Policy Analysis
No. 569 May 30, 2006

Routing

Health Savings Accounts
Do the Critics Have a Point?

by Michael F. Cannon

Executive Summary

Health savings accounts, or HSAs, are a new health insurance option that became available in 2004. HSAs couple a tax-preferred savings account (the HSA) with high-deductible health insurance. Enrollees or their employers, or both, make tax-free contributions to the HSA. Enrollees use the funds in their HSAs to purchase medical care until they reach their deductibles. At that point, health insurance begins paying part or all of enrollees' medical expenses.

HSAs reduce government's influence over consumers' medical decisions by reducing the price distortions created by the federal tax code. However, HSAs as they exist today do not eliminate those distortions. Current HSA law restricts consumers' health insurance choices, makes it difficult for the chronically ill to save for their future medical needs, and discourages cost sharing above the health insurance deductible.

To address some of those shortcomings, President Bush proposes to reduce the price distortions further, through higher HSA contribution limits and tax credits for individuals who contribute to their HSAs or who purchase their own HSA-compatible insurance. Although those steps would be helpful, HSAs should be expanded further still to give individuals full ownership of and control over all their health care dollars.

Unfortunately, HSAs (and proposals to expand them) have become politicized. Critics contend that HSAs benefit only the healthy and the wealthy and that HSAs are ineffective or even harmful. In most cases, criticisms of HSAs fall flat. In some cases, the critics do have a point. However, the failures they identify stem not from HSAs or proposals to expand them but from the problems that HSAs are meant to correct. Expanding HSAs would help to correct those problems faster.

Michael F. Cannon is director of health policy studies at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It *(2005).*

HSAs emerged from a recognition that federal tax laws distort the private-sector decisions that people make about how to pay for health care and how much health care to consume.

Introduction

Health savings accounts, or HSAs, are a new type of health insurance option that first became available in 2004. As a concept, however, HSAs have been discussed by policymakers and economists for decades.[1] Originally called "medical savings accounts," HSAs emerged from a recognition that federal tax laws distort the private-sector decisions that people make about how to pay for health care and how much health care to consume.

Federal tax law treats employer-provided health insurance differently than cash wages. Whereas cash wages are subject to federal payroll taxes (15.3 percent), federal individual income taxes (which range from 0 percent to 35 percent), and state individual income taxes (which range from 0 percent to 10 percent), the amount that employers pay for employee health benefits is not subject to those taxes. (In some cases, neither are employee contributions.) That encourages workers

1. to obtain health insurance through an employer, because the tax savings lower the relative price of employer-sponsored coverage;
2. to demand comprehensive third-party health coverage, because any medical care purchased through their employer plan is effectively tax-free; and
3. to consume more medical care than they otherwise would, because comprehensive third-party coverage insulates patients from the cost of care at the point of service.

Those responses contribute to the rising cost of medical care and health insurance.[2] Conversely, the tax code penalizes people without employer-sponsored health insurance.

HSAs were proposed by economists to reduce the distortions of consumer behavior and to encourage more sensible decisionmaking about how much medical care to consume and how to pay for it. HSAs partially level the playing field between employer-sponsored health insurance and self-insurance—that is, saving for one's medical expenses. Thus, HSA deposits largely enjoy the same tax-preferred status as employer-provided health insurance.

How HSAs Work

HSAs combine a high-deductible health insurance policy with a tax-free savings account (the HSA).[3] Enrollees or their employers, or both, make tax-free contributions to the HSA. Enrollees can withdraw funds from their HSAs tax-free for out-of-pocket medical expenses. Once an enrollee reaches her health insurance deductible, the insurance coverage begins to pay for part or all of her medical care.

People with HSA coverage must have a "qualified high-deductible health plan," or HDHP. Essentially, a health plan covering an individual must have a deductible no lower than $1,050 and a limit on out-of-pocket spending no higher than $5,100. For families, the HDHP must have a deductible no lower than $2,100 and a limit on out-of-pocket spending no higher than $10,200.[4] HDHPs may cover some preventive services below the deductible, but they are not required to do so.

HSA holders or their employers, or both, can make tax-free contributions to the HSA. The maximum contribution that individuals can make in 2006 is the amount of their health insurance deductible or $2,700, whichever is lower. Those with family coverage may contribute the lesser of their insurance deductible or $5,450. HSA holders between the ages of 55 and 64 may make additional "catch-up" contributions of $700 in 2006.[5] Funds from the HSA may be used to cover any medical expense; withdrawals for this purpose are not taxed. Unused HSA funds remain in the account, earn tax-free interest, roll over from year to year, and follow the account holder wherever she goes.

In theory, HSAs will make patients more prudent consumers of medical care, because consumers are more cost conscious when spending their own money. Patients will ask their providers more questions about the costs and benefits of different options, such as

brand-name versus generic drugs. One survey found that people with HSAs or similar coverage were 50 percent more likely to ask providers about costs, 33 percent more likely to seek out treatment alternatives, and three times more likely to choose a less-expensive treatment alternative.[6] Greater cost consciousness on the part of patients should induce providers to pay greater attention to price and quality as well. Just as HSAs are making patients more cost conscious, entrepreneurs are responding with services that make access to care more convenient and affordable.

Since HSAs became available in January 2004, the number of Americans enrolled in HSA-compatible health insurance has grown to three million, though the number who have opened HSAs is smaller and less certain.[7] HSA asset growth has outpaced the initial growth of IRA assets. Observers have variously projected that there will be six million HSAs with $5 billion in assets by 2008[8] and as many as 25 million HSAs holding $75 billion by 2010. One report projects that HSAs will cover 1 of every 10 individuals by 2010.[9]

HSAs do not eliminate the price distortions that federal tax laws create between health and nonhealth expenditures. Nor do they completely eliminate the price distortions that federal tax laws create between different types of health expenditures (i.e., employer-paid insurance premiums, individually purchased insurance, self-insurance, and out-of-pocket medical spending). People without access to employer-sponsored health insurance still face large tax penalties when purchasing health insurance or contributing to an HSA.

More concretely, HSAs unnecessarily restrict consumer choice. Current law requires enrollees to accept a government-designed health insurance policy in order to save tax-free for their medical needs. Chronically ill patients, for example, cannot combine an HSA with a health plan that covers prescription drugs below the catastrophic deductible. Moreover, chronically ill patients are effectively prevented from accumulating savings in their HSAs because they cannot contribute even one penny more than the amount of their deductible, even if they are likely to exceed their insurance deductibles year after year.

President Bush has proposed small steps that would address many of those shortcomings. He proposes (1) to increase the annual limit on HSA contributions from the amount of an enrollee's health plan deductible to the health plan's limit on out-of-pocket costs, (2) to create tax credits that would eliminate the price distortions between individual and employer contributions to an HSA, (3) to create tax credits that would eliminate the price distortions between individually purchased and employer-purchased HDHPs, and (4) to allow people to use their HSA funds to pay the premiums of HSA-compatible health insurance. The higher proposed contribution limits (up to $5,250 for individuals and $10,500 for families) would help more people save for their future medical needs. Those proposals would provide tax parity to millions who are unfairly punished by the tax code.

Although those steps would be helpful, HSAs should be expanded further still. First, HSA contribution limits should be raised so that nearly all individuals could take 100 percent of their health benefits as a tax-free cash deposit into their HSA. For example, the contribution limits could be raised to $8,000 per individual and $16,000 per family. Second, consumers with such "large HSAs" should be permitted to use those dollars to purchase health insurance tax-free from any source. Large HSA holders could purchase coverage from their employer, the individual market, or elsewhere. Third, Congress should eliminate the HDHP requirement and allow large HSA holders to purchase whatever health plan they wish. Those changes would give individuals full ownership of and control over all their health care dollars.[10] President Bush's proposals take measured steps toward that larger goal.

HSAs should be expanded to give individuals full ownership of and control over all their health care dollars.

