

**Health Savings Accounts I: Short- and Long-term Effects of Health Savings Accounts**

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## **I. Introduction and Background**

The tax treatment of health insurance and health spending has a major influence on the composition and features of private health insurance markets, coverage, and health care costs in the United States. Due to the exclusion of employer contributions to health insurance from income and payroll taxes, the vast majority of nonelderly receive their health insurance through employer-sponsored insurance (ESI). In fiscal year 2007, these subsidies were estimated to reduce the government's income and payroll tax revenue by as much as \$200 billion.<sup>1</sup> Recent changes in law have introduced new provisions to provide tax-favored health spending. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established Health Savings Accounts (HSAs), which allow tax benefits for out-of-pocket health spending when paired with a high-deductible health insurance plan (HDHP).

Individuals may contribute to an HSA when covered only by a HDHP; they may not have health insurance coverage from an additional source.<sup>2</sup> Contributions to HSAs made by individuals are deductible from their income for federal income tax purposes, but the contributions are generally not deductible from payroll taxes. In contrast, contributions to HSAs made by employers are excluded from the employee's income for both federal income tax and employment taxes (i.e. Social Security, Medicare, and federal unemployment tax act) purposes. Unused funds in the HSA may accumulate (and earn interest, dividends or capital gains) tax-free. Funds may be withdrawn tax-free for

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<sup>1</sup> Burman, L. Testimony Before the House Committee on the Budget, "Tax Code and Health Insurance Coverage," October 18, 2007. (See Footnotes 8 and 9).

<sup>2</sup> The IRS allows some additional employer health benefits such as discount cards for certain prescription drugs. See Medical Economics, "Getting around the limits of an HSA," August 18, 2006, [www.memag.com](http://www.memag.com).

qualified medical expenses of the individual who owns the HSA, or of the spouse or dependent. Qualified medical expenses generally do not include health insurance premiums. Funds contributed to HSAs are actually owned by the individual, as is true with Individual Retirement Accounts (IRAs), however, unlike IRAs, the tax advantages of HSAs do not phase out as income increases. In addition, contributions, earnings, and withdrawals to HSAs may all occur without tax, unlike any other tax-preferred savings vehicle.

Advocates say that the cost-sharing features of HDHPs are designed to increase individual's sensitivity to the costs associated with the use of health care. High-deductible health insurance plans have always been a part of the non-group and small group health insurance markets, however HSAs introduced new tax advantages affecting the out-of-pocket expenditures related to these HDHPs. Enrollees in a HDHP/HSAs can have a relatively large financial exposure before meeting the deductible, because health spending comes from either the tax-advantaged HSA account or from regular non-tax preferred out-of-pocket spending. In 2008, individuals who own an HSA must be covered by a health plan with an annual deductible of not less than \$1,100 for single coverage and of not less than \$2,500 for family coverage.<sup>3</sup> However, as discussed below, average deductibles among those holding HDHP/HSAs are substantially higher. Proponents of HDHP/HSAs argue that providing individuals enrolled in these plans with health care cost and quality information along with appropriate financial incentives will result in more efficient health care purchases relative to care purchased under plans with less cost-sharing.

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<sup>3</sup> Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2009 Revenue Proposals," February 2008. Accessed February 11, 2008 at <http://www.treas.gov/offices/tax-policy/library/bluebk08.pdf>.

HDHPs tend to have lower premiums than more comprehensive insurance plans for two primary reasons. The first and obvious reason is that HDHPs cover a smaller share of health care expenditures than traditional insurance. However, increased deductibles may not translate into dollar for dollar reductions in premiums because administrative costs (e.g. costs of marketing and administering health insurance plans) will not fall proportionately with benefits. Also, some HDHPs cover routine preventive services for enrollees before their spending reaches the deductible, which tends to shift costs from the out-of-pocket component to the premium component. The second and less obvious reason that HDHPs tend to have lower premiums, is that they tend to attract healthy people who expect to have low medical expenses. Because health insurance premiums are related to the underlying expected health care costs of those enrolling in a particular plan, a plan that enrolls a lower-cost population would generally have lower premiums than one that enrolls a higher-cost population, even if the cost-sharing and covered benefits were identical.<sup>4</sup>

The Internal Revenue Service (IRS) regulates several features of HDHP/HSAs in addition to the minimum deductible level. In 2008, annual out-of-pocket liability for deductibles and other health care expenses in HDHP/HSAs were limited to \$5,600 for single coverage and \$11,200 for family. In addition, annual contributions to HSAs were limited to \$2,900 for single coverage and \$5,800 for family coverage. In order to encourage savings for health expenses after retirement, individuals who are age 55 and older are allowed to make additional catch-up contributions. As mentioned above, an

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<sup>4</sup> In addition, Fuchs and James (2005) point out that marketing may influence premium rates for new enrollees in HDHP/HSAs: insurers may offer discounted premium rates to first-time customers in order to increase enrollment in new HDHP/HAS plan, however these discounts may not be incorporated into subsequent premium rates.

HSA-qualifying HDHP may provide preventative medical benefits and coverage before the deductible is met. IRS guidelines state that certain preventive services, such as periodic health evaluations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight loss programs, and certain screening services, can be covered in full and do not have to be subject to the deductible.<sup>5</sup>

Tax-favored HSAs were not permissible until Congress changed federal tax policy by making health care expenditures paid through such an account excludible for income tax purposes, when the account is combined with a HDHP. Prior to 1996, the insurance market, especially the employer group market, was dominated by plans with relatively low deductibles and coinsurance. Health benefits received as an employee fringe benefit were exempt from federal income and payroll taxes, but individual out-of-pocket spending on health care was tax-deductible only if total health expenses in a year exceeded 7.5 percent of adjusted gross income.<sup>6</sup> In 1996, Congress established a favorable federal tax status for medical savings accounts (MSAs) – a precursor to today’s HSAs – available as an option to the self-employed and workers of employers with 50 or fewer employees.

MSAs laid the foundation for HSAs by establishing a savings account connected to a HDHP, but there were eligibility restrictions, and contributions could be made by either the employee or the employer, but not both. Initially, interest among insurers was low. However, with the return of double-digit increases in private insurance premiums in 2001, policies with higher deductibles, greater cost sharing and lower premiums began to

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<sup>5</sup> Fuchs and James 2005; Department of the Treasury: Internal Revenue Service. 2005. “Health Savings Accounts and Other Tax-Favored Health Plans.” Publication 969.

<sup>6</sup> Section 213 of the Internal Revenue Code of 1986.

attract attention from employers seeking to limit their spending on health benefits.<sup>7</sup>

Employers have used flexible spending accounts (FSAs), authorized under Section 125 of the IRC as a part of the Revenue Act of 1978, to reduce employee health care costs and soften the impact of benefit reductions.<sup>8</sup> FSAs allow employees to use pre-tax dollars to pay for health care services not covered by health insurance. Unlike HSAs, FSAs do not need to be combined with a HDHP, and any dollars remaining in the FSA at the end of the plan year are forfeited to the employer. Health reimbursement arrangements (HRAs), authorized by the IRS in 2002, provide another vehicle for employers to provide tax-free contributions for employees health care expenses.<sup>9</sup> HRAs need not be accompanied by a HDHP, and they can be funded by employer contributions only. In addition, unlike an HSA, the employer rather than the employee owns the HRA account.

Since HDHP/HSAs have been available only since 2004, it is too early to gauge the full effects of HDHP/HSAs on costs and health insurance markets. However, it is clear that relative to traditional health insurance plans, HDHP/HSAs change spending and coverage incentives along a number of different dimensions, with effects both in the short and long term.<sup>10</sup> Some have argued that in the short term, HDHP/HSAs will make individuals who enroll in them more cost conscious when making their health care choices, which should in turn lower spending on health care, particularly on discretionary

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<sup>7</sup> Goff, Veronica. 2004. "Consumer Cost Sharing in Private Health Insurance: On the Threshold of Change." NHPF Issue Brief No. 798. The George Washington University: Washington, DC.

<sup>8</sup> Fronstin, Paul. 2004 "Health Savings Accounts and Other Account-Based Health Plans." EBRI Issue Brief No. 273.

<sup>9</sup> IRS Rev. Rul. 2002-41 and Notice 2002-45 (June 26, 2002).

<sup>10</sup> Fuchs and James 2005; Fronstin, Paul, and Sara Collins. 2005. "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; Parente, Stephen, Roger Feldman, and Jon Christianson. 2004. "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization." *Health Services Research* 39(4): 1189-1209; Solanki, G., H.H. Schauffler, and L.S. Miller. 2000. "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services." *Health Services Research* 34(6): 1331-1350; Newhouse, Joseph. 2004. "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs* Volume 23(6): 107-113.

health services.<sup>11</sup> Others contend that their impact on overall spending growth is at best ambiguous, and that HDHP/HSAs will shift health care spending burdens onto those who are sick and provide investment benefits to those in higher-income families.<sup>12</sup> It is also yet unknown what effect these plans will have on rates of health insurance coverage in the long term. Some have argued that the new tax subsidy for out-of-pocket health costs incurred under HDHP/HSAs might induce individuals to enroll in insurance, reducing uninsurance rates. Others have argued that these new subsidies may further selection of lower-risks into high-deductible plans, raising premiums for individuals with higher health risks, which could in turn lead to more uninsurance.

Over the past several years, numerous policies have been proposed with the goal of increasing enrollment in HDHP/HSAs by making these plans more attractive to individuals and employers.<sup>13</sup> Changes in the tax treatment of HDHP/HSAs could substantially change the short- and long-term impacts of HDHP/HSAs. Proposals include providing an income tax deduction for HDHP premiums, expanding the definition of HSA-qualifying HDHPs to include plans with a 50 percent or more coinsurance requirement, and allowing larger employer contributions to HSAs of employees who are chronically ill, or have a spouse or dependent who is chronically ill.

