Statement

on

Health Savings Accounts

by

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Introduction

As of January 1, 2004, 250 million nonelderly Americans now have access in principle to Health Savings Accounts (HSAs), provided they are combined with catastrophic insurance. The idea behind HSAs is quite simple. Individuals should be able to manage some of their own health care dollars through accounts they own and control. They should be able to use these funds to pay expenses not paid by third-party insurance, including the cost of out-of-network doctors and diagnostic tests. They should be able to profit from being wise consumers of medical care by having account balances grow tax free and eventually be available for nonmedical purchases.[1]

Reforming the Health Care System

HSAs have the potential to inaugurate fundamental reform in the way health care is practiced in this country.

Creating a Level Playing Field between Third-Party Insurance and Individual Self Insurance. Health Savings Accounts are designed to help correct a major flaw in tax law that distorts the entire health care system. Every dollar an employer pays for employee health insurance premiums avoids income and payroll taxes. For a middle-income employee, this generous tax subsidy means that government is effectively paying for almost half the cost of health insurance. On the other hand, the government previously taxed away almost half of every dollar employers put into savings accounts for employees to pay their medical expenses directly. The result was a tax law that lavishly subsidized third-party insurance and severely penalized individual self insurance. This has encouraged consumers to use third-party bureaucracies to pay every medical bill, even though it often makes more sense for patients to manage discretionary expenses themselves.

The new law, part of the recently-enacted Medicare prescription drug bill, gives deposits to HSAs the same tax advantages formerly granted only to health insurance premiums. Employer and employee deposits to HSAs will avoid all federal income and payroll taxes. When combined with individually owned insurance, HSA deposits will be a deductible expense, even for income tax filers who do not itemize. The insurance premiums, however, are not deductible unless the purchaser is self-employed.

Making Choices. Medical research has pushed the boundaries of what doctors can do for us in every direction. As a result we could probably spend the entire gross domestic product on health care in useful ways:[2]

- The Cooper Clinic in Dallas now offers a comprehensive checkup (with a full body scan) for about $2,500. If everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by one-half.
- There are more than 900 diagnostic tests that can be done on blood alone, and one doesn't need too much imagination to justify, say, $5,000 worth of tests each year. But if everyone did that we would almost double the nation's health care spending.

- Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought a physician's advice before making such purchases, we would need 25 times the current number of primary care physicians.[3]
- Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another.[4] At, say, $1,000 a test, it would cost more than $1 million for a patient to run the full gamut. But if every American did so, the total cost would be about 30 times the nation's total output of goods and services![5]

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. In these examples, we are simply collecting information. If in the process we actually found something that warranted treatment, we could spend even more.

So how do we decide which procedures are worthwhile and which are not? There are basically only three ways. In other developed countries, these decisions are made either directly or indirectly by government. But government-imposed rationing is arbitrary, inefficient, unfair and probably unacceptable to most Americans. The second method is to restrain spending using managed care techniques. But during the 1990s voters expressed discomfort with having employers and large insurers ration their health care. The third option is to allow individuals to make their own choices between spending on health care or other needs, through a vehicle such as HSAs.

Restoring the Doctor-Patient Relationship. In a managed care world, doctors too often look to employers and insurers for direction in the practice of medicine. In a very real sense, providers view insurers rather than patients as their customers. For example, if a patient is covered by Blue Cross, providers tend to view Blue Cross rather than the patient as the real buyer of care. How symptoms are treated, what tests are ordered, what follow-up procedures are indicated — all such decisions tend to be heavily influenced by Blue Cross guidelines rather than the wishes and needs of individual patients. Similarly, for Medicare patients, Medicare is the real buyer of care; for Medicaid patients, the buyer is Medicaid, etc.

With HSAs, patients become the primary buyers of health care services with the right to compare prices and treatments, and to make decisions. Doctors are free to serve as the principal agents of patients and advise them on options — helping them make informed decisions. However, physicians must be more than medical agents of their patients. They 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.

Creating Portability. One disadvantage of employer-based insurance is that employees must switch health plans whenever they switch employers. In the old fee-for-service days, this defect imposed less of a hardship because employees were generally free to see any doctor under any plan. Today, however, changing jobs often means changing doctors as well. For an employee or family member with a health problem that means no continuity of care. Because HSA funds are portable, they can travel with employees on their journey through the labor market. They are a step in the direction of truly portable heath insurance coverage.

