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Health Savings Accounts

Defining the Future of Health Care for Texans

By Devon M. Herrick
National Center for Policy Analysis

Many economists and health care experts predict that consumer-driven health insurance plans will soon replace managed care as the next big health insurance initiative. Approximately 88 percent of Americans with private health insurance are insured through their jobs, but there is a crisis of rising health insurance premiums. Additionally, there is a backlash against the rationing of care by third parties, such as managed care providers.

Consumer-driven plans may account for as much as half of the market for employer-sponsored health insurance within the next few years. This is a truly amazing development, considering that a couple years ago only about one percent of U.S. workers were enrolled in these plans.

The Problem With Health Care

People first began receiving coverage as a "non-cash" benefit during World War II because of wage controls. A few years later Congress confirmed that health insurance was exempt from taxable wages. The result is that many workers receive tax relief worth up to 40 cents or more for every dollar they spend through employer plans, but no tax benefit for funds paid for individual insurance. The same has been true of funds used to pay for incidental medical needs. As a result, coverage received in lieu of wages is more affordable than using after-tax wages to purchase health insurance. Thus most Americans today purchase health coverage through their employer and pay third parties to manage all their health care spending — including routine medical care.

Unfortunately, this has created a whole set of problems, including wasteful utilization, rising prices, fewer choices and, in many cases, rationing of care. From the standpoint of health economists, the essential problem in health care is too much third-party payment. Third parties – government, employers or insurance companies – pay for about 85 percent of all health care received today. The proportion of health care paid directly by consumers has been falling for years:

- In 1960, consumers paid about 56 percent of health care directly.
- In 1980, the proportion of health care costs borne directly by consumers had fallen to about 28 percent.
- Today, consumers pay about 15 percent of health care costs.

Most of the funds consumers pay directly for health care purchase over-the-counter (OTC) drugs, vision care, dental care and cosmetic surgery such as Lasik.

But, due to third-party payments, most medical services are free (or cost little) at the point of service. So consumers and doctors have the incentive to use as many services as insurers will pay for. In other words, if consumers only pay 15 percent of medical costs directly, they have an incentive to consume $1 of care

Texas Public Policy Foundation
411 Brazos Street, Suite 99
Austin, Texas 78701
(512) 472-2700
www.texaspolicy.com

until a dollar is only worth 15 cents to them. This is very inefficient, since patients would consume fewer medical services (and pay less for health care in the long run) if most incidental medical services were paid out-of-pocket rather than through an "all you can eat buffet" managed-care model.

Another problem with giving more control to third parties is that consumers have less power. When third parties control our health care, it will always be rationed. For instance, managed care was supposed to counter the tendency to over-utilize care by telling patients which medical services they needed and could have. This attempt to control the amount of medical services consumed resulted in a backlash from consumers. Third parties also have higher overhead and administrative costs since many of their procedures are designed to ensure that only appropriate care is given and claims are not fraudulent.

Finally, too much payment by third parties reduces patients' ability to express preferences and make tradeoffs as they do in other areas of their lives. It also creates a moral hazard. For instance, consumers do not bear the burden of their own poor lifestyle decisions. People who smoke or lead unhealthy lifestyles generally do not pay more for care, giving them little incentive to change their behavior. Likewise, people with first-dollar health (and drug) coverage are not penalized for wasteful health care spending for unnecessary physician visits. Nor are there incentives to choose low-cost generic drugs over name-brand drugs. Thus, we all have little incentive to be prudent consumers of health care.

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However, if patients controlled a portion of the money used to pay for incidental medical services and got to keep a proportion of any money saved, then the incentive to over-indulge would be sharply reduced. Economists know this. In a recent poll, two-thirds of the members of the National Association of Business Economics (NABE) said that consumer-driven health insurance is either very important or extremely important in controlling costs, improving access and increasing health care quality.

Research bears out this concept. Several decades ago, researchers with the RAND Corporation performed a series of health insurance experiments in which they provided randomized samples of participants with different levels of health care deductibles and cost-sharing. Those with higher co-pays and levels of cost sharing consumed about 30 percent less health care annually with no ill effects on health.