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<sup>11</sup> Feldstein, 2004; Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler. 2004. "Healthy, Wealthy, and Wise: The American Health Care System is Broken. Here's How to Fix it." The Hoover Institution, Hoover Digest. No. 3; Mango, Paul D. and Vivian E. Riefberg. 2005. "Health Savings Accounts: Making Patients Better Consumers." *McKinsey Quarterly* web exclusive; Pendleton, James L. November 2005. "Market Insurance and Health Savings Accounts." Consumers for Health Care Choices. Members paper number 4.

<sup>12</sup> Blumberg, Linda J. 2004. "Health Savings Accounts and Tax Preferences for High Deductible Policies Purchased in the Non-Group Market: Potential Impacts on Employer-Based Coverage in the Small Group Market." Statement for the United States House of Representatives. March 18; Davis, Karen, Michelle Doty, and Alice Ho. April 2005. "How High is Too High? Implications of High-Deductible Health Plans." The Commonwealth Fund; Fronstin and Collins, 2004.

<sup>13</sup> Rovner, Julie. February 8, 2006. "Bush Makes Push for Health Care Savings Plans." National Public Radio Online: [www.npr.org/templates/story/story.php?storyId=5179309](http://www.npr.org/templates/story/story.php?storyId=5179309); Fuchs, Beth, and Julia James. April 2005. "Health Savings Accounts: The Fundamentals." NHPF Background Paper, The George Washington University: Washington, DC; Feldstein, Martin. 2004. "Health and Taxes." *The Wall Street Journal* Commentary.

This paper presents an overview of trends in HDHP/HSAs offer and enrollment, and then discusses the likely short- and long-term effects. We first present information on enrollment and offer rates of these types of plans, and an overview of their basic features. We then discuss how HDHP/HSAs may affect health care costs and service use, risk segmentation in the group health insurance market, spending burdens, spending growth, and overall levels of health insurance coverage. We present data regarding the health care expenses of individuals and households in relation to the features of a typical HDHP/HSA, including analyses by effective marginal tax rates.<sup>14</sup>

## **II. HDHP/HSA offer, enrollment and characteristics: description and trends**

Even after several years of availability, no definitive data source yet exists that provides a full picture of who is offered a HDHP/HSA, who is enrolled in a HDHP/HSA, and what the features of both the plans and accounts are. The available data suggests that HDHP/HSAs constitute a small share of the health insurance market. For some groups, offer and enrollment in HDHP/HSAs may have increased slightly between 2006 and 2007.<sup>15</sup>

### ***Offer in the group market***

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<sup>14</sup> Effective marginal tax rates are defined as the additional tax liability incurred if an individual's income were to increase by a dollar. Effective marginal tax rates differ from statutory marginal tax rates due to phase-ins and phase-outs of a variety of credits (such as the Earned Income Tax Credit) and deductions, and due to the alternative minimum tax. See Leiserson, G. "Income taxes and tax rates for sample families, 2006," December 2006.

<sup>15</sup> There are several limitations to the data that are available to assess the level of participation in HSA plans and the characteristics of the participants and plans. First, the Kaiser/HRET surveys obtain information from employers and the AHIP survey obtains information from insurance companies. Due to the contrasting sample frames, it is difficult to compare the results or to combine them together. Second, while the AHIP data show HSAs prevalence in the non-group market, we do not have another data source for comparison. Since the survey pertains just to AHIP members, it may not provide an accurate representation of the full market.

In 2006, many observers predicted that the percentage of employers offering HSA-qualified HDHPs would increase significantly between 2006 and 2007, particularly among large employers. However, this trend appears to be rather muted in the available data. One important source of data regarding health plan offer and enrollment in the group health insurance market is the Survey of Employer-Offered Health Benefits conducted by The Henry J. Kaiser Family Foundation (Kaiser) and the Health Research and Education Trust (HRET), an annual national survey of private and public employers with three or more employees.<sup>16</sup> The Kaiser/HRET survey indicates that among firms offering benefits, the share of firms offering an HDHP/HSA was 7 percent in 2007, which was not statistically different from the previous year's estimate of 6 percent. However, among firms offering benefits, firms with 200 to 999 employees did exhibit a statistically significant increase in offer of HDHPs with a Savings Option (HDHP/SO, where the savings option is either an HSA or an HRA) between 2006 and 2007, increasing from 5 percent to 13 percent. Offer rates must be interpreted with caution, however, as survey authors report that "some employers report offering single but not family coverage."<sup>17</sup>

The 2007 Kaiser/HRET survey also showed that, among firms offering health benefits, about 18 percent of covered employees work in firms that offer one or more HDHP/SO. The rates vary by firm size, as 21 percent of firms with 200 or more employees offer one or more HDHP/SO, while only 12 percent of firms with 3 to 99 employees do so.

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<sup>16</sup> In 2007, the Kaiser/HRET survey included responses from 3,078 firms, with 1,997 firms responding to the full survey.

<sup>17</sup> Kaiser/HRET 2007, footnote 5, page 121.

American's Health Insurance Plans (AHIP), a national association representing health insurance companies, conducted a survey of 96 health insurance companies in January 2006.<sup>18</sup> The survey suggests that employers that previously did not offer coverage to their employees purchased 33 percent of small group HDHP/HSA policies. However, relatively few companies were able to provide enough information to answer the survey question.

### ***Enrollment in the group market***

Enrollment in group HDHP/HSAs appears to be relatively flat, according to the Kaiser/HRET survey. In 2007, 5 percent of covered employees were enrolled in HDHP/SOs, which was not statistically different from the previous year. Enrollment rates differ by firm size, as 8 percent of covered workers in firms with 3 to 99 employees are enrolled in an HDHP/SO, while only 4 percent of firms with 200 or more employees are enrolled in this type of plan.

A survey of 87 health insurance companies was conducted in January 2007 by AHIP.<sup>19</sup> This survey suggests that in the group market, enrollment in HDHP/HSAs increased to 3.4 million in January 2007. While AHIP also conducted this survey in 2006, no definitive comparisons can be assessed between the years since the January 2006 survey could not distinguish between non-group, small group and large group for approximately 1 million enrollees. The 2007 survey also suggests that among new enrollees, smaller groups enrolled a larger share in HDHP/HSAs (17 percent) than larger groups (8 percent). The same survey also suggests that among all enrollees in

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<sup>18</sup> AHIP, "January 2006 Census Shows 3.2 Million People Covered By HSA Plans". Accessed February 14, 2008 at <http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf>.

<sup>19</sup> AHIP claims that "virtually all" companies that offer HDHP/HSAs participated in the survey. Accessed February 14, 2008: [http://www.ahipresearch.org/PDFs/FINAL%20AHIP\\_HSAReport.pdf](http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf)

HDHP/HSAs in both the group and non-group markets, larger groups account for nearly half (49 percent) of all enrollees.<sup>20</sup>

As Park and Greenstein (2006) show, empirical evidence regarding the characteristics of those enrolling in HDHP/HSAs is not conclusive.<sup>21</sup> However, most studies show that HDHP/HSA enrollees are more likely to be healthier and higher-income than those enrolling in other plans are. One study shows that those choosing a HDHP had higher levels of education, fewer chronic illness, and better health and health behaviors than either low-deductible CDHP enrollees or PPO enrollees.<sup>22</sup> A study of the Federal Employees Health Benefits Program (FEHBP) conducted by the GAO found that HDHP enrollees were younger and earned higher salaries than other enrollees.<sup>23</sup>

#### ***Enrollment in the non-group market***

The January 2007 AHIP survey suggests that enrollment in the non-group market, was approximately 1.1 million. Due to inconsistencies between the 2006 and 2007 AHIP surveys, it is not possible to assess whether this constitutes an increase or a decrease over the 2006 number of non-group enrollees. The 2007 survey reports that 27 percent of new enrollees in the non-group market were previously uninsured, although this may be consistent with the share of new enrollees who were previously uninsured that is typical across all health insurance markets. Several surveys indicate that the majority of early

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<sup>20</sup> While the authors note that small group is generally defined as firms with 50 or fewer employees, distinctions between small and large group in this survey must be interpreted with caution, since the survey categorizes small group and large group according to each insurer's own definition. In addition, some companies did not report enrollment separately for small groups and large groups.

<sup>21</sup> Park and Greenstein 2006.

<sup>22</sup> Hibbard et al. 2004.

<sup>23</sup> GAO 2006.

purchasers of HDHP/HSAs in the non-group market had moderate to high incomes.<sup>24 25</sup>

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***HDHP/HSA benefit packages in the group and non-group markets***

The 2007 Kaiser/HRET survey provides information on specific features of HDHP/HSAs. Plan averages for total annual premiums (including both employee and employer shares) for single and family coverage in HDHP/HSAs are \$3,826 and \$9,666, respectively, compared to total annual premiums of all other non-HDHP/SOs health plans for single and family coverage, which are \$4,514 and \$12,183, respectively. Average plan deductibles for employees enrolled in HDHP/HSAs are \$1,923 for single coverage and \$3,883 for family coverage, substantially above the IRS minimum of \$1,100 for single coverage and \$2,200 for family coverage in that year.<sup>27</sup> Three percent of employees enrolled in single coverage HDHP/HSA plans had a deductible over \$3,000. Thirty-three percent of employees enrolled in family coverage HDHP/HSA plans had a deductible over \$5,000. The annual plan averages for maximum out-of-pocket liability were \$3,090 for single coverage and \$6,505 for family coverage, substantially lower than the maximums allowed by the IRS in that year, which were \$5,500 for single coverage and \$11,000 for family coverage. The January 2007 AHIP survey reports premiums, deductibles, and out-of-pocket maximum liability for a companies “best-selling product” in the small and large group markets. The AHIP survey’s “best-selling” policies generally have lower premiums than the plan averages reported in the Kaiser/HRET

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<sup>24</sup> eHealthInsurance. 2005. “Health Savings Accounts: The First Six Months of 2005,” July 25, 2005; Assurant Health. 2005. “Quick Facts: Health Savings Accounts,” September 16, 2005;

<sup>25</sup> eHealthInsurance 2005.

<sup>26</sup> Assurant Health 2005.