Ten Advantages of Health Savings Accounts[1]

Saving Money. When people purchase medical care with funds in a HSA, they are spending their own money rather than someone else's. As a result, they tend to become careful, prudent consumers in the medical marketplace.

Restoring the Doctor-Patient Relationship. Bureaucratic efforts to control costs often interfere with the doctor-patient relationship. With HSAs, patients and doctors are encouraged to manage the care.

Maintaining the Quality of Care. Bureaucratic efforts to reduce costs can also threaten the quality of patient care. To the degree that patients are spending their own money, and doctors are free to act as the agents of their patients, there are natural forces in place to maintain quality.

Encourage Rationing by Choice. Unless someone makes the difficult choice between medical care and other uses of money, we could spend the entire GDP on health care. HSAs allow individuals — rather than large, impersonal bureaucracies — to make those decisions.

Creating a Competitive Marketplace. Most patients cannot discover the price of even routine procedures before entering a hospital and cannot decipher the bill when they are discharged. But with HSAs, a single package price stated in advance will become the norm as is the case with cosmetic surgery in the United States and privately paid surgery in England.

Providing Funds for Preventive Care. HSAs are source of funds for services not covered by third-party health insurance.

Providing Funds for Health Insurance Premiums. HSAs provide funds to continue health insurance coverage when people are unemployed.

Providing Funds for Long Term Care. HSA funds not spent during a person's working years will be available for long-term care, long-term care insurance and other post-retirement medical needs not met by Medicare.

Creating Real Insurance. With HSAs, health insurance will be likely to resemble casualty insurance in other markets — paying for risky, unforeseen, costly medical episodes and allowing individuals to pay directly for other forms of care.

Creating Personal and Portable Employee Benefits. HSAs will be the private property of the individual account holder. Their establishment would be a movement in the direction of a worthwhile social goal: making all employee benefits personal and portable.

[1] See John C. Goodman and Gerald L. Musgrave, "Personal Medical Savings Accounts (Medical IRAs): An Idea Whose Time Has Come," Policy Backgrounder No. 128, National Center for Policy Analysis, July 22, 1993, p. 3.

Advantages and Disadvantages of Other Types of Savings Accounts[6]

Besides Health Savings Accounts (HSAs), several well-known mechanisms for consumer-directed spending are Flexible Spending Accounts (FSAs), Medical Savings Accounts (MSAs) and Health Reimbursement Arrangements (HRAs).

Medical Savings Accounts. These accounts became available to small businesses and the self-employed through a 1996 pilot program. Unfortunately, Congress imposed restrictions on MSAs that limited their appeal. For example, the size of the deductibles and MSA deposits were unduly restricted. Because of the short duration of the pilot project, as well as a cap on the number of participants, few insurance companies were interested in competing for a limited market. Due to these many restrictions, only about 70,000 people were able to take advantage of these accounts.

Flexible Spending Accounts. These accounts offer employees the chance to set aside funds tax free for medical care. Employees with FSAs usually fund these accounts through pretax deductions from their paychecks.[7] However, the popularity of these accounts is limited by restrictions on their funding and use. For example, FSAs have a use-it-or-lose-it provision. The law requires employees to forfeit any unused funds at the end of the year, even though they had to decide at the beginning of the year how much to deposit each month. Failure to accurately predict their health care spending means sacrificing the end-of-year balance or engaging in last-minute spending on items of marginal value.[8] This forfeiture provision encourages employees to waste money on unnecessary care and makes most people apprehensive about depositing money except when they can precisely predict their future medical needs. This is one reason why, of the estimated 29 million employees with access to such accounts, only about six million use FSAs to pay medical bills. Far more use the accounts solely to pay their portion of health insurance premiums.

Although FSA deposits are made from the employee's paycheck, employees do not really own their FSAs. Not only is the account balance forfeited at year's end or with a change in jobs, the employee's heirs are not entitled to the funds in case of death. These restrictions need to be changed. On May 12, 2004, the House of Representatives passed a bill that would allow individuals to roll over up to $500 of unused FSA account funds to the following plan year or to move it into an HSA for use in the next year.[9] Employees should also have other options for saving unspent FSA balances, including rolling over accumulated balances into other tax-deferred accounts — IRAs, 401(k)s and 403(b)s.