Criticisms That Fall Flat

The president's HSA expansion proposals have put HSAs back on the national agenda. Unfortunately, those proposals have become

unnecessarily politicized, drawing fire from the president's critics.[11] Though many criticisms of HSAs come from the left side of the political spectrum, it is worth noting that early supporters included former senate majority leader Tom Daschle (D-SD) and former senator John Breaux (D-LA).[12]

Detractors charge that HSAs benefit only people who are healthy or wealthy, or both. They also argue that HSAs will fall short of proponents' claims, are unfair to low-income workers, and may even be harmful. This section explores the least defensible criticisms of HSAs.

Health Savings Accounts Don't Work for Those Who Are Not Healthy

Critics most often allege that HSAs coupled with high-deductible health insurance are a good deal if you are healthy but a bad deal if you are sick.[13] Supporters typically respond by citing data showing that HSAs are attracting enrollees of all ages; this is meant to suggest that because HSAs attract older individuals, they must be attractive to less-healthy individuals. However, many older people use very little medical care. One study found that the demographic profile of workers who chose HSA-like plans was similar to that of workers who chose traditional plans, yet those who chose the traditional plans nonetheless had significantly higher past medical expenses.[14]

HSAs and the Healthy

HSAs do enable generally healthy people to save, tax-free, the money that they would otherwise spend on unnecessary health coverage. Data from the Kaiser Family Foundation suggest that the premium savings that come from switching to high-deductible coverage can be considerable. In 2005 the average employer-provided health plan cost $4,024 for self-only coverage and $10,880 for family coverage. The average annual premium for an HSA-compatible HDHP was $2,700 for self-only coverage and $7,909 for family coverage. The difference in premiums was $1,324 for individuals and $2,791 for families, which is enough to cover about 70 percent of the average HSA deductible for individuals ($1,901) and families ($4,070).[15] After two years, the premium savings alone could more than cover the average annual deductible. Therefore, HSAs would allow healthy people to save money that they are currently "throwing down the premium hole," while still maintaining protection against large medical bills.

Savings of that magnitude could leave millions of Americans better off. In 2001, 60 percent of nonelderly individuals with health insurance spent less than $1,000 on medical care, and 90 percent spent less than $5,000.[16] Merely by being a good deal for the healthy, HSAs would benefit the vast majority of the population.

Moreover, most individuals could accumulate substantial HSA assets over time, because most of those with high health expenses in a given year have lower expenses in subsequent years. Economists Matthew Eichner of Columbia University and David Wise of Harvard University simulated the balances that workers could accumulate in HSAs. The researchers assumed that workers saved $2,000 per year in HSAs beginning at age 25 and invested those funds in stocks. Even after accounting for lifetime health expenditures, Eichner and Wise found that by age 60, 90 percent of men would accumulate more than $150,000 in their HSAs, and 90 percent of women would accumulate more than $100,000. The authors concluded that, by funding an HSA, "the typical employee would see a substantial increase in assets at retirement."[17]

HSAs and the Sick

What about people who are sick? The best evidence available shows that, on average, those in ill health fare no worse with high-deductible insurance than they do with other types of coverage, including "free" health care. Over a 12-year period, the RAND Health Insurance Experiment studied 2,000 families that were randomly assigned to different types of health insurance. Some of those families were given "free" health care. Others were assigned coverage with cost sharing, including some plans that resembled HSAs.

Merely by being a good deal for the healthy, HSAs would benefit the vast majority of the population.

Health outcomes for people with high deductibles were overall no worse than for those with any other type of coverage. That is despite the fact that those with high-deductible insurance consumed far less medical care.[18] Those findings were consistent regardless of whether an individual was high- or low-income and regardless of whether an individual was initially in good or ill health.[19] The investigators wrote, "Our results show that the 40 percent increase in services on the free-care plan had little or no measurable effect on health status for the average adult." In fact, those with high deductibles had fewer restricted activity days.[20] As discussed further below, there is little evidence to suggest that high-deductible insurance results in worse outcomes for those in ill health. The RAND experiment provides significant evidence to suggest that it does not.

Nonetheless, some critics allege that HSAs will be unattractive to less-healthy individuals. Yet many scholars have argued the opposite: that HSAs can be attractive to those with high expected medical expenses. Moreover, expanding HSAs—by permitting larger contributions and more health insurance choices—would make them even more attractive to those individuals. Finally, people who frequently interact with the health care system stand to benefit the most if HSAs encourage patients to be more prudent consumers and force providers to become more competitive.

Some researchers, including critics of HSAs, note that HSAs would attract unhealthy as well as healthy individuals. Scholars at the RAND Corporation have projected that, "depending on the size of the catastrophic [deductible], waste from the excessive use of generously insured care could be reduced, and [HSAs] would be attractive to both sick and healthy people."[21] Others have reached similar conclusions.[22] Some evidence even suggests that the chronically ill prefer the more flexible access to providers that comes with HSA-like plans.[23]

This suggests that predicting who will prefer HSAs and who will prefer more traditional health insurance is difficult. The nonpartisan Congressional Research Service observes:

> Some less healthy people may find HSA plans attractive because they enable them to circumvent the restrictions of managed care plans. Conversely, some healthy people may find them unattractive because they are very risk-averse; they would prefer to pay more for comprehensive insurance with low deductibles. Older people may find HSA plans attractive because of the tax advantages: being in higher tax brackets (since average earnings increase with age until people are in their 50s), their tax savings from contributions would be greater. People who are 55 but not yet 65 years of age would also be attracted by the additional catch-up contributions they may make. By the same token, younger people with low incomes may consider the HSA tax advantages inconsequential.[24]

Thus the appeal of HSAs cannot be reduced to blanket statements that they are good for the healthy and bad for those with high health care costs, or vice versa.

The HSA features most likely to be unappealing to less-healthy consumers are the current limits on tax-free contributions and the lack of health insurance choices. Under the current contribution limits, for example, the chronically ill likely would use up all their HSA deposits in a given year and have little opportunity to save for future medical needs. President Bush's proposal to increase the contribution limits would help some chronically ill individuals. The president also proposes allowing employers to make larger contributions to the HSAs of chronically ill workers than to the HSAs of other workers. However, those proposals still would not allow HSA contributions in excess of an enrollee's out-of-pocket exposure. Thus some chronically ill enrollees still would have no opportunity to build up savings in their HSAs. As discussed further below, the prohibition of any below-the-deductible coverage

HSA features most likely to be unappealing to less-healthy consumers are the current limits on tax-free contributions and the lack of health insurance choices.

for treatment of chronic illnesses also makes HSAs unappealing to those patients.

Health Savings Accounts Shift Costs to Workers

Some critics maintain that HSAs allow employers to shift the cost of health benefits to workers.[25] Rather than provide comprehensive third-party health coverage, employers will switch to HSA plans, making workers shoulder a greater share of their health care costs. That criticism rests on a misunderstanding of the economics of employee health benefits. Rather than shift costs to workers, HSAs give workers more control over their compensation.

Rather than shift *costs* to workers, HSAs shift to workers greater *control* over the health benefits portion of their compensation.

Economists generally agree that the cost of health benefits is already borne by workers.[26] Health benefits, cash wages, and other remuneration are all components of an employee's total compensation. Employees bear the burden of an increase in the cost of health benefits because employers react to such increases by reducing other forms of compensation. That is one reason why real nonwage benefits increased 26.2 percent between 1989 and 2004, but real wages rose just 7.5 percent.[27] Workers understand this intuitively: an employer that does not offer health benefits must offer higher cash wages to compete for workers. Workers who choose the job with health coverage bear the cost of that benefit in the form of the higher cash wages forgone. HSAs cannot shift to workers costs that workers already bear.

Rather than shift *costs* to workers, HSAs shift to workers greater *control* over the health benefits portion of their compensation. Before 2004 Congress generally exempted workers' health care dollars from taxation only if workers surrendered control over those dollars to an employer. In contrast, HSA deposits, which the employee owns and controls, enjoy the same tax treatment as employer-provided health benefits. HSAs thereby allow workers to reclaim control over a part of their compensation that the government previously encouraged them to surrender to their employers.