<sup>27</sup> IRS-defined minimum deductibles were unchanged between 2007 and 2008; similarly, plan averages for deductibles were virtually unchanged been the 2006 and 2007 Kaiser/HRET survey. See also <http://www.treasury.gov/offices/tax-policy/library/bluebk07.pdf>

survey<sup>28</sup>, but the two surveys reported generally similar deductibles and out-of-pocket maximum liabilities. In addition to the annual deductible, 64 percent of employees covered by an HDHP/HSA in the Kaiser/HRET survey have a copay or coinsurance for in-network physician office visits, and the rate increases to 82 percent for out-of-network visits. Most also encounter a copay or coinsurance for hospital admissions and outpatient surgery.

According to the Kaiser/HRET survey, fourteen percent of employees enrolled in an HSA-qualified HDHP do not receive coverage for preventive health care benefits before their out-of-pocket health expenditures exceed the deductible. In contrast, a July 2007 survey of 13 to 35 insurers conducted by AHIP asserts that nearly all HDHP/HSA policies in the small and large group markets do offer such coverage for preventive benefits.<sup>29</sup>

In the non-group market, premiums depend importantly upon premium rating regulations and guaranteed issue rules. These vary across states, and determine the type of risks enrolling in each non-group market. Due to these complexities, average premiums among those enrolled in HDHP/HSAs in the non-group market belie the tremendous premium variation faced by individuals in the non-group market. While deductibles and out-of-pocket maximum among HDHP/HSAs in the non-group market also have substantial variation, average values may provide insight into average plan generosity. Compared to HDHP/HSAs in the group market, HDHP/HSAs in the non-

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<sup>28</sup> The AHIP survey's reported group HDHP/HSA premiums are lower than those reported in the Kaiser/HRET survey by approximately one-quarter. This may indicate that those plans selected as "best-selling" HDHP/HAS plans tend to have lower premiums, and perhaps more cost sharing or lower risk enrollees, than the average HHP/HSA.

<sup>29</sup> AHIP, "A survey of preventive benefits in Health Savings Account (HSA) Plans, July 2007." November 2007.

group market may have similar out-of-pocket maximum liability but higher deductibles, according to the January 2007 AHIP survey. In addition, the July 2007 AHIP survey indicates that a larger share (41 percent) of non-group enrollees in an HSA-qualified HDHP do not receive coverage for preventive health care benefits before their out-of-pocket health expenditures exceed the deductible,<sup>30</sup> compared to 14 percent or less of those enrolled in -qualified HDHPs through the group market.

### ***Contributions to HSAs***

Despite the preferential tax treatment of contributions to an HSA, it appears that many enrollees in HDHP/HSAs and their employers do not take advantage of these savings. The 2007 Kaiser/HRET survey reports that 66 percent of employers offering single coverage through an HDHP/HSA and 47 percent of employers offering family coverage through an HDHP/HSA contribute nothing to the accounts. Among those whose employers did contribute, employer contributions to HSAs average \$806 for single coverage and \$1,294 for family coverage. An analysis of tax return data by the U.S. Government Accountability Office (GAO) reflected the average deductions for HSA contributions in 2004, when HDHP/HSAs were primarily purchased through the non-group market.<sup>31</sup> This data shows that about 45 percent of tax filers reported no HSA contributions, and those that did reported an average contribution of \$2,100. Contributions were higher among those with higher adjusted gross income. The January

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<sup>30</sup> AHIP, "A survey of preventive benefits in Health Savings Account (HSA) Plans, July 2007." November 2007.

<sup>31</sup> U.S. Government Accountability Office, Health Savings Accounts GAO-06-798. Accessed February 15, 2008 at <http://www.gao.gov/new.items/d06798.pdf>

2007 AHIP survey reported that 69 percent of those holding an HSA in 2006 had account balances less than \$1,000, while 12 percent had account balances over \$2,501.<sup>32</sup>

### **III. Short- and Long-term Impacts of HDHP/HSAs on Costs and Service Use**

The rapid growth in health care expenditures, which have grown far faster than overall GDP growth, and the growth in health insurance premiums, which have grown faster than general inflation, are seen by many as unsustainable and a serious problem that needs to be addressed. Some have asserted that health insurance plans with low deductibles and low cost-sharing leave such a large proportion of costs covered by the premium component, that individuals have incentives to over-consume health care (sometimes referred to as “moral hazard”) since consumers have incentives to consume health services until the marginal benefit is zero. Proponents of HDHP/HSAs argue that expanding enrollment in HDHP/HSAs would decrease overall health expenditures and unnecessary medical services by providing consumers with greater incentives to be prudent users and purchasers of health care.<sup>33 34</sup> HDHP/HSAs aim to achieve this through neutralizing the tax treatment of insured versus out-of-pocket medical spending, increasing incentives to reduce comprehensiveness of insurance policies purchased.

However, while HDHP/HSAs can increase the share of health expenditures that are out-of-pocket, Richardson and Seligman (2007) observed that the marginal cost of expenditures below the deductible of these plans could actually be significantly reduced

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<sup>32</sup> These figures were based on a relatively small sample of HDHP/HSAs enrollees.

<sup>33</sup> Cogan et al. 2004; Feldstein 2004; Pendleton 2005; Mango and Riefberg 2005

<sup>34</sup> In addition, cost-sharing features such as a high deductible may reduce utilization of both unnecessary care and cost-effective care.

compared to traditional plans, depending on an individual's effective marginal tax rate.<sup>35</sup> Indeed, the marginal cost of contributions to an HDHP/HSA plan decreases as tax rates increase, which raises equity issues, particularly since lower-income families bear a disproportionately large share of illness.<sup>36</sup> In addition, the new tax subsidy for out-of-pocket health spending can be used even for health spending on products and services not traditionally covered by the traditional comprehensive plans, e.g. eyeglasses, acupuncture, and nonprescription medicine. Overall, incentives to eliminate unnecessary service use and incentives to seek out lower prices for care operate primarily for spending below the deductible, but spending below the deductible accounts for a small share of total health care spending. Thus, HDHP/HSAs may have a relatively modest effect on aggregate spending, service use, and the rate of spending growth over time.

Health insurance plans with higher deductibles are generally expected to lead to lower levels of health spending.<sup>37</sup> This expectation is based on both the implications of economic theory and the findings from the Rand Health Insurance Experiment (HIE) that was conducted between 1974 and 1982.<sup>38</sup> The HIE study showed that spending was lower when consumers were faced with higher cost sharing. Those with a 95 percent coinsurance rate used 25 to 30 percent fewer services than those in the free-care plan.<sup>39</sup>

Numerous attempts have been made to simulate the effects of a broad adoption of high-

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<sup>35</sup> Richardson and Seligman 2007.

<sup>36</sup> Pleis JR, Lethbridge-Çejku M. Summary health statistics for U.S. adults: National health interview survey, 2005. National Center for Health Statistics. Vital Health Stat 10(232). 2006. Bloom B, Dey AN, Freeman G. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2005. National Center for Health Statistics. Vital Health Stat 10(231). 2006.

<sup>37</sup> American Academy of Actuaries. 2004. "The Impact of Consumer-Driven Health Plans on Health Care Costs: A Closer Look at Plans with Health Reimbursement Accounts." Public Policy Monograph Report; Newhouse 2004.

<sup>38</sup> Newhouse, Joseph P. and the Insurance Experiment Group. 1993. *Free for All? Lessons from the Rand Health Insurance Experiment*. Cambridge, MA: Harvard University Press; Newhouse 2004.

<sup>39</sup> Newhouse 2004.

deductible plans based on the HIE study findings, producing a range of cost savings of between 4 and 15 percent.<sup>40</sup> However, an important difference between the health plans offered in the HIE and the current structure of HDHP/HSAs is that deductibles were income-related: families were randomly assigned to have a maximum out-of-pocket liability of 5, 10, or 15 percent of income, or of \$1000, whichever was lower.<sup>41</sup>

Furthermore, the HIE found that for those who were poor and less healthy, the reductions in health service utilization had adverse effects on health, despite the income-related liability maximums. Thus, Furman (2006) reports that “evidence suggests that a single level of deductibles and coinsurance for all incomes is not appropriate,” since a high deductible of, for example \$2000, may result in adverse health effects for a low-income family, while the same deductible level may do little to constrain health spending for a higher-income family.<sup>42</sup>

In addition, the presence of a savings account, combined with a high-deductible plan may mitigate overall cost savings because individuals have already set aside those funds and can spend them on health care on a tax-free basis. Individuals may consider funds in an HSA account as allocated for current health spending as opposed to potential long term savings or savings for future health spending. Researchers have estimated that combining a high-deductible plan with a health savings account might reduce the savings associated with a high-deductible plan by an estimated 50 percent.<sup>43</sup>

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<sup>40</sup> Buntin, Melinda Beeuwkes, Cheryl Damberg, Amelia Haviland, Nicole Lurie, Kanika Kapur, and M. Susan Marquis. June 2005. “Consumer-Directed Health Plans: Implications for Health Care Quality and Cost.” RAND Report Prepared for the California HealthCare Foundation.

<sup>41</sup> Newhouse, Joseph. 2004. “Consumer-Directed Health Plans and the RAND Health Insurance Experiment.” *Health Affairs* Volume 23(6): 107-113.

<sup>42</sup> Furman, Jason (2006). “Two Wrongs Do Not Make a Right,” *National Tax Journal*. Volume 59 (3).

<sup>43</sup> Buntin et al. 2005.