Health Reimbursement Arrangements. These are another type of personal account from which employees can pay directly for their medical care. A U.S. Treasury Department ruling in 2002 clarified that employer deposits to HRAs are not taxable employee compensation and can be rolled over from year to year. A number of large companies have established such accounts,[10] and at last count, 1.5 million employees had enrolled.[11]

Unfortunately, these accounts also face unreasonable restrictions.[12] Currently HRA funds must be spent only on qualified medical services. This means employees can never withdraw their HRA funds as cash for nonmedical uses and that they are barred from choosing between health care and other uses of the money.

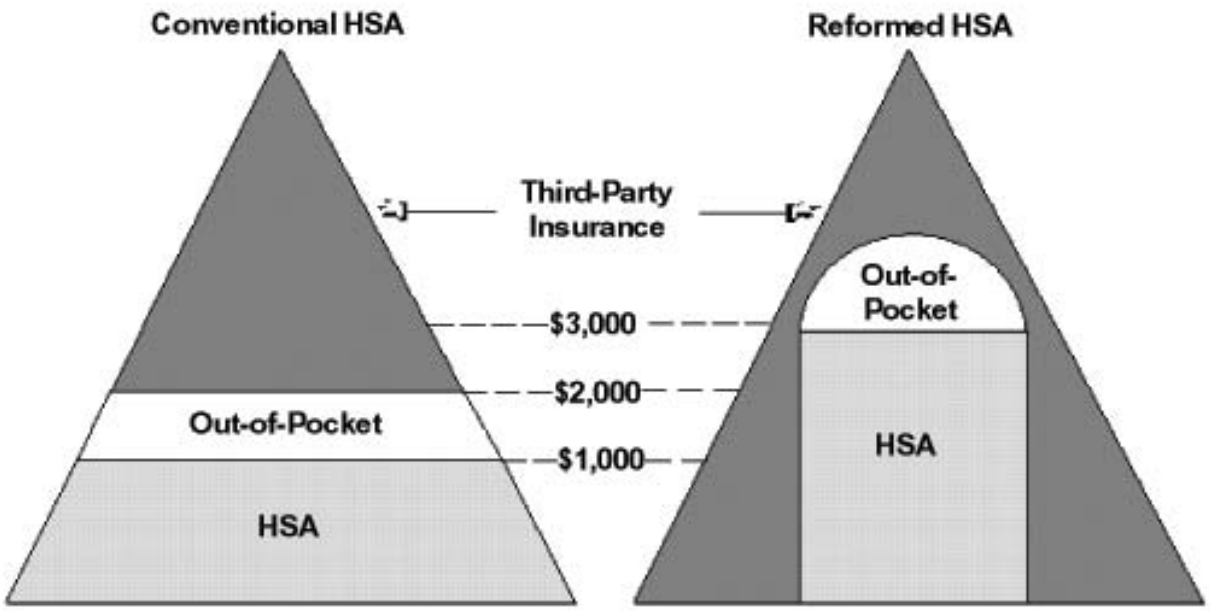
Making HSAs Better

In principle, 250 million Americans are eligible to establish Health Savings Accounts. But because of restrictions imposed by Congress many will not be able to do so. Congress required that HSAs be accompanied by a traditional indemnity insurance plan with a specified deductible and specific limit on total out-of-pocket expenses. Less restrictive HSAs would allow individually tailored insurance to serve the needs of each patient, rather than imposing a one-size-fits-all solution.

HSA Design. The left side of Figure I illustrates the most common design of HSAs in employer plans. The plan pays all costs above a deductible of, say, $2,000. The HSA deposit in this example is $1,000. Thus the employee pays the first $1,000 of medical expenses from the HSA and the next $1,000 is paid out of pocket. Any remaining costs are paid by the plan.

However, this is not necessarily the ideal way to design HSAs. The design pictured on the right side of Figure I is preferable because the plan pays first-dollar for some treatments, while leaving the insured free to pay higher amounts for other services. For instance, it makes little sense to require high deductibles for hospitalization since this is likely beyond the control of patients. Likewise, offering first dollar coverage (or lower deductibles) for chronic illnesses might improve compliance and save money over the long term.

FIGURE I



The South African Experience. In South Africa, beginning under the administration of Nelson Mandela, Medical Savings Accounts (MSAs) became available that could be combined with any form of third-party insurance. These MSAs are similar to the new HSAs in the United States, but without restrictions.

In South Africa, MSA plans have captured about two-thirds of the market for private health insurance. However, the most popular plans in that country are not allowed under the rigid parameters set for the U.S. market.