HSAs Will Lead to Adverse Selection

Some observers predict that HSAs will cause premiums to rise for "traditional" health plans that offer more comprehensive third-party coverage. If healthy workers leave traditional insurance products for HSAs, then traditional plans will be left with a less-healthy pool of customers. More formally, HSAs would experience *advantageous* selection by healthier workers, while traditional plans would experience *adverse* selection by less-healthy workers. That would cause traditional insurance premiums to rise, which in turn could encourage additional healthy people to leave traditional plans, causing those premiums to increase further. Thus the rational choices of individual workers could make traditional coverage increasingly unaffordable. Some scholars have predicted that premiums for traditional plans could rise by as much as two-thirds.[28]

Though the evidence thus far is mixed,[29] it is probable that HSAs will lead to some degree of risk selection. The following hypothetical illustrates the effects that HSAs may have on traditional coverage and why concerns about risk selection should not stand in the way of encouraging and expanding HSAs.

Selection and Subsidies: A Hypothetical

Suppose an aging professor proposes to a student an insurance policy, which we will call Plan A. The policy would cover 100 percent of their medical expenses, and each would pay a premium equal to one-half of their combined medical expenses. From the professor's point of view, Plan A is a great deal. The student's premiums would heavily subsidize his larger medical expenses. From the vantage point of the student, Plan A would be less desirable. Her expected medical costs would be well below the proposed premium, meaning that she could purchase equivalent coverage at a much lower price. She likely would turn the offer down, but we will assume she does not.

When we expand Plan A to 1,000 students and 1,000 aging professors, all of whom pay

the same premium, we see that it would be socially undesirable as well. First, because it would heavily subsidize the professors' medical consumption, it would encourage the professors to waste resources on low-value health care. In fact, the professors could be expected to consume care that provides little or no benefit, and even care that is harmful.[30] Plan A might even induce the students to do the same, because the cost of care would be zero at the point of service. Second, increased consumption by either group would make Plan A more expensive for the entire pool, even those who did not increase their consumption. Third, Plan A would discourage socially desirable behaviors. Because neither students nor professors could reduce their premiums by quitting smoking or monitoring their diabetes, fewer would do so. Again, if this were the students' only health insurance option, many would likely go uninsured rather than pay such excessive premiums. But we will assume that all students participate.

Now suppose the group alters the contract. The group agrees that students and professors should have the choice of another health plan, Plan B. Plan B's premiums would be determined the same way as Plan A's: by averaging the medical expenses of all the people in that pool. However, Plan B would offer no coverage until one's medical expenses exceeded a high deductible. The high deductible would ensure that Plan B's premiums would be lower than Plan A's, because fewer enrollees would file claims and those claims that were filed would be smaller. Enrollees who switched to Plan B could deposit the premium savings in an account.

Plan B would experience advantageous selection by the students, because it would narrow the wide gap between the premiums they would pay and the benefits they would receive under Plan A. Conversely, Plan A would fall prey to adverse selection by the professors. As more students opted for Plan B, Plan A's pool of enrollees would become professor-heavy, causing that plan's premiums to rise. As a result, additional students would leave Plan A, and the cycle would repeat itself.

Initially, the professors would not find Plan B very attractive because it would greatly reduce the subsidies they received from students. (For that reason, they might even resist Plan B's introduction.) However, as their premiums under Plan A became less and less affordable, professors would also begin to switch to Plan B. This response is socially desirable, because professors (and students) would pay for medical care below the deductible directly, rather than through the financial instrument of insurance. Because participants would be spending their own money, they would be less wasteful consumers.

Eventually, premiums for Plan A could rise so much that all professors would move to Plan B. If that happened, Plan B would exhibit the same dynamic as Plan A did: students would again subsidize professors, because the premiums would be based on the average risk of the entire pool. The subsidy would be smaller than in Plan A, because Plan B would pay only those expenses above the deductible. Still, each student would be paying more than it would cost to insure herself, because she would be less likely than the "average" enrollee to have medical expenses that exceed the deductible.

Now consider one final change to the contract. Suppose the group also allows members to choose from Plans C through Z, each of which has a different deductible and sets premiums according to an individual's age, gender, behavior, and known medical conditions. Again, we would expect students to migrate to plans that gave them their preferred deductible at the lowest price. That would further reduce the subsidies that professors received from students.

Even though the professors would be likely to resist, these changes would also be socially desirable. All participants would have more health insurance choices. Lower premiums would mean that fewer students would go without health insurance. Students would have more disposable income to spend on other items (e.g., tuition and books). Professors would seek to reduce their insurance premiums

Concerns about risk selection should not stand in the way of encouraging and expanding HSAs.

Though HSAs may reduce hidden subsidies to sicker workers, they do not preclude subsidizing those workers in other ways.

by choosing higher deductibles, which would encourage them to be even more careful consumers. Allowing premiums to vary according to one's expected medical expenses would create financial incentives for participants to take better care of themselves. If participants can reduce their insurance premiums by quitting smoking, monitoring their blood sugar, lowering their blood pressure or cholesterol, and the like, then more participants will do so.

Though the professors would lose the cross-subsidies they received under Plan A, those losses would essentially be temporary transition costs. The higher health insurance premiums for today's professors would convey to today's students the importance of saving for their future medical needs. Thus tomorrow's professors would face greater incentives to save for their future medical needs. Because their current premiums would be lower, they would be better equipped to do so.

Risk Selection in Job-Based Insurance

Plan A in this hypothetical roughly describes how employment-based insurance pools operate. Some healthy workers opt out of the pool. The healthy workers who do enroll in an employer-based plan often pay more (in premiums and reduced wages) than they cost to insure. Those extra payments subsidize the medical spending of workers with higher medical expenses. All involved face incentives to overconsume medical care and diminished incentives to take care of themselves.

Critics fear that HSAs (and proposals to expand them) will reduce the subsidies that workers with high expected medical expenses ("professors") receive from healthier workers ("students"). Within firms, healthier workers may gravitate toward an HSA option (akin to Plan B), reducing subsidies for those who remain in traditional plans. Critics also fear that HSAs may induce healthier workers to leave employer plans and purchase coverage on the individual market (Plans C–Z). That option may be more attractive to some workers if premiums in the individual market correspond to their expected medical costs, rather than the (higher) expected costs of their coworkers. If so, that too would reduce subsidies to higher-cost workers.

The above hypothetical illustrates that the risk selection process produces desirable results. First, a level playing field for all types of health insurance, including self-insurance, respects the right of consumers to choose how to plan for their medical needs. Second, it makes health insurance more affordable for many who now face unnecessarily high health insurance premiums. Third, all workers, healthy and unhealthy alike, likely will gravitate toward insurance with higher deductibles. That will encourage all workers to be more cost conscious medical consumers and should force health care providers to become more efficient. Fourth, consumers will take better care of their health when doing so can save them money on their premiums.

HSA critics fear that risk selection will also produce undesirable outcomes. First, many less-healthy individuals may be left paying more for their health insurance or with less-comprehensive coverage, or both. However, if adverse selection causes premiums for traditional health plans to rise dramatically, that, by definition, indicates that those plans were economically inefficient and covered medical expenses that were not insurable. Second, and of greater concern, sicker individuals may not be able to afford the high out-of-pocket expenses for which they will be responsible, and they may not be able to afford health insurance at all. Yet veiled redistribution under the rubric of health "insurance" is not the way to address that concern. Such redistribution produces the overconsumption and other harmful incentives that we currently see in the private health care sector.

