed August 6, 2005.
[35] Vladeck, B.C. "Letters: Ineffective Approach." Health Affairs. Vol 23:2. March/April 2004. 285-286.
[36] US Department of Commerce, US Census Bureau. "Home Computers and Internet Use in the United States: August 2000." Issued September 2001.
[37] Henry J. Kaiser Family Foundation. "Employer Health Benefits 2005 Annual Survey" September 14, 2005. http://www.kff.org/insurance/7315/sections/upload/7316.pdf. Accessed November 1, 2005.

[38] Henry J. Kaiser Family Foundation. "Employer Health Benefits 2004 Annual Survey" September 9, 2004. http://www.kff.org/insurance/7148/upload/2004-Employer-Health-Benefits-Survey-Summary-of-Findings.pdf. Accessed November 1, 2005.
[39] Henry J. Kaiser Family Foundation. "Employer Health Benefits 2003 Annual Survey" September 9, 2003. http://www.kff.org/insurance/upload/Kaiser-Family-Foundation-Summary-of-Findings.pdf. Accessed November 1, 2005.
[40] Feldman, A., Carbonara, P. "Are You Ready To Own Your Health Care?" *Money*. Vol 33:11. November 2004. 135-140.
[41] Transcript, U.S. Senate Special Committee on Aging. May 19, 2004.
[42] "Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey." EBRI Issue Brief No. 288. December 2005. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3606. Accessed January 15, 2006.
[43] American Medical Student Association. "Principles Regarding Health-Care Delivery and Delivery Systems." http://www.amsa.org/about/ppp/delivery.pdf#zoom=120,40,50. Accessed August 3, 2005.