Even if those enrolled in HSA-qualified HDHPs do constrain their health expenditures in response to cost-sharing, their ability to affect aggregate health spending is limited due to the distribution of health care spending relative to the deductible.<sup>44</sup> This is due to the fact that the distribution of health care expenditures is highly skewed—the highest spending 10 percent of the population accounts for about 70 percent of total expenditures in the country, while the lowest 50 percent of spenders account for only 3 percent of expenditures.<sup>45</sup>

Table 1 below shows total health care expenses for singles and families under the hypothetical assumption that they have health insurance through a simulated HDHP. This simulated health insurance has a single/family “high” deductible of \$2,500/\$5,000, coinsurance of 20%, and single/family maximum annual out-of-pocket of \$3,500/\$7,000. Health care expenses include both out-of-pocket and insured costs. All dollars are reported in \$2008. Uninsured individuals have been assigned simulated health care spending under insurance.<sup>46</sup>

While 78.7 percent of single policy-holders with ESI and 85.2 percent of single policy-holders with non-group insurance have total health care expenditures below the

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<sup>44</sup> Blumberg and Burman 2004; Davis, Doty and Ho 2005; Pendleton 2005; Robinson, James. December 2005. “Consumer-Direct Health Insurance: The Next Generation.” *Health Affairs* web exclusive.

<sup>45</sup> Berk, Marc and Alan Monheit. 2001. “The Concentration of Health Care Expenditures, Revisited.” *Health Affairs* 20(2): 9-18.

<sup>46</sup> The following procedure is used to simulate health care spending of an uninsured individual under insurance. First, we estimate the probability of positive health care spending for people in good health separately from people in fair/poor health or with at least one chronic condition as a function of demographic characteristics and whether the person is insured. We use these estimates to predict the probability that the individual has positive health expenditures when uninsured and when insured based on their characteristics, including household size, family income, wages, geographic region, age, race, education, marital status, and health status. Using the spending of individuals who are insured and have positive expenditures, we then predict the level of positive expenditures given any expenditures for all individuals when insured using a similar set of covariates to those listed above. We then assign some people who have zero expenditures when uninsured to have positive expenditures when insured, with those who have higher predicted probabilities of positive expenditures more likely to be given positive insured expenditures.

high deductible of \$2,500, their expenditures accounted for just 13.0 percent and 16.5 percent of expenditures for singles within their health insurance type, respectively. Singles whose total spending exceeded the high deductible accounted for 88.9 percent of total expenditures for single policy-holders across all insurance types.

Among those with family policies, 59.6 percent of those with ESI and 72.8 percent of those with non-group insurance have total health care expenditures below the family high deductible of \$5,000. Total expenditures for these groups accounted for just 10.9 percent and 18.2 percent of total expenditures for families within their health insurance type, respectively. Families whose total spending exceeded the high deductible accounted for 89.0 percent of total family expenditures across all insurance types. Consequently, the vast majority of health care costs are associated with spending that exceeds even the average deductibles associated with HSA-qualified HDHPs, which are higher than the minimum allowable HSA-qualifying deductibles.<sup>47</sup>

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<sup>47</sup> In a similar analysis, Blumberg and Burman (2004) estimated that 79 percent of all spending occurs above the minimum HSA-qualified HDHP deductible and those whose spending exceeded these minimum deductibles incurred more than 95 percent of all spending (including spending above and below the deductible).

**Table 1**  
**Total Health Care Expenses if Insured through a HDHP, in Relation to the Deductible**  
**Non-elderly Population by Baseline Health Insurance**

	Actual Insurance Status				
	ALL	ESI	Nongroup	Medicaid or SCHIP	Other Public
<b>Single Policies</b>					
Minimum HDHP/HSA Deductible by IRS Regulation (2008)	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100
HDHP: Deductible <sup>1</sup>	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
HDHP: Coinsurance	20%	20%	20%	20%	20%
HDHP: Maximum Out-of-Pocket Liability	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500
Population (millions)	61.1	29.2	5.3	5.8	2.3
Total Health Care Expenditures if Insured through the HDHP (\$ billions) <sup>2</sup>	\$213.0	\$84.8	\$12.7	\$57.4	\$13.0
Population with Total Health Care Expenditures < Deductible	47.2	23.0	4.5	3.1	1.6
Percent of Population with Total Expenditures < Deductible	77.2%	78.7%	85.2%	53.8%	68.3%
Total Health Care Expenditures (\$ billions) of those with Total Expenditures < Deductible	\$23.7	\$11.0	\$2.1	\$1.4	\$0.8
Percent of Total Health Care Expenditures attributable to those with Total Expenditures < Deductible	11.1%	13.0%	16.5%	2.5%	6.5%
Population with Total Health Care Expenditures > Deductible	13.9	6.2	0.8	2.7	0.7
Percent of Population with Total Expenditures > Deductible	22.8%	21.3%	14.8%	46.2%	31.7%
Total Health Care Expenditures (\$ billions) of those with Total Expenditures > Deductible	\$189.3	\$73.8	\$10.6	\$56.0	\$12.1
Percent of Total Health Care Expenditures attributable to those with Total Expenditures > Deductible	88.9%	87.0%	83.5%	97.5%	93.5%
Percent of Health Care Expenditures < Deductible, among those with Total Expenditures > Deductible	15.5%	17.8%	15.5%	10.2%	12.6%
Percent of Health Care Expenditures > Deductible, among those with Total Expenditures > Deductible	84.5%	82.2%	84.5%	89.8%	87.4%
<b>Actual Insurance Status in Family (by Predominant Coverage w</b>					
	ALL	ESI	Nongroup	Medicaid or SCHIP	Other Public
<b>Families Policies</b>					
Minimum HDHP/HSA Deductible by IRS Regulation (2008)	\$2,200	\$2,200	\$2,200	\$2,200	\$2,200
HDHP: Deductible <sup>1</sup>	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
HDHP: Coinsurance	20%	20%	20%	20%	20%
HDHP: Maximum Out-of-Pocket Liability	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
Population (millions)	61.8	42.4	2.7	9.8	1.3
Total Health Care Expenditures if Insured through the HDHP (\$ billions) <sup>2</sup>	\$522.0	\$368.9	\$16.7	\$79.7	\$11.6
Population with Total Health Care Expenditures < Deductible	38.5	25.3	2.0	6.6	0.8
Percent of Population with Total Expenditures < Deductible	62.3%	59.6%	72.8%	67.0%	62.3%
Total Health Care Expenditures (\$ billions) of those with Total Expenditures < Deductible	\$57.6	\$40.2	\$3.0	\$7.7	\$1.0
Percent of Total Health Care Expenditures attributable to those with Total Expenditures < Deductible	11.0%	10.9%	18.2%	9.6%	9.0%
Population with Total Health Care Expenditures > Deductible	23.3	17.1	0.7	3.2	0.5
Percent of Population with Total Expenditures > Deductible	37.7%	40.4%	27.2%	33.0%	37.7%
Total Health Care Expenditures (\$ billions) of those with Total Expenditures > Deductible	\$464.4	\$328.6	\$13.7	\$72.0	\$10.6
Percent of Total Health Care Expenditures attributable to those with Total Expenditures > Deductible	89.0%	89.1%	81.8%	90.4%	91.0%
Percent of Health Care Expenditures < Deductible, among those with Total Expenditures > Deductible	21.2%	22.0%	22.9%	19.0%	19.8%
Percent of Health Care Expenditures > Deductible, among those with Total Expenditures > Deductible	78.8%	78.0%	77.1%	81.0%	80.2%

Source: Urban Institute analysis, HIPSM 2007

Notes:

- The HDHP/HSA policy deductibles are slightly higher than those reported in the Kaiser/HRET for group policies. They are intended to reflect average annual deductibles in the nongroup market, and are based on survey results from "best-selling" HDHP/HSA Policies in the nongroup market published in America's Health Insurance Plans, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible April 2007," [http://www.ahipresearch.org/PDFs/FINAL%20AHIP\\_HSARreport.pdf](http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSARreport.pdf)
- Health care expenses include both out-of-pocket and insured costs, assuming enrollment in a HDHP with a single/family deductible of \$2,500/\$5,000, coinsurance of 20% and maximum annual out-of-pocket of \$3,500.
- All dollars in \$2008.

Thus, making significant inroads into spending would require achieving spending reductions among the most sick, high spending enrollees, who incur the majority of costs. However, early evidence from insurance companies shows no significant changes in utilization among these types of enrollees, such as those with diabetes, when enrolled in a HDHP.<sup>48</sup> In addition, if these plans attract mainly younger, healthier enrollees, there would be even lower opportunities for large-scale savings. Because health care spending is heavily concentrated among a small share of the population with high health care needs, a product that attracts a largely healthy, low spending enrollee population will not be able to have significant effects on national health spending.

The potential for HDHP/HSAs to impact health costs also relies importantly on whether or not it is feasible for individuals to bargain with providers over prices for health care services. There is scant evidence for optimism. The Center for Studying Health System Change investigated experiences regarding consumer shopping for health services, including the market for LASIK eye surgery, and found that unless the service is non-urgent, relatively uniform in quality across providers, and involves relatively little medical judgment as to diagnosis, consumer shopping showed little potential to reduce costs.<sup>49</sup> Adding to the difficulty, some providers report that when patients request prices for health services, confidentiality agreements with payers prevents them from providing

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<sup>48</sup> Robinson 2005.

<sup>49</sup> Citation in E. Park, Informing the Debate About Health Savings Accounts: An Examination of Some Misunderstood Issues, Center on Budget and Policy Priorities, June 13, 2006. Paul Ginsburg, Written Testimony before the Subcommittee on Health, U.S. House Committee on Energy and Finance, "Consumer Price Shopping in Health Care," Center for Studying Health System Change, March 15, 2006. Paul Ginsburg, Statement before the Joint Economic Committee, Center for Studying Health System Change, May 10, 2006.

prices, and the price ranges that they provide may be wide.<sup>50</sup> In addition, professional fees for certain medical staff may be an extra cost in addition to the procedure price, such as fees for an anesthesiologist, and these fees can be substantial and may vary based on the actual staff available at the time of the service.