Though HSAs may reduce hidden subsidies to sicker workers, they do not preclude subsidizing those workers in other ways. Other options include government subsidies or private charity, including assistance from family and friends, churches, civic associations, and uncompensated care from hospitals and doctors. Employers are also an

option. To the extent that cross-subsidization currently exists within firms, it may be understood as an implicit agreement under which employers pay workers with high medical expenses more than those with low medical expenses. There is nothing about HSAs that prevents people from perpetuating such agreements. Indeed, HSAs could be used to facilitate them: President Bush has proposed allowing employers to contribute more to the HSAs of chronically ill workers than to those of other workers. However, those agreements would have to be explicit, and the subsidies visible.

Explicit subsidies are in fact preferable to hidden subsidies. Explicit subsidies give firms, workers, and voters an opportunity to weigh costs and benefits. Hidden subsidies deny the public that opportunity. The fact that subsidies might be rejected if explicit is no argument for preserving hidden subsidies. As Harvard University economist Martin Feldstein argues, "It is inappropriate in a democracy to use a deliberately opaque system to achieve a redistribution of income that would be rejected if proposed in a more transparent way."[31]

Much Ado about Nothing?

Nonetheless, the risk selection resulting from HSAs may not be as dramatic as critics fear. First, the extent of "pooling" (i.e., cross-subsidization) that takes place within firms may be less than is commonly believed. A number of factors act to reduce risk pooling within firms. Workers sort themselves into firms, and into health plans within firms, in ways that reduce risk pooling. Younger, healthier workers disproportionately choose jobs without health insurance, which limits the ability of employer plans to pool risk. Within firms, younger and healthier workers tend to choose less-comprehensive health plans (or decline coverage altogether),[32] which further reduces pooling.[33]

Firms also work to defeat risk pooling. Employers often screen job applicants for health risks[34] and tend to adjust cash wages to compensate for easily observable differences in risk.[35] That is, firms that offer health insurance pay older workers less than firms that do not provide coverage; the lower wages partly offset the added costs those workers impose on the company health plan. That means that many high-cost workers are already paying more for their health coverage—they are just paying in the form of reduced wages rather than higher premiums. Firms are responding to the rising cost of health insurance by increasing deductibles, coinsurance, and copayments. As in the above hypothetical, greater cost sharing reduces the subsidies that "professors" receive from "students." That strategy reduced the average annual premium increase for employment-based coverage by 2 to 4 percentage points each year from 2002 through 2004, and somewhat less than that in 2005.[36] (At present, that process is less kind to the "professors" than when HSAs reduce cross-subsidies, because the "professors" must meet the added out-of-pocket expenses with after-tax dollars.)

Second, research indicates that significant pooling occurs in the individual health insurance market. That is because insurers in that market have long offered products that keep premiums relatively stable even when the purchaser's health status deteriorates. Some scholars hypothesize that those subsidies will increase as more workers move from employer pools to the individual market.[37]

Finally, insofar as HSAs enable health care and health insurance markets to operate more efficiently, they will reduce the need for such subsidies, and their cost.

HSAs Will Not Expand Health Insurance Coverage

Some observers contend that a combination of risk selection and worker migration toward the individual health insurance market would encourage many employers to stop offering health insurance. Economist Jonathan Gruber has estimated that, although President Bush's HSA proposals would enable some currently uninsured people to obtain coverage, even more people would lose the coverage they have. On balance, Gruber predicts that President Bush's proposals would increase the number of Americans without health insurance by

The fact that subsidies might be rejected if explicit is no argument for preserving hidden subsidies.

600,000, primarily as a result of employers ceasing to offer health benefits.[38]

HSA supporters tend to dismiss such claims by pointing to data that seem to show that HSAs are extending coverage to the uninsured. However, the evidence that supporters cite is less than definitive. A survey of insurers conducted by the insurance lobby, America's Health Insurance Plans, found that approximately one-third of consumers purchasing HSA-compatible insurance in the individual and small group markets were previously uninsured.[39] A report by the online insurance broker eHealthInsurance found similar results in the individual market. That report also found that one-half of those with incomes below $15,000 who purchased HSA-compatible coverage in the first half of 2005 were previously uninsured.[40]

However, as Columbia University's Sherry Glied notes, a significant share of new purchasers of any type of health insurance on the individual market will be previously uninsured.[41] Thus those data do not reveal whether HSAs are any more attractive to the uninsured than other types of coverage. A survey by the Blue Cross Blue Shield Association did compare HSAs with other types of coverage. It found that 12 percent of those purchasing HSA-eligible insurance were previously uninsured, compared to 6 percent for traditional coverage.[42] While those results are promising, further study is in order.

HSAs will have complicated effects on health insurance coverage that cannot be known in advance, particularly if one assumes away changes they are likely to induce.

Gruber's projection that the president's proposals would reduce the number of Americans with health insurance by 600,000 is plausible, but so are many other outcomes. Gruber himself notes that, like all such econometric projections, his are "fraught with uncertainty." His model required him "to make important assumptions as to the attractiveness of HSAs relative to traditional non-group insurance options, and as to the ultimate premiums that will result in a much-broadened high-deductible plan marketplace."[43] As noted earlier, projections about the appeal of HSAs to particular individuals are not simple. Nor is projecting the relative prices of HDHPs and traditional plans in both the job-based and individual markets. Given that Gruber was looking at a population of more than 200 million individuals and found a change of 600,000 covered lives (or 0.3 percent), it is likely that that finding is sensitive to the underlying assumptions.

It is also important to put those projections in context. The Census Bureau reports that from 2000 to 2004 the number of Americans with employment-based health insurance dropped by 3.7 million from 64 percent to 60 percent of all Americans.[44] In other words, more than 900,000 Americans lost employment-based coverage on average in each of those four years. That is in part because premiums for employer-provided insurance increased a total of 73 percent from 2000 to 2005.[45] HSAs, and proposals to expand them, are efforts to arrest those trends by encouraging more cost conscious behavior.

However, Gruber acknowledges that his model did not include "any effect [that HSAs might have] on behavior in either the non-group or employer markets."[46] That is, his model accounts for the effects of the president's proposals on workers' decisions to buy health *insurance*, but not for the effects of those proposals on workers' decisions to purchase health *care*. The latter are crucial to understanding the overall effects of expanded HSAs. The president's proposals would change the relative prices of different types of insurance. However, they would have an even more dramatic effect on the prices that patients pay for medical care, by encouraging patients to pay directly for a larger share of their medical care. Medical consumption in turn has a large impact on the cost of health insurance. Yet Gruber assumes no secondary or tertiary effects of consumers facing higher out-of-pocket prices, such as more cost consciousness or downward pressure on prices.

HSA supporters expect that HSAs will make medical care and coverage more affordable *primarily* as a result of the behavioral changes they will induce on the part of both patients and providers. If supporters are correct, those unmeasured effects could easily overwhelm the effects that Gruber does mea-

sure. Moreover, any benefits of downward pressure on prices would be enjoyed by those with and without HSAs. In Gruber's defense, the effects that HSAs will have on medical consumption and provider behavior are even more difficult to estimate than the effects on coverage levels. HSAs will have complicated effects on health insurance coverage that cannot be known in advance, particularly if one assumes away changes they are likely to induce.

HSAs Are Special Interest Legislation

Sen. Richard Durbin (D-IL) has likened HSA expansion proposals to special interest legislation. On a television news program, he referred to HSAs as

> the brainchild of the Golden Rule Insurance Company back in the Gingrich era. . . . That's why they are being proposed. This is not good policy. We can have private sector health insurance, but we shouldn't be buying on to these schemes that haven't been well vetted and well thought out.[47]

In fact, the HSA concept was developed in the 1970s by Jesse Hixson, an economist with the American Medical Association, and Paul Worthington, a fellow at the Social Security Administration.[48] Over the subsequent 30 years, that concept was vetted and endorsed by prominent economists, including Nobel laureates.[49] The concept drew significant support from the results of the RAND Health Insurance Experiment, the most rigorous scientific experiment ever conducted on the effects of different health insurance designs. That academic pedigree fairly well establishes that HSAs and proposals to expand them are not designed to benefit the health insurance industry, or any particular industry.