In the United States, federal law dictates what the insurance contract must look like. In particular, the health insurance policy that accompanies an HSA must have an across-the-board deductible of at least $1,000 for an individual or $2,000 for a family, with exceptions for preventive care.

In a typical South African plan there is no deductible for hospital care, on the theory that patients are exercising very little discretion in a hospital setting. By contrast, there is roughly a $1,200 deductible for out-patient care on the theory that patients exercise a lot of discretion with respect to those services.

Most drugs also face a high deductible. When the insurer wants to encourage drug therapies, however, the deductible may drop back to zero. This flexible approach encourages patients to make prudent choices when patient discretion is appropriate, but not when discretion is inappropriate.[13]

There are also other interesting innovations. For example, diabetics can enroll in a center of excellence for diabetic care. They pay one-third of the cost from their MSA, while the employer (or insurer) pays the other two-thirds.

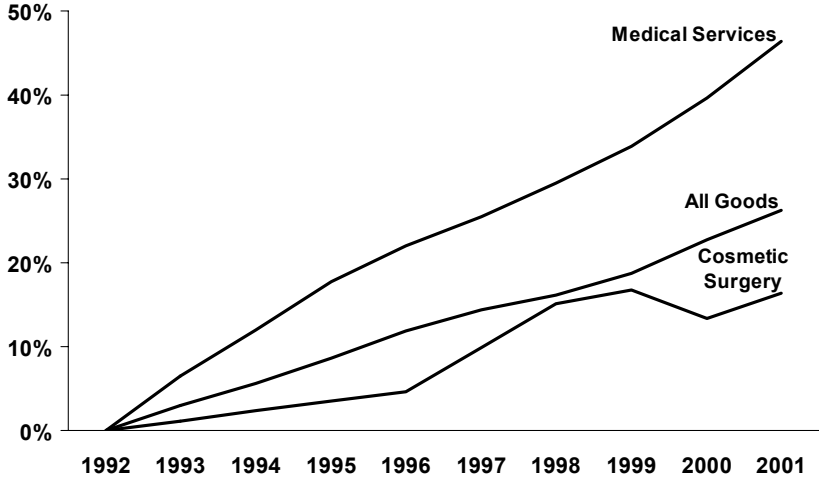
Case Study: Cosmetic Surgery[14]

Cosmetic surgery is one of the few types of medical care for which consumers pay almost exclusively out of pocket. Even so, the demand for cosmetic surgery exploded in recent years. Of the 6.6 million cosmetic procedures performed in 2002, 1.6 million were surgical procedures, nearly four times the number performed in 1992. Despite the quadrupling of the number of surgeries, cosmetic surgeons' fees remained relatively stable. The average increase in prices for medical services from 1992 through 2001 was 47 percent. (See Figure II.) The increase in the price of all goods, as measured by the Consumer Price Index (CPI), was 26 percent. Cosmetic surgery prices went up about 16 percent. Thus, while the price of medical care generally rose almost twice as fast as the CPI, the price of cosmetic surgery went up less than two-thirds as much. Put another way, while the real price of general health care rose, the real price of cosmetic medicine fell.

What explains this price stability? One reason is patient behavior. When patients pay with their own money, they have an incentive to be savvy consumers. A second reason is supply. As more people demanded the procedures, more surgeons began to provide them. Since almost any

FIGURE II

Price Increases for Medical Services and Cosmetic Surgery



Source: Author's calculations using data from the Consumer Price Index (CPI) and the American Society of Plastic Surgeons.

Note: Cosmetic surgery index is calculated based on average price of common procedures weighted by their respective proportion of all cosmetic procedures. Procedures selected represent 54 percent of all cosmetic procedures performed.

licensed medical doctor may obtain training and perform cosmetic procedures, entry into the field is relatively easy. A third reason is efficiency. Many providers have operating facilities located in their offices, a less expensive alternative to outpatient surgery at a hospital. Surgeons generally adjust their fees to stay competitive and usually quote patients a package price. Absent are the gatekeepers, prior authorization and large medical office billing staffs needed when third-party insurance pays the fees. A fourth reason is the emergence of substitute products. For example, cheaper procedures designed to reduce the appearance of aging have held the cost of facelift surgery in check. These include laser resurfacing, Retin-A treatments, botox injections, collagen injections, chemical peels, dermabrasion and fat injection. These less invasive (and less expensive) procedures may be attractive, compared to a facelift costing $5,000 or more in surgeons' fees alone.

Cosmetic surgeons also have incentives to find new products to meet customer needs. Laser hair removal, for example, is now common.