Overall, since most costs of those enrolled in HDHP/HSAs still occur above the deductible, negotiations over provider rates will still be concentrated on the interaction between insurance plans and providers. In addition, in conventional health insurance plans, insurers negotiate discounted prices with physicians and hospitals, but enrollees in HDHP/HSAs may not always have access to discount arrangements with provider networks.<sup>51</sup> When patients do have access to the provider discount negotiated by their insurer, practical considerations make it difficult for individuals to verify that the appropriate price has been charged. For example, different rates are charged for 15 minute physician visits compared to 25 minute visits, and it may be difficult for an individual to accurately quantify the length of their appointment.<sup>52</sup>

Moreover, there are two additional difficulties for patients seeking to have their out-of-pocket payments credit toward reaching their insurance deductible. First, services that count towards the deductible may only include services that would otherwise be covered once the deductible has been met. That means that many HSA-qualified medical expenses may not count toward the deductible. For example, if a family purchases a non-group HDHP/HSA policy and decides not to pay extra premium costs for routine

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<sup>50</sup> Healthcare Financial Management Association (HFMA) Executive Roundtable, “Health Savings Accounts: Are you prepared?”, December 2006.

<sup>51</sup> The January 2007 AHIP survey reports that enrollees “generally have access” to these discounts, but report no data.

<sup>52</sup> The difficulty in understanding prices charged for health services is highlighted by the recent disclosure that out-of-pocket medical costs of insured consumers of a large health insurer may have been inflated by potentially hundreds of millions of dollars. Abelson, R. New York Times, February 14, 2008, “Inquiry set on health care billing.”

maternity care (also known as a “maternity rider”), any health expenditures for maternity care may not count toward the deductible. Second, under current law, minimum deductible level and maximum out-of-pocket liability apply only to in-network health expenditures. Like many low-deductible plans, only in-network health expenditures count toward reaching the in-network deductible.<sup>53</sup> However, there is no statutory limit regarding maximum out-of-pocket liability for out-of-network health care expenditures.

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Recent empirical evidence indicates that people enrolled in HDHP/HSAs generally spend less than those in other plans. However, some results are ambiguous or mixed. Some empirical investigations have found lower costs for HDHP/HSA enrollees compared to PPO enrollees.<sup>55</sup> Some have found higher costs for CDHP compared to HMO enrollees.<sup>56</sup> Some have found declines in inpatient and emergency room admissions but increases in specialist visits for enrollees switching from to HDHP/HSA coverage.<sup>57</sup> Of particular concern, however, is whether cost reductions resulting from individual’s responses to high deductibles come from eliminating excessive and unwarranted care or from eliminating health-enhancing care. Several studies have found that enrollees in HDHPs receive less preventive care,<sup>58</sup> that those enrolled in CDHPs are more likely to miss necessary care, or delay care than those enrolled in more comprehensive health insurance,<sup>59</sup> and that these problems are exacerbated for those with lower incomes or those in worse health.<sup>60 61</sup> While the short-term impact of

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<sup>53</sup> Jost and Hall, 2005.

<sup>54</sup> Park, E. 2006.

<sup>55</sup> Buntin et al. 2005.

<sup>56</sup> Parente et al. 2004.

<sup>57</sup> Robinson 2005.

<sup>58</sup> Solank, Schaffler, and Miller 2000.

<sup>59</sup> Ibid.

<sup>60</sup> Fronstin and Collins 2005.

reductions in preventive or necessary care on enrollees health may be relatively small, these reductions may increase the probability of catastrophic health problems over the longer term. In fact, when preventive care is not covered through the premium component of an HDHP/HSA (before the deductible is met), the tax-advantaged nature of HSAs creates an incentive to let the account balance accumulate. If these incentives lead to delays in purchasing preventive or maintenance health care, the incidence of catastrophic claims may increase in the long run. Furthermore, the period of enrollment with a particular insurance carrier is frequently limited, especially in the non-group market where the median enrollment length is reported to be five months.<sup>62</sup> Given this level of churning as individuals switch between insurance carriers, there may be little incentive for an insurer to encourage utilization of necessary or preventive care if the individual would likely have insurance through another source when the probability of catastrophic claims is highest.

Some researchers have argued that HDHP/HSAs alone will not constrain spending growth, and that overall cost containment in the long run can be achieved only by a combination of greater cost sharing and modern managed care mechanisms working in tandem to control spending above the deductible and the out-of-pocket maximums.<sup>63</sup>

In addition, while many studies attribute the majority of the growth in health care

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<sup>61</sup> Davis, Doty, and Ho 2005.

<sup>62</sup> Monheit, A. C., J. C. Cantor, M. Koller, and K. Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets: Trends in the New Jersey Individual Health Coverage Program." *Health Affairs* 23 (4): 167–75., citing T. McBride et al., "The Dynamics of Individual Insurance Coverage in the U.S." (Paper presented at the Twentieth Annual Research Meeting of AcademyHealth, Nashville, Tennessee, 27–29 June 2003).

<sup>63</sup> Newhouse 2004.

spending to technological innovation, there is little evidence indicating that greater cost sharing will slow the adoption of new technology.<sup>64</sup>

There are numerous proposals to expand enrollment in HDHP/HSAs. How much savings, if any, these new plans will ultimately generate and for whom depends on a number of factors, not least of which are policy changes in the tax treatment of HDHP/HSAs. Even if those switching from conventional low-deductible plans to HDHP/HSAs experienced decreases in health care spending over the short run, policies aimed at expanding enrollment in HDHP/HSAs through greater tax incentives could increase total health spending in the short run. If new policies include greater tax incentives to spend out-of-pocket on health, those enrolled in HDHP/HSAs before the new policy would then experience greater incentives to spend on health care after the policy. Thus, the net effect of new HDHP/HSA policy on total health spending could depend on the number of individuals already in HDHP/HSAs compared to the number who enroll due to the policy change.<sup>65</sup>

#### **IV. Short- and Long-term Impacts of HDHP/HSAs on the Coverage in the Non-group and Group Health Insurance Markets**

*“Since Arrow (1963), health insurance has been the leading example of market failure due to asymmetric information. Adverse selection will lead riskier individuals to seek out more generous health insurance, driving up prices and driving healthier people away. The*

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<sup>64</sup> Buntin et al. 2004.

<sup>65</sup> Furman, Jason (2006). “Two Wrongs Do Not Make a Right,” National Tax Journal. Volume 59 (3).

*market solution, a Rothschild-Stiglitz (1976) separating equilibrium, entails sub-optimal underinsurance for healthier types.”<sup>66</sup>*

The rationale for combining people with different health care risks into the same health insurance risk pool is that it allows health care spending burdens to be spread more evenly across the population. The principle of collective health insurance, which has been the dominant paradigm for decades in the group health insurance market, is that most enrollees in each health insurance plan are in good health and use fewer covered benefits in a given year than the population average. This allows the premium payments from those in better health to subsidize health care for those enrollees who have higher expenditures in that year.<sup>67</sup> This principle contrasts fundamentally with the logic underlying an increasing practice in the health insurance industry: categorizing individuals according to health risk and marketing separate health plans to each risk class. Incentives to expand enrollment in HDHP/HSAs accelerate this trend.

The consequence of the proliferation of plans with these designs — higher deductibles, more cost sharing, and higher out-of-pocket maximum liability — is that health care expenses associated with high-cost medical cases are being increasingly shifted away from the pooled premium component of health insurance, and towards the individual.<sup>68</sup> As the costs of medical care are spread less broadly, financial burdens for seriously ill individuals who have very high medical costs can increase dramatically,

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<sup>66</sup> Furman, Jason (2006). “Two Wrongs Do Not Make a Right,” *National Tax Journal*. Volume 59 (3).

<sup>67</sup> Robinson, James C. 2004. “Reinvention of Health Insurance in the Consumer Era.” *The Journal of the American Medical Association* 291(15): 1880-1886.

<sup>68</sup> Blumberg, Linda J., Lisa Clemans-Cope, and Fredric Blavin. 2005. “Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs.” Health Policy Brief No. 17. The Urban Institute: Washington, DC.

particularly for chronically ill individuals who repeatedly reach the maximum financial liability.

Non-group health insurance markets in most states allow insurers to charge individually risk-adjusted premiums, which are based on an individual's medical history, age, gender, and other characteristics such as credit score.<sup>69</sup> This practice is known as "medical underwriting." To the extent that those with favorable underwriting results are also higher income, expansion of HDHP/HSAs may produce new variants of benefit packages targeted towards individuals seeking to use the plan as an investment vehicle. For example, those who are healthy and have higher incomes may seek a non-group plan with extremely low premiums, and not be concerned with having more limited health care benefits or the risk of higher out-of-pocket liability in the case of illness. The low premiums and limited benefits demanded by these individuals would limit insurers' ability to retain mixed-risk pools among their non-group enrollees, which would increase risk segmentation and limit cross-subsidization of low and high-risk enrollees.

Individually-purchased health insurance in the non-group market has become a focus of attention among those researching the effects of HSAs, since the uninsured are primarily low-income individuals who do not have access to employer-sponsored offers of health insurance. In 2005, approximately 70 percent of uninsured employees did not have access to an offer of employer-sponsored insurance, either through their own employer or through the employer of a family member.<sup>70</sup> The non-group market covers a

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<sup>69</sup> "Block underwriting," to produce rated premium for selected groups of individuals in the non-group market, is also used in the non-group market to assess profit and to "evaluate the financial impact and risk characteristics of retained versus cancelled groups." Jim Gallasso of Actuarial Modeling, January 30, 2008. jgalasso@actuarialmodeling.com.