Moreover, if any industry stands to gain from making HSA contributions tax-free, it is not the insurance industry but the financial services industry. Until recently, the tax treatment of employer-provided health benefits put banks at a competitive disadvantage relative to insurance carriers. Since World War II, workers have been able to prepay their medical expenses tax-free through comprehensive third-party insurance. In contrast, saving for one's medical needs could be done only with after-tax dollars, which diverted resources from banks to insurers and arguably contributed to America's low level of national saving. HSAs stand to benefit the financial services industry—and *harm* the insurance industry—by granting self-insurance the same tax advantages as third-party insurance. Yet in the decades-long debate over HSAs, the financial services industry was inexplicably absent.

Criticisms That Raise Serious Issues

Some questions that critics pose about the effects of HSAs do raise serious issues. However, those criticisms are less an indictment of HSAs than of the problems that HSAs are designed to correct. Those problems include a tax code that unfairly discriminates against workers and reduces their health insurance choices and a health care sector that is unresponsive to patients. The way to address those underlying problems, however, is not to repeal or limit HSAs but to expand them.

Will HSAs Encourage People to Skimp on Necessary Care?

Some observers fear that, because HSAs are coupled with high-deductible insurance, they will discourage people from obtaining needed medical care. Avoiding or delaying needed care today could result in more costly episodes of care down the road, making HDHPs a blunt cost containment tool.[50] The preponderance of evidence suggests that high-deductible health insurance does not induce people to skimp on care in ways that harm their health. However, it is nonetheless possible that high-deductible insurance may do so in some circumstances. Moreover, the existing HDHP requirement restricts consumers' ability to choose their own health

The HSA concept was vetted and endorsed by prominent economists, including Nobel laureates.

plans. That requirement should be removed or relaxed to give consumers and insurers the right to experiment with coverage designs that reduce overall costs.

One survey reports that people with HSAs or similar coverage "were significantly more likely to avoid, skip, or delay health care because of costs than were those with more comprehensive health insurance, with problems particularly pronounced among those with health problems or incomes under $50,000."[51] However, surveys tell us nothing about the health effects of reducing medical expenditures.

Surveys tell us nothing about the health effects of reducing medical expenditures.

The RAND experiment found that high-deductible health insurance and other forms of cost sharing reduced health care expenditures, but those reductions in use resulted in no adverse health effects overall. However, that is not to say that high-deductible insurance never induced harmful reductions in use. Rather, it suggests that any harmful reductions were offset by *beneficial* reductions in use. The RAND investigators found that compared to "free" coverage, greater cost sharing induced people to reduce their use of appropriate and inappropriate care in equal proportions:

> We interpret the proportionate changes in appropriate and inappropriate care to mean that the benefits of the additional appropriate care were offset by the additional inappropriate care received by those with full coverage. In other words, the increased inappropriate care was not just zero-benefit care; it actually had negative effects.[52]

In other words, "free" coverage encouraged some patients to obtain medical care that was on balance harmful. Examples include adverse side effects from unnecessary prescriptions, harmful drug interactions, and other treatment-induced injuries.

Therefore, even though there were no adverse health effects from high-deductible insurance overall, it is possible that the beneficial reductions in use induced by high-deductible insurance masked harmful reductions in use among certain subgroups. Some people argue that the RAND experiment provides evidence of such harmful skimping. The RAND investigators did find one area where the cost-sharing plans were associated with a worse health outcome: the cost-sharing plans appeared to do a worse job of controlling blood pressure than "free" care. That resulted in a slightly higher mortality risk for low-income subjects with hypertension who were enrolled in the cost-sharing plans.[53]

However, that finding fails as a criticism of HSAs. First, it is possible that that effect was the result of chance.[54] Second, even if it was not the result of chance, the comparison is inapt. Only patients with access to "free" care experienced a reduced mortality risk. Most privately insured individuals today do face some degree of cost sharing. Thus, the relevant comparison would be between high-deductible plans and plans with lower levels of cost sharing. Using that comparison, the RAND investigators found no health effects: "In comparing results within the group of cost-sharing plans, we could detect no differences among the plans."[55] Third, the improved mortality risk was only among the poor, who already have access to "free" care through Medicaid. Fourth, the RAND investigators note that "the effect of having a screening exam . . . is almost as large as the effect of free care; this result suggests that a screening exam might be an effective alternative."[56] Current HSA rules allow insurers to provide free blood pressure screening. The RAND Health Insurance Experiment provides no evidence that HSAs will lead to harmful skimping on medical care.

Since the RAND experiment, at least one study has suggested that greater cost sharing for prescription drugs could result in greater emergency room use by and hospitalization of the chronically ill.[57] Although these findings are far from definitive, it is entirely possible that insurers could reduce the incidence of expensive episodes of care by offering full or partial coverage of certain expenses, beginning at a low (or zero) deductible. Drugs that

treat chronic illnesses would be a prime candidate.

To reduce health care costs overall, public policy should allow insurers and consumers to experiment with coverage designs that encourage cost-effective care while discouraging inappropriate care. In general, that requires generating information on effective medical care, making that information available to patients, and giving patients incentives to use it. HSAs are an indispensable part of those efforts. HSAs encourage patients to ask more questions—and demand answers—about the cost-effectiveness of treatment options. They provide strong incentives for patients to forgo unneeded medical care. At the same time, they provide strong incentives to obtain appropriate medical care, because HSA holders will want to protect their HSA deposits from even bigger medical expenses later on.

Yet the rigid HDHP requirement prevents insurance companies from providing additional incentives for patients to obtain cost-effective care. For example, that rule prevents any coverage below the deductible for drugs that treat an existing injury, illness, or condition—even if covering those drugs would save the plan and the patient money in the long run. HSA-compatible insurance can cover preventive care below the deductible for conditions that are asymptomatic or from which the patient has recovered. Indeed, HSA plans available to federal workers often provide better coverage of preventive care than traditional plans.[58] But HSA-compatible insurance cannot provide any drug coverage below the deductible for diabetics, asthmatics, or patients with multiple sclerosis.

Congress should remove or relax the HDHP requirement currently tied to HSA eligibility. First, doing so would give consumers a greater choice of health insurance designs. Current rules require some HSA holders to carry higher health insurance deductibles than they would prefer and even require other HSA holders to purchase *lower* deductibles than they would prefer.[59] HSAs are intended to give consumers more control over their health care dollars; it is inconsistent with the philosophy underlying HSAs to use them to restrict consumers' health insurance choices.

Second, allowing HSA-compatible insurance to create financial incentives for cost-effective care below the deductible would make HSAs an even more valuable tool for promoting appropriate care and discouraging inappropriate care. Just as Congress has no business dictating to consumers what type of health insurance they should purchase, it has no competence to design cost-effective health coverage.[60]

Finally, the HDHP requirement is the largest single factor inhibiting HSA growth; removing it would encourage HSA growth. Most Americans are not accustomed to high-deductible health insurance. In 2005 more than 75 percent of workers with self-only PPO coverage had deductibles below $500, while 10 percent of all covered workers faced separate prescription drug deductibles averaging just $122.[61] Deductibles upward of $1,050 are intimidating to consumers accustomed to low out-of-pocket exposure. Removing or relaxing this requirement would allow more individuals to open HSAs with their existing coverage, which would create more HSA holders.

Allowing coverage below current HSA deductibles would reduce patients' incentives to be cost conscious. That is why removing the insurance requirement should be coupled with reforms that give consumers ownership of the dollars used to purchase their health coverage and that limit the overall amount of medical expenditures that individuals may deduct from taxes. Large HSAs are one option.[62] If workers own the dollars used to purchase their health coverage, there is no need for Congress to specify what type of insurance consumers purchase.

Why Do HSAs Allow Wealthy Individuals to Shelter Funds?