Answering the Critics of Health Savings Accounts

Despite the fact that both economic studies and common sense suggest that patient power reforms are needed and desirable, there has been a steady stream of critics, repeating claims made more than a decade ago and seemingly impervious to a mountain of evidence that refutes them.

Will personal health accounts control costs? There is abundant evidence that HSAs change patient behavior and that those changes help control costs. A study of South African employees covered by Discovery Health Medical Savings Accounts plans found that:[15]

- Relative to those in non-MSA plans, MSA families reduced their health care spending significantly, ranging from a 56 percent reduction for families in which the head of household is relatively young to a 47 percent reduction for the elderly.
- On average, joining an MSA plan induces people to cut their discretionary spending by more than half.

A follow up study focused specifically on prescription drug costs. Among the findings:[16]

- Those purchasing prescriptions with insurance company money spent 7.1 percent more per prescription filled, and they filled 19.1 percent more prescriptions per month.
- Overall, those using insurance spent 27.6 percent more per month on prescriptions than those using a Medical Savings Account.

Preliminary evidence from the U.S. experience with HRAs suggests that we are experiencing similar cost control behavior. Employees with personal accounts tend to reduce the number of physician visits, switch from brand name drugs to generics and take other actions to reduce waste and inefficiency in health care consumption.[17]

Will personal health accounts encourage people to forgo needed care? Critics worry that people with HSAs will skimp on needed medical care in order to save money.[18] There is no evidence of this. In fact, the evidence shows that when people take responsibility for their own health care, they fare just as well as others.

HSAs have only been available for a few months in the United States, but we do have evidence from experience with HRAs. Employee behavior differs depending on the specific design of the health plan. That said, in several popular plans employees received more preventive care than those enrolled in traditional health insurance.

For example, enrollees in Definity Health's HRA plans received preventive care that met or exceeded widely-accepted standards of care — including several types of diabetes preventative testing, mammograms and medications to control asthma.[19] In fact, those enrolled in HRAs tended to participate in more preventive care than a control group.[20]

Among enrollees in Aetna HealthFund's HRA plan, preventive care office visits increased by 30.1 percent compared to a 14 percent increase for a similar population.[21]

Members of Destiny Health's HRA plan also receive preventative care at higher rates than traditional health insurance enrollees. They are more than twice as likely to say that lifestyle choices directly impact health care costs. Consequently, they were 147 percent more likely to participate in a wellness or nutrition program in the last year. They are more than twice as likely to have educated themselves about their health plan as members of other plans.[22]

These findings are consistent with the classic RAND Health Insurance Experiment which randomly assigned people to high-deductible plans. This research found that both groups (that is, high and low-deductible cost sharing) had similar outcomes even though those in high-deductible plans spent less on health care.[23]

Will personal health accounts appeal only to the healthy young people? Some of the critics of personal health accounts often argue that they will experience favorable selection by appealing only to the "young healthy" — leaving older, sicker individuals in traditional risk pools.[24] However, preliminary data show that the average age of Aetna's HealthFund HRA enrollees is slightly higher than in other plans, not lower as critics suggest. Overall, about two-thirds of HealthFund enrollees were between the ages of 35 and 55.

Will personal health accounts encourage employers to cut benefits and move employees into unpopular stripped down health plans? Employers do not need an excuse to cut benefits.[25] They provide health benefits to retain a competitive workforce. Where provided, health benefits are a nontaxable form of compensation. Employers do not "give" employees health benefits, employees accept health benefits in lieu of wages. For a given expenditure, it is in the employer's self-interest to choose a compensation package that is most attractive to employees.

In fact, enrollees in HRA plans have expressed a high degree of customer satisfaction. Ninety percent of those enrolled in Aetna's HRA plans reported satisfaction with their choice and were likely to renew for the following year.[26] In Definity Health's HRA plan, only about one percent to two percent reported being very dissatisfied.[27] Almost three-quarter of Destiny Health members agreed that consumer driven plans are better than managed care, compared to only about one-third of enrollees in other types of heath plans.[28]

Will personal health accounts force patients to pay higher prices for medical care? Critics of HSAs often claim they will be inefficient because cash-paying customers will pay "retail" while HMOs pay "wholesale." But in virtually all HSA plans, patients spending from their account pay the same prices their third-party insurer pays — rates negotiated with provider networks. In addition, cash-paying patients often find physicians willing to provide discounts for services paid for at the time of delivery — allowing doctors to avoid the cost and delay of billing and collecting from insurers.[29]

Conclusion

The concept of HSAs is not conservative or liberal. It's an empowerment idea. It should appeal to liberals who want an alternative to HMO rationing. It should appeal to conservatives who want an alternative to government rationing. It should appeal to everyone who suspects that impersonal bureaucracies care less about us than we care about ourselves. Giving employees more choice and control over their health care makes good sense. It leads to lower costs and more individual control.