<sup>70</sup> Clemans-Cope, Lisa and Bowen Garrett. (Urban Institute) 2006. Unpublished estimates based on the February 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

small share of the population, and although some suggested that the introduction of HSAs could expand this market considerably, there is little evidence to suggest that this has occurred. Rates of enrollment in non-group health insurance have been fairly flat between 2003 and 2006.<sup>71 72</sup>

Since non-group enrollment in HDHP/HSAs, estimated to be approximately 1.1 million, is small compared to the number of uninsured, estimated to be 47 million, it is clear that the short-term impacts of previous HDHP/HSA policies on rates of uninsurance have been relatively small. This is likely due to the fact that most uninsured individuals are low-income and do not benefit substantially from the current structure of HSA tax benefits. Furthermore, they will continue to face financial barriers to enrollment due to premiums for even the high-deductible plans, and may have more difficulty gaining offers in the non-group market due to the relatively large disease burden among the low-income.<sup>73</sup>

Table 2 shows the distribution of the non-elderly population by effective marginal income and payroll tax rates. Combining effective marginal income plus payroll tax

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<sup>71</sup> U.S. Census Bureau, Current Population Survey, 2000 to 2007 Annual Social and Economic Supplements. Accessed February 16, 2008 at

<http://www.census.gov/hhes/www/hlthins/historic/hihist4.html>

<sup>72</sup> Some had suggested that HDHP/HSAs in the non-group market would likely be attractive to unhealthy individuals who usually reach or exceed out-of-pocket maximums. However, this phenomenon was likely sharply limited by two features of the non-group market. First, in the non-group markets, higher premiums can generally be charged for a given plan to unhealthy individuals. Therefore, these non-group carriers can segment unhealthy enrollees without moving enrollees into different plans. Second, tight medical underwriting practices are nearly ubiquitous in the non-group market, except in a small number of states that prohibit these practices. Research has shown that underwriting practices limit the availability of non-group coverage offers for those with chronic conditions, and that offers of coverage are affected by even mild medical conditions. [Pauly and Nichols 2002; Pollitz, Karen, Richard Sorian, and Kathy Thomas. 2001. How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health? Menlo Park, CA: Henry J Kaiser Family Foundation.] Since few states have guaranteed issue laws that would allow those in poor health to have open access to the non-group market, it is likely that HSA-qualifying plans in the non-group market will be limited to healthy individuals, particularly those in high-income families who can experience large benefits from the tax preferential treatment of HSAs.

<sup>73</sup> Glied and Remler 2005.

rates, 30.9 percent of uninsured children and 40.7 percent of uninsured adults currently have either negative tax liability or less than 10 percent tax liability. The uninsured are the most likely to have no tax liability, compared to those with ESI or non-group.

**Table 2**  
**Effective Marginal Income and Payroll Tax Rates**  
**Non-elderly Population**

	ALL		ESI		Nongroup		Medicaid or SCHIP		Other Public		Uninsured	
	Millions	Percent	Millions	Percent	Millions	Percent	Millions	Percent	Millions	Percent	Millions	Percent
<b>Effective Marginal Income Tax Rate</b>												
<i>Children</i>												
Less than zero	10.80	13.6%	2.22	5.2%	0.46	13.4%	6.29	26.4%	0.17	12.5%	1.66	21.6%
0-10%	14.13	17.8%	3.90	9.1%	0.53	15.4%	7.60	31.9%	0.32	23.8%	1.79	23.2%
10-20%	28.63	36.2%	19.63	45.7%	1.26	36.7%	5.11	21.4%	0.46	34.8%	2.18	28.3%
20% or greater	25.63	32.4%	17.19	40.0%	1.18	34.5%	4.81	20.2%	0.38	28.8%	2.06	26.8%
All	79.19	100.0%	42.92	100.0%	3.43	100.0%	23.82	100.0%	1.33	100.0%	7.69	100.0%
<i>Adults</i>												
Less than zero	13.32	7.3%	4.00	3.5%	1.25	11.3%	2.52	17.7%	0.54	8.3%	5.00	14.0%
0-10%	36.99	20.3%	11.58	10.1%	2.97	26.7%	6.88	48.3%	2.90	44.8%	12.66	35.4%
10-20%	74.69	41.0%	53.43	46.7%	4.04	36.4%	2.84	19.9%	1.97	30.4%	12.42	34.7%
20% or greater	57.04	31.3%	45.43	39.7%	2.83	25.6%	2.00	14.1%	1.07	16.5%	5.70	15.9%
All	182.04	100.0%	114.45	100.0%	11.09	100.0%	14.24	100.0%	6.47	100.0%	35.79	100.0%
<b>Effective Marginal Payroll Tax Rate</b>												
<i>Children</i>												
0 - mean	9.94	12.6%	8.32	19.4%	0.47	13.7%	0.65	2.7%	0.12	8.9%	0.39	5.0%
mean - 7.65%	69.25	87.4%	34.61	80.6%	2.96	86.3%	23.17	97.3%	1.21	91.1%	7.31	95.0%
All	79.19	100.0%	42.92	100.0%	3.43	100.0%	23.82	100.0%	1.33	100.0%	7.69	100.0%
<i>Adults</i>												
0 - mean	19.47	10.7%	16.85	14.7%	1.03	9.3%	0.35	2.5%	0.24	3.8%	0.99	2.8%
mean - 7.65%	162.57	89.3%	97.60	85.3%	10.06	90.7%	13.89	97.5%	6.23	96.2%	34.79	97.2%
All	182.04	100.0%	114.45	100.0%	11.09	100.0%	14.24	100.0%	6.47	100.0%	35.79	100.0%
<b>Effective Marginal Income plus Payroll Tax Rates</b>												
<i>Children</i>												
Less than zero	9.61	12.1%	1.97	4.6%	0.42	12.1%	5.56	23.3%	0.15	11.6%	1.52	19.7%
0-10%	6.87	8.7%	1.78	4.1%	0.28	8.0%	3.84	16.1%	0.11	8.5%	0.86	11.2%
10-20%	11.63	14.7%	4.14	9.6%	0.48	14.1%	5.39	22.6%	0.25	18.7%	1.36	17.7%
20% or greater	51.08	64.5%	35.04	81.6%	2.26	65.8%	9.03	37.9%	0.81	61.2%	3.95	51.3%
All	79.19	100.0%	42.92	100.0%	3.43	100.0%	23.82	100.0%	1.33	100.0%	7.69	100.0%
<i>Adults</i>												
Less than zero	8.80	4.8%	2.76	2.4%	0.78	7.1%	1.91	13.4%	0.25	3.9%	3.11	8.7%
0-10%	32.52	17.9%	9.06	7.9%	2.86	25.8%	6.27	44.0%	2.86	44.2%	11.47	32.0%
10-20%	19.96	11.0%	9.81	8.6%	1.33	12.0%	1.92	13.5%	0.79	12.2%	6.11	17.1%
20% or greater	120.76	66.3%	92.82	81.1%	6.12	55.2%	4.15	29.1%	2.57	39.8%	15.10	42.2%
All	182.04	100.0%	114.45	100.0%	11.09	100.0%	14.24	100.0%	6.47	100.0%	35.79	100.0%

Source: Urban Institute analysis, HIPS M 2007

Table 3 shows total health care expenses for uninsured singles and families under the hypothetical assumption that they are enrolled in health insurance through an HSA-qualifying HDHP.<sup>74</sup> Importantly, this analysis does not model premiums, which are likely to be significantly higher for those with more health expenditures. The analysis also assumes that all uninsured individuals can gain an offer in the non-group market, which is not realistic in most states. The analysis applies the individual's effective marginal tax rate to out-of-pocket health expenditures, which results in the amount of tax savings on out-of-pocket expenditures that the individual would encounter if they paid these costs through an HSA. For uninsured singles gaining coverage, the average per person tax savings for those with total health care expenditures below the high deductible of \$2,500 ranges from \$0 to \$157, depending on the effective marginal tax rate. Among singles exceeding the deductible, average tax savings ranges from \$0 to \$865. For uninsured families gaining coverage, the average per person tax savings for those with total health care expenditures below the high deductible of \$5,000 ranges from \$0 to \$409, depending on the effective marginal tax rate. Among families exceeding the deductible, average tax savings ranges from \$0 to \$1,430. Without knowing the premiums faced by each enrollee in each market, it is impossible to compare the financial value of these HDHP/HSA plans to more comprehensive plans for enrollees with different risks and tax rates. Whether or not the tax advantages of HDHP/HSAs can generate savings relative to more comprehensive plans for some individuals depends on

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<sup>74</sup> Uninsured families are defined in this table as any tax filing unit that has at least one uninsured member. Each family member, regardless of actual insurance status, is then treated as enrolling with their tax filing unit in a family HDHP/HSA.

whether increases in out-of-pocket spending under the HDHP are offset by tax savings and decreases in premium payments.

**Table 3**  
**Uninsured Gaining Coverage Through HDHP/HSA, by Effective Marginal Income Tax Rates**  
**Non-elderly Uninsured Population by Single or Family Policy**