A number of researchers have debunked the common assumption that HSA enrollment would skew heavily toward the wealthy.[63] Dana Goldman and Jesse Malkin of the RAND Corporation posit that "the prototypical HSA user will only be slightly wealthier than those in

Public policy should allow insurers and consumers to experiment with coverage designs that encourage cost-effective care while discouraging inappropriate care.

Furman's interpretation falters because he compares HSAs to the wrong tax deductions.

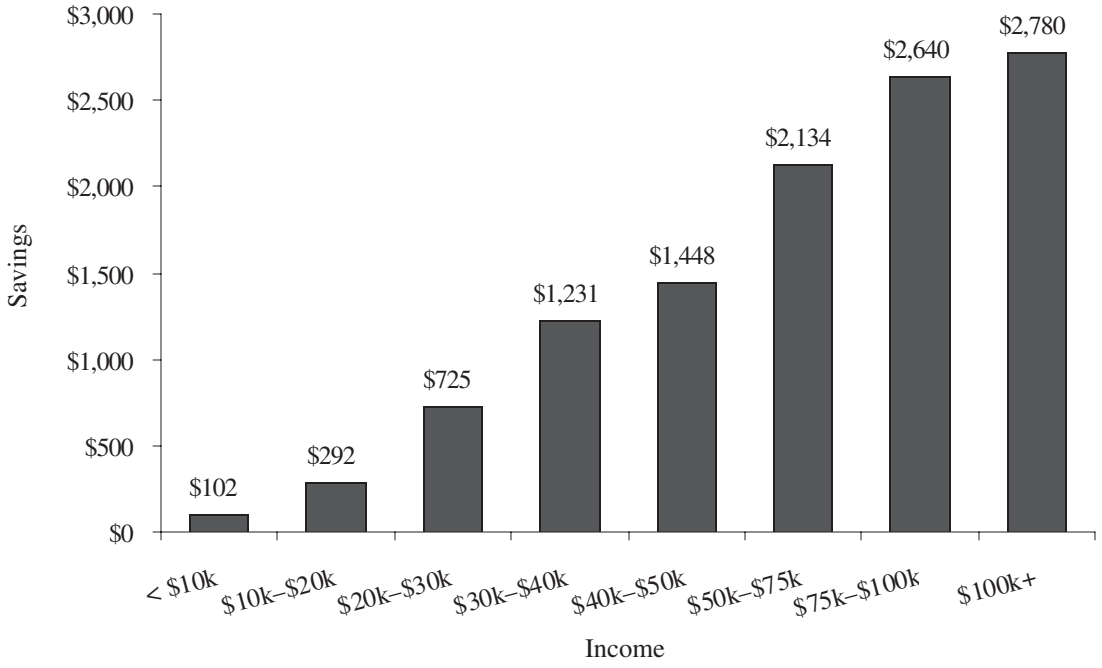
conventional insurance, and HSAs would be attractive to the seriously ill in high tax brackets." Just what are these high tax brackets? "This group includes employees earning under the $94,200 Social Security [payroll tax] ceiling—certainly a well-compensated group but hardly the CEOs of America."[64] An earlier study of HSAs also estimated, "The median [HSA] user would be only slightly richer than people in conventional FFS and HMO plans, which already contain substantial tax breaks."[65]

Still, many observers object that the tax benefits of HSAs do skew heavily to the wealthy. Some argue that this is because HSAs receive more advantageous tax treatment than other tax-preferred savings accounts. Jason Furman of New York University and the Center on Budget and Policy Priorities writes:

> First, HSA contributions are tax deductible, amounts earned on the accounts (which can be invested in stocks, bonds, real estate, or other investments) accumulate tax free, and withdrawals also are tax free as long as they were [*sic*] used for medical expenses. No other savings vehicle in the U.S. tax code offers the potential for both tax-free contributions and tax-free withdrawals. Second, under the President's proposals, HSA contributions would qualify for a 15.3 percent tax credit, a substantial advantage as compared to contributions to 401(k)s or IRAs, for which no such tax credit is provided. Third, unlike IRAs, HSAs have no income limits. The exceedingly generous HSA tax breaks thus are available to very high-income families.[66]

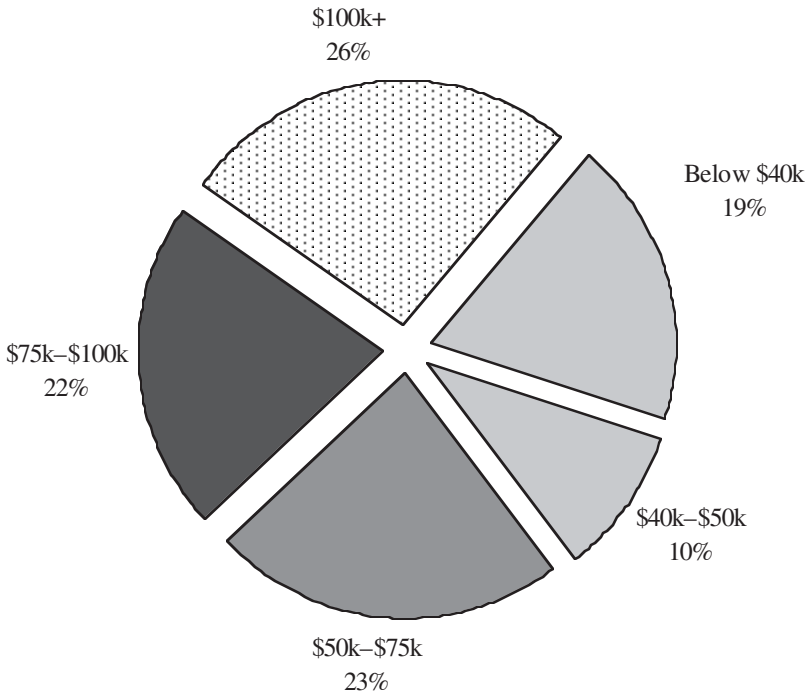
Furman's description of HSAs is accurate. However, his interpretation of those facts falters because he compares HSAs to the wrong tax deductions. The relevant comparison is not other tax-preferred savings vehicles but the tax exclusion for employer-provided health insurance premiums.

Figure 1
Average Federal Tax Savings from Health-Related Deductions by Family Income Level, 2004



Source: John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web Exclusive, February 25, 2004, pp. W4-106–W4-112.

Figure 2
Distribution of Federal Tax Savings from Health-Related Deductions: Percent of Total Tax Savings by Family Income Level, 2004



Source: John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web Exclusive, February 25, 2004, pp. W4-106–W4-112.

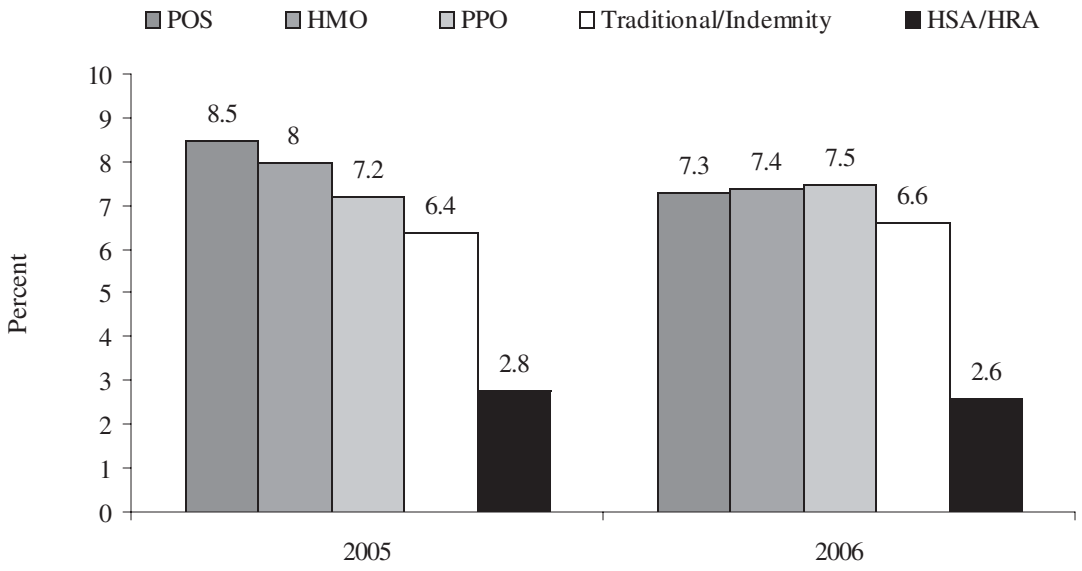
The tax treatment of HSAs was designed to provide tax parity between employer-sponsored health benefits and financing medical care through personal savings. The reason why (1) contributions to an HSA and (2) disbursements from an HSA for medical expenses are untaxed is so that they will mirror the tax treatment of (1) employer-sponsored health insurance premiums and (2) claims paid by employer-sponsored health insurance—both of which are untaxed. The effect is to level the playing field between employer-sponsored third-party insurance and personal savings. The president proposes to make non-employer HSA contributions "qualify for a 15.3 percent tax credit" because employer contributions to an HSA are exempt from the 15.3 percent federal payroll tax.[67] In other words, the proposed credit would level the playing field between HSA contributions made by employers and HSA contributions made by individuals. Finally, HSA enrollment is not limited by income because the tax breaks for employer-sponsored insurance are not limited by income.