With experiments like this it became obvious that the key to improving health care and holding down prices is getting consumers involved in decisions regarding their own care. One of the ways employers are attempting to connect employees with decision-making is through defined contribution health insurance. Employers "define" their contributions while employees choose among the types of policies they purchase. An employee wanting a richer benefit package might have to contribute additional money out-of-pocket to cover the cost. On the other hand, employees choosing less expensive (high-deductible) health plans might have funds left over to deposit into a personal health account, such as a health savings account (HSA). This works because high deductible policies are less expensive than policies offering first-dollar coverage. The funds placed in an HSA are controlled by the employee and can be used to pay for incidental health care needs up to the health insurance policy deductible. Employees also may shore up these accounts by depositing additional funds into the HSA tax free. Balances not used can be invested in a fund of the enrollee's choosing.

How HSAs Work

HSAs are the most flexible, consumer-friendly accounts yet devised. They allow individuals and employers to make deposits each year equal to their health insurance deductible. The health insurance policy that must accompany an HSA is required to have an overall deductible of at least $1,000 for an individual or $2,000 for a family policy. A typical plan will work like this: When individuals enter the medical marketplace, they will spend first from their HSA. If they exhaust their HSA funds before reaching the deductible, they will then pay out-of-pocket. Once they reach their deductible, insurance pays all remaining costs.

Annual HSA deposits cannot exceed the amount of the health insurance deductible, and typically cannot exceed $2,600 for individuals and $5,150 for families. However, the account balances can earn interest or be invested in stocks or mutual funds, where they will

grow tax free. Thus, a young person could accumulate hundreds of thousands of dollars by the time he or she retires.

HSA balances belong to the individual account holders and remain theirs if they switch jobs, become unemployed or retire. The funds can be used to pay expenses not covered by insurance, insurance premiums during unemployment and health expenses during retirement. In the event of death, HSAs may be bequeathed to a spouse, or (like an IRA) the funds may flow to other heirs.

Health Reimbursement Arrangements (HRAs) are another type of personal account from which employees can pay directly for their medical care. A June 2002 Internal Revenue Service (IRS) revenue ruling clarified that HRA funds can roll over each year and grow tax free. Like HSAs, the accounts are not a taxable employee benefit, and employers' contributions are tax deductible. Employers have great flexibility in designing plans to meet their employees' needs. An employer can place a uniform amount into every employee's HRA, which the employees use to pay medical expenses or insurance premiums.

Indeed, employers can tailor benefits to suit different types of employees' medical needs. For instance, to encourage employees to seek preventive care, employers can stipulate that a portion of the HRA is forfeited if not used within the year.

However, HRAs only allow employer contributions. Employees may not contribute to HRAs either directly, or in lieu of wages. If an employer's HRA plan allows it, employees are allowed post-employment access to accumulated funds to use for retirement health benefits. However, many plans do not allow employees to access accumulated funds once they leave the employer. An HRA can also never be "cashed out," with accumulated balances used to purchase non-medical goods. These restrictions most likely reduce an employee's willingness to economize since unused funds are not seen as cash, and may benefit the employer rather than the economizer.

HSAs For State And Local Employees

State and local government workers enjoy generous health plans when compared to private industry workers. According to the Bureau of Labor Statistics, the proportion of compensation spent on health benefits was 50 percent greater among state and local government workers, and the average cost of health benefits per hour was more than double that of workers in private industry. For instance, the average cost of health benefits per hour of compensation for all state and local government workers was $3.38 in 2004, accounting for 9.9 percent of their total compensation. By comparison, the average hourly cost of health benefits for private industry workers was only $1.54, accounting for 6.6 percent of total compensation. The high cost of health benefits is straining the budgets of many state and local governments. At the same time, workers themselves suffer since, over the long run, workers pay the cost of their health benefits directly, or indirectly, through reduced wages. Excessive health benefits are inefficient in another way; some workers may prefer fewer health benefits in return for increased cash wages. The excess funds spent on health benefits for those employees are not an efficient form of compensation.

The solution is to give these workers incentives to be wise consumers of health care, while allowing them more control over how they spend their own money. Workers with greater health needs, or those merely wanting more health services, could use funds set aside in their HSA. Those wishing to do so could add to the HSA funds tax free for use during the year or later in life. Employees wishing to cash out some of their benefits and take funds as compensation would also be free to do so after paying a penalty equal to the taxes they would pay on cash wages. Most employees would roll over a portion of the funds each year for future use.

HSAs For Medicaid Beneficiaries

A few years ago several states experimented with allowing certain Medicaid recipients to control a portion of the dollars spent on their non-health care needs. These recipients were mainly allowed to choose their home care providers and control the funds that paid them. This experiment worked well since patients had greater choice over their providers, and the providers looked to the patients as customers, rather than to the state.

