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# Making HSAs Better

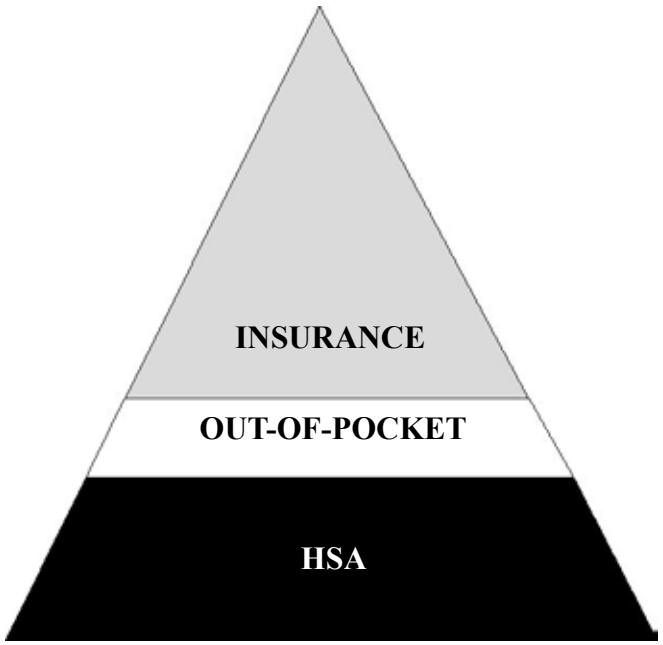
**by John C. Goodman**

Health Savings Accounts (HSAs) are having an enormously beneficial effect on the design of health insurance in this country. Instead of an employer or insurer paying medical bills, more than one million people are managing some of their own health care dollars. Instead of relying solely on third-party insurance, people can now partly self-insure through these accounts. Yet despite their many advantages, HSAs can be made even better**.**

**Making Incentives Better.** Not all medical services are the same. Patients *can* exercise discretion for many of their health care needs, and it is *appropriate* for them to do so. Take arthritic pain relief. The annual cost of brand-name drugs is typically $800 more than over-the-counter substitutes and they are riskier. (Vioxx and Betra, for example, have been removed from the market.) Is the extra cost and risk worth the marginal improvement in pain relief offered by a prescription drug? Since drugs affect people differently, none of us can determine for another individual whether the tradeoff between cost and pain relief is worthwhile. So it is appropriate and desirable for people to make these decisions themselves, and reap the benefits and bear the costs of their decisions.

By contrast, a semiconscious patient on a gurney is not in a position to make choices about alternative treatments. Even if he could, discretion in this setting is typically *inappropriate*. Or consider the case of a diagnosed schizophrenic. He may choose to stop taking his prescribed medication, but it's in our self-interest to make sure he is not encouraged to do so.

**FIGURE I**
**Current Law**




Unfortunately, the HSA law treats all these cases the same. It requires a high, across-the-board deductible and requires the patient to bear the costs of purchases below the deductible amount. [See Figure I.] A better approach would allow insurers to design their plans so that different deductibles (and copayments) apply to different medical services. Where patient discretion is possible and appropriate, the deductible should be high. Where patient discretion is more difficult, and in any event inappropriate, the deductible should be low or nonexistent.

**Creating Opportunities for the Chronically Ill.** The chronically ill are responsible for an enormous amount of health care spending. In fact, almost half of all health care dollars are spent on patients with five chronic conditions (diabetes, heart disease, hypertension, asthma and mood disorders)**.** This is where HSAs have the greatest potential to reduce costs and improve the quality of care.

Healthy people tend to interact with the health care system episodically. Once in awhile they go to the emergency room or take a prescription drug. On these occasions, they gain knowledge that improves their skills as medical consumers. But it may be several years before they use that knowledge again, by which time it may be obsolete.

The chronically ill are different. Their treatments are usually repetitive, requiring the same procedures, visits and/or medicines, week after week, year after year. Consequently, cost-saving discoveries by these patients are not one-time events. Rather, they pay off indefinitely. Suppose a diabetic patient learns how to cut the costs of her drugs in half, by comparing prices, shopping online,

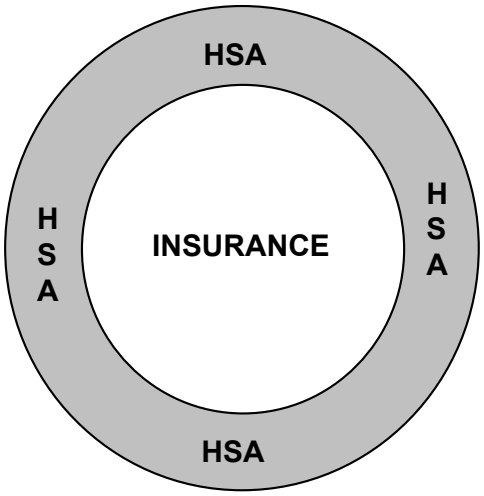
bulk buying, pill splitting or switching to a generic brand. Such a discovery could be financially very rewarding to a patient who must pay these costs out of pocket.

Numerous studies have found the chronically ill can reduce costs and improve quality by managing their own care. But health care management is difficult and time consuming. So patients should reap both health rewards *and* financial rewards from making better decisions. Insurers should be able to create versatile HSA accounts for patients with differing chronic conditions. They should be able to adjust the accounts' funding to fit specific circumstances. A typical Type II diabetic, for example, might receive one level of HSA deposit from his employer; a typical asthmatic patient another.

The problem is: The HSA law requires employers to deposit the same amount to each employee's HSA account, irrespective of medical condition. This is a strange requirement because employers who give employees choices of health plans are risk-rating their premium payments whether they are aware of it or not. If the sickest employees all choose Plan B and the healthiest choose Plan A, then the employer will invariably pay more premiums per employee to Plan B. Although employers risk-rate their premium payments, they are not allowed to risk-rate HSA deposits.

**FIGURE II**

**Wrap-Around HSA**




**Letting Markets Work.** The current HSA law's primary problem is that decisions the market should make have been made by the tax-writing committees of the U.S. Congress instead.

What is the appropriate deductible for which service? How much should be deposited in the HSAs of different employees? How can we use these accounts to meet the needs of the chronically ill? In finding answers, markets are smarter than any one of us because they benefit from the best thinking of everyone. Further, as medical science and technology advance, the best answer today may not be the best answer tomorrow.

**Case Study: South Africa.** HSAs (called Medical Savings Accounts) emerged in the 1990s in Nelson Mandela's South Africa and have now captured more than half the market for private health insurance there. Since the South African government never passed a law dictating an HSA design, their plans developed in a relatively free market. The South African "free market HSAs" are different, and in some ways more attractive, than what we have in this country. For example, one of the most popular plans there offers first-dollar insurance coverage for most hospital procedures — on the theory that hospitalized patients have little opportunity to make choices, and discretion is not appropriate in that setting in any event. A high deductible applies to "discretionary" expenses, however, including most services delivered in doctors' offices.

South Africa's more flexible approach also allows more sensible drug coverage. While a high deductible applies to most drugs, a typical plan pays from the first dollar for drugs that treat diabetes, asthma and other chronic conditions. The reason is obvious: It would be counterproductive to encourage patients to skimp on drugs that prevent more expensive-to-treat conditions from developing.

**Conclusion.** Ideal reform in this country would allow unlimited contributions to HSAs and permit such accounts to wrap around third-party insurance — paying for any expense the insurance plan does not pay. [See Figure II.] Barring that, we should at least allow flexible deductibles and risk-rated deposits to HSAs.

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