Though Furman criticizes the president's HSAs proposals for heavily skewing the tax savings toward high-income households, Figures 1 and 2 show that the distribution of tax savings from the exclusion of employer-provided health premiums and other health-related deductions already skews heavily toward wealthier families. This is true in terms of both the amount that wealthy families save and their share of the total tax benefits.[68] If HSAs disproportionately benefit the wealthy, it is because they are intended to offset the distortions of an even larger tax loophole that already does so.

All of these skewed tax benefits are the product of deductions that reduce one's taxable income under a system in which the wealthy pay higher marginal tax rates. If your marginal tax rate is 40 percent and your neighbor's is 30

If HSAs disproportionately benefit the wealthy, it is because they are intended to offset the distortions of an even larger tax loophole that already does so.

Figure 3
Percentage Increase in Insurance Premiums over Previous Year, by Year and Type of Plan



Source: Deloitte Consulting, "Reducing Corporate Health Care Costs 2006 Survey," January 2006, p. 3, http://www.deloitte.com/dtt/cda/doc/content/us_chs_red_cor_hea_costs_0106.pdf.

percent, and if you each reduce your taxable income by $100, then your tax savings will be $40 and your neighbor's will be $30. That inequity stems, not from the size of the deduction, but from the combination of deductions and rising marginal tax rates. High marginal income tax rates and health-related deductions both result in economic inefficiency. Ideally, Congress should discard all health-related deductions and reduce marginal income tax rates. HSAs are merely a second-best option.[69]

Ideally, Congress should discard all health-related deductions and reduce marginal income tax rates. HSAs are merely a second-best option.

Are HSAs a Bad Deal for People with Low Incomes?

HSAs offer the biggest tax breaks to people with the highest incomes and require enrollees to carry insurance with significant out-of-pocket exposure. Thus some critics contend that HSAs are a bad option for those with low incomes. In fact, HSAs can be attractive to many low-income households. Whether high-deductible insurance is the best option for a low-income household, however, is a decision that should be made only by those individuals, not by their employers or Congress. Low-income workers (like everyone else) have varying preferences for risk and must evaluate HSA-compatible coverage relative to the alternatives. Nonetheless, HSAs are less attractive to low-income workers than they could be, because the tax code continues to discriminate against those workers. Expanding HSAs would make them a better deal for low-income workers.

A number of features make HSA coverage potentially attractive to low-income workers. Premiums for high-deductible insurance are typically much lower than premiums for traditional coverage. That alone makes HSA-compatible coverage more affordable. In addition, those premiums have been increasing more slowly than premiums for traditional plans. In 2005 and 2006 premiums for HSA-compatible and similar insurance grew at roughly one-third the rate of premiums for traditional plans (Figure 3). In fact, eHealthInsurance reports that in 2005 premiums for HSA-eligible policies *decreased* by 15 percent from the previous year.[70] Those results could stem from healthier-than-average people enrolling in such plans. Nonetheless, premiums for HDHPs rise less

rapidly for all enrollees, if only because any rate of increase is applied to a smaller base.

As noted earlier, healthy low-income workers might be drawn to HSAs because they would no longer be required to purchase more coverage than they need or to pay more than necessary to cover themselves. One study by HSA critics concluded, "Wealthier workers may be more willing to bear the financial risks of increased out-of-pocket liabilities, but our results show that on average, lower wage workers would benefit from switching to [HSA]/catastrophic plans."[71]

Though many health policy analysts would prefer to see such workers obtain comprehensive third-party insurance, low-income workers pay for those benefits through either higher premiums or reduced wages. Thus, to claim that high deductibles are bad for those workers is to claim that low-income workers would be better off with less take-home pay (and comprehensive insurance) than with more take-home pay (and catastrophic insurance). HSA critics should neither presume to know the risk preferences of low-income workers nor dictate their own preferences to those workers. Ultimately, only low-income workers can decide for themselves what type of coverage best meets their needs.

However, the critics are correct that HSAs fail low-income workers. First, current HSA rules do not let workers choose the health insurance they prefer. Just as HSA opponents should not dictate to low-income households their preference for comprehensive third-party coverage, HSA supporters should not dictate their preference for high-deductible insurance. Low-income workers should have the right to control all of their health care dollars and not be penalized if they purchase more (or less) health insurance than HSA supporters (or critics) think they should.

Second, HSAs discriminate against low-income workers because current law fails to provide tax parity between employment-based coverage and health insurance purchased on the individual market. One study found that low-income workers would be very attracted to HSAs, but only if contributions were exempt from payroll taxes.[72] The only way low-income workers can purchase health insurance with payroll-tax-exempt earnings is if an employer purchases it for them. Yet low-income workers are the least likely to be covered by job-based insurance. That means that those workers must purchase health insurance and contribute to their HSAs with after-tax dollars.

President Bush has proposed remedying that problem through tax credits that reimburse workers the payroll taxes they pay on earnings that are contributed to an HSA or that go toward the purchase of an HDHP on the individual market. That would be a positive step, but the president's proposal would still require those workers to purchase government-prescribed health insurance. Allowing workers to take all their health benefits as a cash contribution to a large HSA would give low-income workers full tax parity and full control over their health insurance decisions.

Expanding HSAs would make them a better deal for low-income workers.

Are Patients Unable to Shop Around for Health Care?

Critics claim that HSAs unreasonably expect patients to shop around for care, even though there are many instances in which patients cannot. Many episodes of care are emergencies, and useful price and quality information is scarce even for nonemergency care.[73] Yet patients can shop around for many health care needs. In those situations, HSAs correct the perverse incentives that have suppressed useful price and quality information. Indeed, markets are already responding to consumer demand for such information. HSAs also allow patients to benefit from the negotiating clout of insurers in areas where patients cannot negotiate themselves. Though critics are correct that price and quality information is scarce, that is not a shortcoming of HSAs. Indeed, it is a problem that HSAs are intended to correct.

Most health care spending occurs in circumstances under which the patient can comparison shop. For example, emergency room care accounts for only 3.3 percent of health expenditures.[74] Hospital and nursing home

Far from being a shortcoming of HSAs, the lack of information on health care prices and quality is among the problems that HSAs are designed to correct.

care combined account for 45 percent of personal health care expenditures,[75] yet many hospital expenditures are discretionary.[76] Spending on physicians, prescription drugs, home health care, and other services accounts for 55 percent of personal health care expenditures.[77] Those data suggest that a large share of health care spending does allow time for considering one's options.