It is time to expand experiments like these and create similar programs that allow certain Medicaid patients to control a portion of their health care dollars. A type of unqualified HSA (or HRA) could accomplish similar results if applied to those Medicaid recipients with chronic illnesses that are costly to treat. These are precisely the patients whose medical conditions generate the highest costs, and who would benefit from enhanced disease management. Conditions such as diabetes and asthma often lead to higher medical costs if patients do not adhere to treatment protocols. Such plans

would not need to qualify for tax deductions, since most Medicaid enrollees have little, if any, tax burden. Depending on how the plan was structured, patients holding down costs by avoiding unnecessary emergency room visits (or achieving other measurable goals) would enjoy a financial reward. However, to give patients the incentive to save money, they must benefit financially from their efforts. Past attempts to get insured patients to minimize costs for the benefit of a third party have failed miserably.

Data are emerging on how well consumer-driven health plans have performed. Early analysis of Medical Savings Accounts (MSAs), the forerunner of HSAs, provides evidence of how the right incentives lower discretionary spending. For instance, a recent study published by the National Center for Policy Analysis on MSAs in South Africa found that for those enrolled in MSA plans, discretionary spending (primarily outpatient spending) was 47 percent lower. Individuals with an MSA were also much more likely to purchase a generic equivalent rather than a name-brand drug. By contrast, prescription drug spending by members increased 7.1 percent, and the number of prescriptions filled per month grew 19.1 percent after the patient reached their policy's deductible and were essentially spending insurance company funds. Once patients were spending insurance company funds use of brand-name drugs jumped 45 percent.

Closer to home, a survey by Aetna of almost 13,500 members with HRAs found that members in their plan (called HealthFund) performed very well compared to a match set of non-HRA enrollees. Employers offering HealthFund as an option experienced very modest increases of 3.7 percent in medical costs, compared to almost 16 percent in populations with similar demographics and more than 14 percent for Aetna's PPO plans. One plan sponsor of HealthFund with full replacement actually saw costs fall 11 percent.

HealthFund members decreased the number of overall prescriptions 6.5 percent and increased the proportion of generic medications they used almost 13 percent, which drove down pharmacy costs 11 percent. Half of the members had funds left over at the end of the year to roll over into the next calendar year — averaging 31 percent of their funds.

An additional benefit is that those enrolled in HSAs and HRAs tend to participate in more preventive care than a control group. This is probably because any savings accrued from prevention are captured by the enrollee. Traditional health insurers are reluctant to invest in preventive care since benefits might be realized years later – often by another company.

For instance, adult Aetna HealthFund enrollees increased their preventive exams 23 percent. Outpatient cases fell 14 percent, primary care visits decreased 11 percent. Yet inpatient admissions only fell 5 percent, specialty visits only fell 3 percent and emergency room visits only fell by one percent — numbers that suggest people still obtained necessary care.

Some critics of personal health accounts argue that they will experience favorable selection by appealing only to the "young healthy" and "wealthy" — leaving the poor and sick in traditional risk pools. However, preliminary data from Aetna (and others) have shown that the age distribution of those enrolling in their plans resembles a bell-shaped curve. In fact, the average age of HealthFund enrollees was slightly older than for other plans, not lower as critics might suggest. Overall, about two-thirds of HealthFund enrollees were between the ages of 35 and 55.

These plans also enjoyed a high degree of customer satisfaction. Ninety percent of those enrolled in the plans reportedly were satisfied with their choice and were likely to renew for the following year.

In conclusion, giving employees more choice and control over their health care makes good sense. It leads to lower costs and more control over the kinds of care they prefer.

About the Author – Devon M. Herrick

Devon M. Herrick, Ph.D., is a senior fellow at the National Center for Policy Analysis who concentrates on health care issues, such as Internet-based medicine, health insurance and the uninsured, as well as pharmaceutical drug issues. Other areas which Dr. Herrick focuses on include managed care, patient empowerment, medical privacy, and technology-related issues.

Dr. Herrick received a Ph.D. in Political Economy and a Master of Public Affairs from the University of Texas at Dallas with a concentration in economic development. He also holds an MBA with a concentration in finance from Oklahoma City University and an MBA from Amber University, as well as a B.S. in accounting from the University of Central Oklahoma.