Tax filing unit with at least one Member Uninsured	Effective Marginal Tax Rate				
	ALL	<0	0 - 10	10 - 20	20+
<b>Single Policies</b>					
Minimum HDHP/HSA Deductible by IRS Regulation (2008)	\$1,100	\$1,100	\$1,100	\$1,100	\$1,100
HDHP: Deductible <sup>1</sup>	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
HDHP: Coinsurance	20%	20%	20%	20%	20%
HDHP: Maximum Out-of-Pocket Liability	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500
Population (millions)	19.3	2.2	7.1	7.6	2.4
Total Health Care Expenditures if Insured through Nongroup HDHP/HSA (\$ billions) <sup>2</sup>	\$46.6	\$5.2	\$17.3	\$17.4	\$6.7
Population with Expenditures < Deductible	15.6	1.8	5.7	6.3	1.9
Percent of Population	81.0%	80.4%	80.8%	82.2%	78.2%
Total Health Care Expenditures (\$ billions)	\$8.6	\$1.0	\$3.1	\$3.4	\$1.0
Percent of Total Health Care Expenditures	18.4%	18.7%	18.2%	19.7%	15.5%
Total Tax Savings (\$ billions)	\$0.8	\$0.0	\$0.0	\$0.5	\$0.3
Average Tax Savings Per Person	\$52	\$0	\$7	\$76	\$157
Population with Expenditures > Deductible	3.7	0.4	1.4	1.4	0.5
Percent of Population	19.0%	19.6%	19.2%	17.8%	21.8%
Total Health Care Expenditures (\$ billions)	\$38.0	\$4.3	\$14.1	\$14.0	\$5.7
Percent of Total Health Care Expenditures	81.6%	81.3%	81.8%	80.3%	84.5%
Percent of Health Care Expenditures < Deductible	20.4%	21.5%	20.4%	20.6%	19.2%
Percent of Health Care Expenditures > Deductible	79.6%	78.5%	79.6%	79.4%	80.8%
Total Tax Savings (\$ billions)	\$1.1	\$0.0	\$0.0	\$0.6	\$0.4
Average Tax Savings Per Person	\$294	\$0	\$33	\$432	\$865
<b>Families Policies</b>					
Minimum HDHP/HSA Deductible by IRS Regulation (2008)	\$2,200	\$2,200	\$2,200	\$2,200	\$2,200
HDHP: Deductible <sup>1</sup>	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
HDHP: Coinsurance	20%	20%	20%	20%	20%
HDHP: Maximum Out-of-Pocket Liability	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
Population (millions)	11.3	2.2	3.3	3.2	2.5
Total Health Care Expenditures if Insured through Nongroup HDHP/HSA (\$ billions) <sup>2</sup>	\$78.6	\$9.9	\$19.4	\$28.5	\$20.9
Population with Expenditures < Deductible	8.1	1.8	2.5	2.1	1.7
Percent of Population	71.6%	78.9%	74.8%	65.7%	68.5%
Total Health Care Expenditures (\$ billions)	\$11.0	\$2.1	\$3.3	\$3.2	\$2.4
Percent of Total Health Care Expenditures	14.0%	21.6%	16.9%	11.4%	11.4%
Total Tax Savings (\$ billions)	\$1.2	\$0.0	\$0.1	\$0.4	\$0.7
Average Tax Savings Per Family	\$147	\$0	\$7	\$76	\$157
Population with Expenditures > Deductible	3.2	0.5	0.8	1.1	0.8
Percent of Population	28.4%	21.1%	25.2%	34.3%	31.5%
Total Health Care Expenditures (\$ billions)	\$67.6	\$7.8	\$16.1	\$25.2	\$18.5
Percent of Total Health Care Expenditures	86.0%	78.4%	83.1%	88.6%	88.6%
Percent of Health Care Expenditures < Deductible	20.1%	25.6%	22.0%	18.6%	18.2%
Percent of Health Care Expenditures > Deductible	79.9%	74.4%	78.0%	81.4%	81.8%
Total Tax Savings (\$ billions)	\$2.0	\$0.0	\$0.1	\$0.8	\$1.1
Average Tax Savings Per Family	\$627	\$0	\$104	\$711	\$1,430

Source: Urban Institute analysis, HIPSM 2007

Notes:

1. The HDHP/HSA policy deductibles are slightly higher than those reported in the Kaiser/HRET for group policies. They are intended to reflect average annual deductibles in the nongroup market, and are therefore based on survey results from "best-selling" HDHP/HSA Policies in the nongroup market published in America's Health Insurance Plans, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans," April 2007, [http://www.ahipresearch.org/PDFs/FINAL%20AHIP\\_HSAReport.pdf](http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf)

2. Health care expenses include both out-of-pocket and insured costs, assuming enrollment in a HDHP with a single/family deductible of \$2,500/\$5,000, coinsurance of 20% and maximum annual out-of-pocket of \$3,500/\$7,000.

3. All dollars in \$2008.

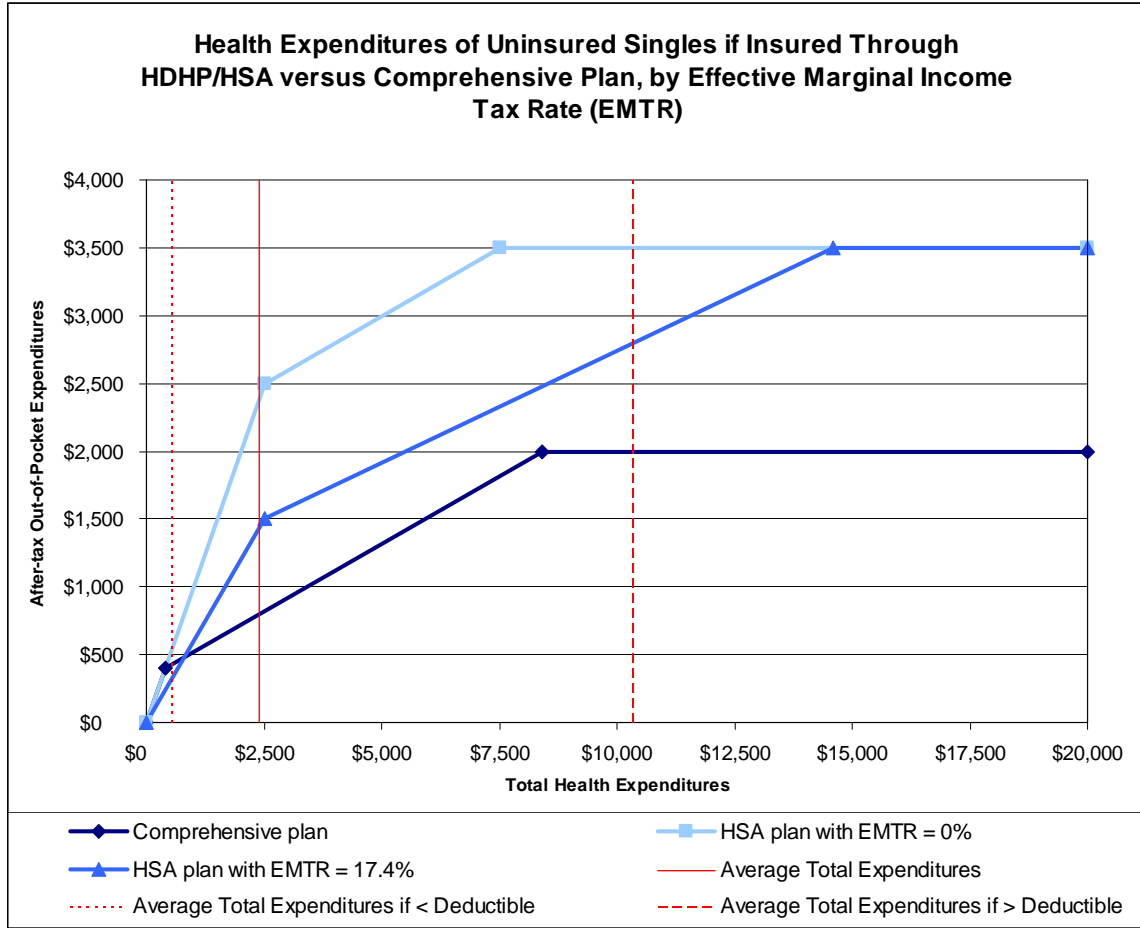
Figure 1 illustrates how cost sharing and effective marginal tax rates (EMTR) affect the after-tax out-of-pocket costs of a typical HDHP/HSA plan compared to a typical comprehensive plan for a single individual.<sup>75</sup> The HDHP/HSA plan has a deductible of \$2,500 and a maximum out-of-pocket limit of \$3,500; the comprehensive plan has a deductible of \$400 and a maximum out-of-pocket limit of \$2,000. The two EMTR depicted under HDHP/HSA plans are zero and 17.4%. Average total expenditures of an uninsured single gaining coverage through an HDHP is \$2,412, which is marked by a vertical line. When an individual's total expenditures are less than the deductible, average total expenditures are \$549 and are marked by a dotted line; if total expenditures exceed the deductible, average total expenditures are \$10,341 and are marked by a dashed line. The graph illustrates several points. First, HDHP/HSA enrollees in the higher EMTR have the lowest marginal cost of out-of-pocket expenditures between \$0 and \$400. HDHP/HSA enrollees in the lower EMTR have the highest marginal cost of out-of-pocket expenditures and the highest out-of-pocket expenditures at all points in the spending distribution. In addition, although HDHP/HSA enrollees have higher out-of-pocket expenditures than comprehensive plan enrollees for any given level of total expenditures, HDHP/HSA enrollees in the higher EMTR have lower marginal cost than comprehensive plan enrollees for between \$2,500 (the HSA deductible) and \$8,400 (the point at which the comprehensive plan incurs the maximum out-of-pocket liability). Those with total expenditures less than the HSA deductible, where marginal cost is highest, account for 81.0 percent of this population. However, with an average total

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<sup>75</sup> Glied and Remler (2006) and Reinhardt (2007) have presented similar graphs where either there is no variation across tax rates and/or the deductible is equal to the maximum out-of-pocket liability.

expenditure of just \$549, their expenditures accounted for just 18.4 percent of expenditures in this population.

Figure 1.



Thus, the effect of new policies regarding HSAs on take-up of HDHP/HSA plans in the non-group market is likely to be driven by how individuals view the tax advantages of HSAs. However, the relatively high administrative loads charged in the non-group market will limit the decrease in the premium relative to the group market. In the long run, however, many individuals may find that the benefits of staying in the non-group market decrease as they age, since “individually risk-adjusted premiums [in the non-

group market] generally only provide insurance against annual uncertainty in health spending but not against persistently costly health conditions.”<sup>76</sup>

In contrast with the non-group market, the effects of increased enrollment in HDHP/HSAs on risk segmentation in the employer-sponsored health insurance market (sometimes referred to as the ESI or “group” market) have more consequence for the current status quo in health insurance. Some proponents of HSAs argue that if employers offer a high-deductible plan, healthy consumers who were previously uninsured because of high premium rates, would newly choose to purchase coverage, lowering the average risk level in the employer pool.<sup>77</sup> While coverage rates may increase for some healthy individuals who choose a high-deductible group plan, these individuals will be induced to purchase insurance only if the plan offers a low premium. Members of such a plan would include primarily those with low expected health expenditures, implying that continued and increased segmentation of risk would be required to keep premiums down to attract these price-sensitive, healthy individuals. The result would be greater segmentation of the employer health insurance market by health status, e.g. by attracting healthy individuals to one plan and leaving less healthy individuals — who experience high health expenditures — in a separate, more comprehensive health plan.<sup>78</sup>

Some individuals, who were uninsured despite having an offer of group coverage, may be induced to take-up the newly offered employer-sponsored HSA-qualifying plan due to the tax advantages and lower premiums. However, those who decline an employer

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<sup>76</sup> Furman, Jason (2006). “Two Wrongs Do Not Make a Right,” *National Tax Journal*. Volume 59 (3).