[1] John C. Goodman, "Health Savings Accounts Will Revolutionize American Health Care," Brief Analysis No. 464, National Center for Policy Analysis, January 15, 2004.

[2] Ibid.

[3] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2 (Summer 1990), pp. 27-28.

[4] Michael Walholz, "Genetic Testing Hits the Doctor's Office" *Wall Street Journal*, December 3, 2003.

[5] The calculations are thus: the U.S. population of 288.4 million people multiplied by $1.1 million per capita for the battery of tests. The resulting figure of $317.2 trillion dollars is approximately 28.67 times the fourth quarter 2003 (annualized) gross domestic product of $11 trillion.

[6] For a brief analysis of the types of health accounts, see Michael F. Cannon, "Three Avenues to Patient Power," Brief Analysis No. 430, National Center for Policy Analysis, January 30, 2003.

[7] For a brief analysis on flexible spending accounts, see Michael F. Cannon, "Flexible Spending Accounts: The Case for Reform," Brief Analysis No. 439, National Center for Policy Analysis, May 13.

[8] Devon Herrick, "Health Reimbursement Arrangements: Making a Good Deal Better," National Center for Policy Analysis, Brief Analysis No. 438, National Center for Policy Analysis, May 8, 2003.

[9] H.R. 4279. There was no corresponding Senate bill.

[10] Regulations governing Health Reimbursement Arrangements (HRAs) were clarified by the IRS in June 2002 paving the way for large firms to begin considering them.

[11] Jon R. Gabel, Anthony T. Lo Sasso and Thomas Rice, "Consumer-Driven Health Plans: Are They More Than Talk Now?" *Health Affairs*, Web Exclusive, W407, November 20, 2002.

[12] Devon Herrick, "Health Reimbursement Arrangements: Making a Good Deal Better," Brief Analysis No. 438, National Center for Policy Analysis, May 8, 2003.

[13] John C. Goodman, "Two Cheers for the Bush Health Plan," Brief Analysis No. 465, National Center for Policy Analysis, January 30, 2004.

[14] This case study is based on Devon Herrick, "Why Are Health Costs Rising?" Brief Analysis No. 437, National Center for Policy Analysis, May 7, 2003.

[15] Shaun Matisonn, "Medical Savings Accounts in South Africa," Policy Report No. 437, National Center for Policy Analysis, June 2000.

[16] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," Policy Report No. 254, National Center for Policy Analysis, August, 2002.

[17] See Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004; and Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

[18] Michael F. Cannon, "Answering the Critics of Health Accounts," Brief Analysis No. 454, National Center for Policy Analysis, September 12, 2003.

[19] Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

[20] Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare" presentation at Galen Institute Briefing, "Consumer Choice Health Care: Reports From the Field," February 11, 2004.

[21] Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004

[22] Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare" presentation at Galen Institute Briefing, "Consumer Choice Health Care: Reports From the Field," February 11, 2004.

[23] For information about the RAND Health Insurance Experiment, see Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, Calif.: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review*, June 1987. The Rand study was conducted from 1974 to 1982. A $1,000 deductible over that period would be equivalent to a deductible between $1,899 and $3,718 today.

[24] Michael F. Cannon, "Answering the Critics of Health Accounts," Brief Analysis No. 454, National Center for Policy Analysis, September 12, 2003.

[25] Ibid.

[26] Robin Downey (Aetna), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004; and Aetna, "Aetna Research Shows Positive Impact of Consumerism on Health Care Decisions," Press Release, Aetna, February 16, 2004. Definity Health experienced similar results. See Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

[27] Results from Definity Health. See Michael Showalter (Definity Health), presentation at Galen Institute Briefing "Consumer Choice Health Care: Reports from the Field" February 11, 2004.

[28] Stuart Slutzky (Destiny Health), "Debunking the Myths of Consumer-Driven Healthcare."

[29] Rebecca Cook, "Fed Up with Insurance, some Doctors want Payment in Cash," Associated Press, April 5, 2004.