<sup>77</sup> Mango and Riefberg 2005.

<sup>78</sup> Holzer, Jessica. February 3, 2006. “The Wealth in Your Health.” *Forbes Online*. [www.forbes.com/healthcare/2006/02/03/hsa-healthcare-insurance-cx\\_jh\\_0203hsa.html](http://www.forbes.com/healthcare/2006/02/03/hsa-healthcare-insurance-cx_jh_0203hsa.html); Blumberg 2004; Hibbard et al. 2004; McNeil 2004; Burman 2006.

offer of ESI are more likely to be lower-income<sup>79</sup>, thus the HAS tax benefits would be less attractive. In any case, enrollment rates in ESI are already quite high; among those who are eligible to enroll in their employer's offer of health insurance, 83.2 percent do enroll.<sup>80</sup> Thus, in terms of number of people affected by the introduction of HDHP/HSA plans, the largest impacts will be on the choices of those previously covered by ESI. Simulation studies of plan choice among a firm's ESI offerings confirm the theoretical hypothesis that plans with features similar to HDHP/HSAs have the potential for exacerbating risk selection based on health status.<sup>81</sup> Survey data from the 2007 Kaiser/HRET shows that, currently, the vast majority (87%) of firms sponsor only one type of health insurance plan.<sup>82</sup> Larger firms are more likely to offer plan choice than smaller firms. The Kaiser/HRET, 44 percent of firms with 200 or more employees sponsor more than one plan, while only 11 percent of firms with 3 to 99 employees do so.

Among large employers who offer multiple plans, the concentration of high-risk individuals in one plan and low-risk individuals in another plan could escalate premiums in the high risk plan. Some analysts forecast a slow erosion of employer-sponsored coverage and that the introduction of HSA-qualifying plans as a choice for employees may precipitate "the disappearance of generous plans, even if these plans had been operating efficiently."<sup>83</sup> If employers scale-down or drop the low-deductible options,

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<sup>79</sup> Clemans-Cope and Garrett, 2006.

<sup>80</sup> Clemans-Cope and Garrett, 2006.

<sup>81</sup> Keeler, Emmett B. et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association*, June 5, 1996, p. 1666-71.

<sup>82</sup> These data are collected at the firm-level, so a firm may sponsor different health insurance plan types at different establishment locations. Hence, a firm that is reported to sponsor more than one plan may yet sponsor only one plan at each establishment location.

<sup>83</sup> Glied and Remler 2005.

some chronically ill individuals may be underinsured, bearing a greater burden for their own health expenses and vulnerable to a potentially large financial risk year after year.<sup>84</sup>

The phenomenon of adverse selection when health insurance plan choice is offered in the group market has been observed in several studies. Cutler and Reber (1998) described adverse selection at Harvard University when it added a less generous HMO health insurance plan option to the more generous PPO health insurance plan option.<sup>85</sup> While the less healthy university enrollees stayed in the more generous option, the healthier enrollees switched to the less generous option due to the lower premiums available in the HMO option. Eventually, based on the health risk selection in the PPO as compared to the HMO, the PPO premiums increased so much that the university dropped the more generous option due to the prohibitive premium cost. In another example of adverse selection, Burman (1997) reported that the Federal Employees Health Benefits Plan (FEHBP) dropped a slightly more generous low-deductible health insurance option after experiencing significant risk selection of young, healthy employees into the slightly less generous a high-deductible option.<sup>86</sup>

Policies offering expanded tax preference to HDHP/HSAs purchased through the non-group market may have deleterious effects on employer-based coverage, particularly among small firms who have individuals in poor health. Healthy workers in small firms with other healthy workers may benefit from the expansion of HDHP/HSAs. However, healthy workers are likely to get an offer of health insurance through the non-group market. Thus, healthy workers who are in small firms with less healthy individuals may reject coverage offers made by small firms, and instead obtain their coverage through an

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<sup>84</sup> Burman 2006; Blumberg 2004.

<sup>85</sup> Cutler and Reber, *The Quarterly Journal of Economics*, May 1998.

<sup>86</sup> Burman, "Medical Savings Accounts and Adverse Selection," 1997.

HDHP/HSA in the non-group market. Group premiums for those individuals left behind – some of whom cannot obtain offers in the non-group market due to their health problems – may then increase unsustainably, leading to decreases in both offer and take-up rates in smaller firms.<sup>87</sup> While healthier small group employees may experience net increases in coverage, those who are less healthy may be uninsured at higher rates, particularly in the absence of non-group reforms, such as nation-wide regulations limiting medical underwriting.

## **V. Conclusion**

High-deductible health insurance plans have always been a part of the non-group and small group health insurance markets, however HSAs introduced new tax advantages affecting the out-of-pocket expenditures related to these HDHPs. Since HDHP/HSAs have been available only since 2004, it is too early to gauge the full effects of HDHP/HSAs on costs and health insurance markets. To date, rates of coverage in these new plans have been relatively modest.

There are numerous proposals to expand enrollment in HDHP/HSAs. In the long-term, the impact of HDHP/HSA plans on coverage and the character of health insurance plans depends on the features of the new policies implemented, and on how employers and individuals respond. Previous research has found that proposals are more likely to reduce uninsurance when they are structured such that those who are currently least likely to purchase coverage (such as lower-income individuals) receive the greatest tax benefit, while those who are likely to purchase coverage even in the absence of a subsidy (the

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<sup>87</sup> Blumberg, 2004; Glied and Remler, 2005.

high income) receive little or no subsidy.<sup>88</sup> The tax advantages associated with current HDHP/HSAs, as well as many new proposals regarding the expansion of HDHP/HSAs, work in precisely the opposite direction.

The extent to which new policies to expand enrollment in HDHP/HSAs will exacerbate risk pool segmentation in the group market is related to how many employers offer a choice of health insurance plans and the resulting employee enrollment patterns. There is historical evidence suggesting that these new subsidies may further selection of lower-risks into high-deductible plans, raising premiums for individuals with higher health risks, which could in turn lead to high financial burdens for the less healthy and chronically ill. Moreover, shifts in the distribution of coverage across markets are an important consideration. If new policies attract more people to the non-group market causing some employers to drop offers, regulations limiting underwriting in the non-group market and enhancing risk pooling may be necessary to ensure that all individuals have an affordable health insurance option. Without substantial reform of the non-group market, even many relatively healthy individuals may find that the benefits of staying in the non-group market decrease as they age, since their premiums will tend to increase dramatically. In the long run, coverage expansions gained through increased enrollment in HDHP/HSAs must be weighed against the problems of risk selection and adverse health outcomes from inappropriate health service utilization in response to increased cost-sharing, both of which may affect have a relatively larger impact on the low-income and less healthy individuals.

In terms of overall cost containment, it is clear that HDHP/HSAs change spending incentives along a number of different dimensions relative to traditional health insurance

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<sup>88</sup> Gruber (2006), Gruber (2008) “Covering the Uninsured in the U.S.”

plans, with effects both in the short and long term.<sup>89</sup> Some have argued that in the short term, HDHP/HSAs will make individuals who enroll in them more cost conscious when making their health care choices, which should in turn lower spending on health care, particularly on discretionary health services.<sup>90</sup> Others contend that their impact on overall spending growth is at best ambiguous, since the marginal cost of expenditures under an HDHP/HSAs could actually be reduced compared to traditional plans, depending on an individual's effective marginal tax rate. In addition, while many studies attribute the majority of the growth in health care spending to technological innovation, there is little evidence indicating that greater cost sharing will slow the adoption of new technology.<sup>91</sup> Moreover, if new policies include greater tax incentives to spend out-of-pocket on health, those enrolled in HDHP/HSAs before the new policy would then experience greater incentives to spend on health care after the policy.<sup>92</sup> Thus, many argue that HDHP/HSAs alone will not constrain spending growth, and that overall cost containment in the long run can be achieved only by a combination of greater cost sharing and modern managed care mechanisms working in tandem to control spending above the deductible and the out-of-pocket maximums.<sup>93</sup>

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<sup>89</sup> Fuchs and James 2005; Fronstin, Paul, and Sara Collins. 2005. "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; Parente, Stephen, Roger Feldman, and Jon Christianson. 2004. "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization." *Health Services Research* 39(4): 1189-1209; Solanki, G., H.H. Schauffler, and L.S. Miller. 2000. "The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services." *Health Services Research* 34(6): 1331-1350; Newhouse, Joseph. 2004. "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs* Volume 23(6): 107-113.

<sup>90</sup> Feldstein, 2004; Cogan, John F., R. Glenn Hubbard, and Daniel P. Kessler. 2004. "Healthy, Wealthy, and Wise: The American Health Care System is Broken. Here's How to Fix it." The Hoover Institution, Hoover Digest. No. 3; Mango, Paul D. and Vivian E. Riefberg. 2005. "Health Savings Accounts: Making Patients Better Consumers." *McKinsey Quarterly* web exclusive; Pendleton, James L. November 2005. "Market Insurance and Health Savings Accounts." Consumers for Health Care Choices. Members paper number 4.

<sup>91</sup> Buntin et al. 2004.

<sup>92</sup> Furman, Jason (2006). "Two Wrongs Do Not Make a Right," *National Tax Journal*. Volume 59 (3).

<sup>93</sup> Newhouse 2004.

The development of policies that include HDHP/HSAs may be useful in addressing the problems of coverage, cost-containment, and the financial burden of health spending for certain individuals and families. However, policymakers need a clearer understanding of the trade-offs. How large or small are the tax savings relative to the premium and out-of-pocket expenditures under alternative health insurance plans? How much do they vary by income and health status? Are these tax savings a cost to the government? To what extent are these tax savings similar to what an individual would have received through a traditional plan in the group market? Are there non-group regulations that could reduce underwriting and increase pooling? Are there better options for pooling risk and increase cost-containment? Answering these questions will be a focus for policy related research in the future.