However, a lack of useful information on prices and quality frustrates patients' efforts to shop around. For example, the Government Accountability Office reports that insurers offering HSA-compatible health plans to federal workers provided spotty price and quality information to their enrollees. The plans provided some information on average prices charged by physicians and pharmacies but never the actual prices that enrollees would pay (with the exception of prices at mail-order pharmacies). The plans provided scant information on the quality of hospitals and even less on the quality of physicians, in large part because such quality information does not exist.[78]

Far from being a shortcoming of HSAs, the lack of information on health care prices and quality is among the problems that HSAs are designed to correct. American patients are so heavily insured that providers—especially hospitals—have little incentive to provide patients with meaningful price and quality information. Some 83 cents of every dollar spent on health care comes from someone other than the patient, usually insurers, employers, or government.[79] Insulating patients from the cost of their medical decisions reduces their incentive to demand price and quality information, which reduces the likelihood that providers will supply it.

In fact, overreliance on third-party payment actually penalizes cash-paying patients, such as the uninsured and HSA holders. Rather than engage in open price competition, private third-party purchasers negotiate exclusive discounts from largely meaningless "list prices" set by providers. The discounts are available only to the particular employer or health insurer and are typically hidden from public view by contractual provisions that prohibit their disclosure.[80] Meanwhile, various legal barriers, including federal antifraud laws and Medicare's administrative pricing system, make it nearly impossible for cash-paying patients to negotiate their own discounts.[81] As a result, hospitals often charge HSA holders and the uninsured more than other payers.

HSAs and other forms of consumer-directed care are already correcting this situation. First, many carriers have begun to provide useful price information to their patient-customers. Knowing that their HSA enrollees need more price information, insurers such as UnitedHealthcare, Aetna, and Humana have begun disclosing their negotiated rates to enrollees.[82] They and other carriers are developing tools to help customers make informed decisions.

Many providers have begun posting their prices as well, some of them combining transparent price information with new modes of delivery. Firms such as MinuteClinic and RediClinic are opening clinics in retail stores. Those clinics offer convenient access to basic care, with posted prices that are usually less than the cost of a doctor's visit. A service called TelaDoc offers members quick telephone access to a doctor (usually within 40 minutes) for $35 per consultation and a $4 monthly membership fee. A company called Doctokr provides a similar service. There is also a small but growing movement of "cash-friendly" physicians who openly advertise their prices. Services such as CashDoctor.com post those prices online for patients. The online service HealthGrades provides average prices for numerous hospital services for a nominal fee. Online services such as Subimo.com and WebMD.com are competing to provide customers with user-friendly information on hospital quality.

Second, HSAs provide layers of protection from excessive prices even when patients cannot shop or negotiate directly with providers. Carriers of HSA-compatible insurance typically extend the discounts they negotiate with providers to their HSA enrollees even when those enrollees are paying out of pock-

et. One survey found that more than 90 percent of consumers enrolled in HSA-compatible plans have a preferred provider network and that those plans generally give patients access to the discounted rates that the insurer negotiates with providers.[83] Thus HSAs lower prices for cash-paying patients even before they come through the emergency room doors.

Finally, by making more patients cost conscious, HSAs will encourage other efforts to hold down prices. Civic groups have proven capable of negotiating discounts on hospital charges for cash-paying patients.[84] Princeton economist Uwe Reinhardt writes, "Partly under pressure from consumers and lawmakers and partly on their own volition, many hospitals now have means-tested discounts off their chargemasters for uninsured patients, which bring the prices charged the uninsured closer to those paid by commercial insurers or even below."[85] Such efforts become more likely as the number of cash-paying patients increases.

If HSAs are permitted to grow and make more patients cost conscious, a critical mass of price sensitive patients will push more insurers and providers to furnish transparent, competitive prices. However, that may not be sufficient. Congress and state legislatures should also eliminate regulatory and legal barriers to price transparency and competition. In particular, Medicare's administrative pricing systems, which effectively set price floors for private payers, will have to be abandoned.

Unfortunately, the Bush administration has proposed forcing doctors and hospitals to post their prices.[86] That would be unwise, because doing so would guarantee that the way prices are presented will serve the purposes of regulators, rather than the needs of patients. The Bush administration has announced it will publish, in a patient-friendly manner, the prices that federal programs such as Medicare pay doctors and hospitals. That step probably will not hurt, and it could even help. However, the administration's efforts to force price disclosure should stop there. If patients demand price information, there will be no need to force providers to supply it: providers will publish it, or perish. But as long as patients have no interest in price information, forcing providers to supply it would be a useless exercise and a costly distraction.

Will HSAs Affect Only a Portion of Health Care Spending?

Critics claim that HSAs will do little to reduce overall health spending. They rightly argue that, although consumers would be much more cost conscious when consuming medical care below the deductible, once they reached the deductible consumers would have little incentive to be cost conscious. Because the overwhelming majority of medical spending comes from a small share of patients who would exceed the deductibles, detractors question whether HSAs would have much of an impact on health spending at all. One study estimated that allowing workers to choose HSAs would reduce overall health spending only modestly.[87] Similar results have been found in the spending patterns of people with HSA-like coverage.[88]

Despite that legitimate concern, HSAs as they exist today have the potential to inject cost consciousness into a significant share of medical spending. If every nonelderly, fully insured individual in 2001 had had health insurance with a $1,000 deductible, 28 percent of that group's total medical spending would have fallen below that deductible.[89] Thus, if adopted widely, HSAs could bring cost consciousness to about one-third of the medical spending of that group. There is also evidence to suggest that patients with HSAs and similar plans do remain cost conscious even when cost sharing disappears. One survey found that such patients were more likely to seek alternative treatments even after they had reached their out-of-pocket maximums.[90]

Moreover, some HDHPs also have cost sharing above the deductible, which injects cost consciousness into an even larger share of overall medical expenditures. The current limit on total cost sharing in a self-only HDHP is $5,100. Suppose that in 2001 all nonelderly,

HSAs as they exist today have the potential to inject cost consciousness into a significant share of medical spending.

Current HSA contribution limits effectively penalize those who do not obtain 100 percent coverage above the deductible.

fully insured individuals had had an HSA plan with a $1,050 deductible and 20 percent coinsurance above the deductible. Even though an individual's total cost sharing would have been limited to $5,100, the total amount of medical spending subject to cost sharing would have been $21,300. That would have introduced price sensitivity into more than 60 percent of medical expenditures by all nonelderly fully insured individuals.[91]

However, the current HSA contribution limits discourage such coinsurance. Annual HSA contribution limits are tied to the amount of the HDHP deductible. Therefore, consumers cannot cover such coinsurance with HSA contributions in a given year. As a result, current HSA contribution limits effectively penalize those who do not obtain 100 percent coverage above the deductible.

Raising HSA contribution limits would help correct that flaw. The president has proposed allowing employers and individuals to make tax-free HSA contributions up to their HDHP's limit on out-of-pocket costs, or as high as $5,100 for those with self-only coverage and $10,200 for those with family coverage. Doing so would encourage cost sharing above the deductible and bring cost consciousness to even more medical decisions.

An even better solution would be to raise the contribution limits high enough so that nearly all workers could take the full value of their health benefits as a cash contribution to their HSAs. Then workers would be cost conscious about every penny they spent on medical care and health insurance premiums.

Would Expanding HSAs Increase the Deficit?

Critics correctly note that expanding HSAs would lead to a revenue loss for the federal government. The president's proposals would lead to an estimated revenue loss of $47 billion from 2007 through 2011.[92] While important, that revenue loss must be understood in context.

Compared to revenue losses under other provisions in the tax code, the revenue loss from current HSA law, or even from the president's proposed HSA expansion, is small. Over the next five years, HSAs are projected to generate a revenue loss equal to 2 percent of the revenue loss created by the tax exclusion for employer-provided health insurance. Even with President Bush's proposals in effect, the revenue loss over that period would be just 7 percent of that larger figure (Figure 4).

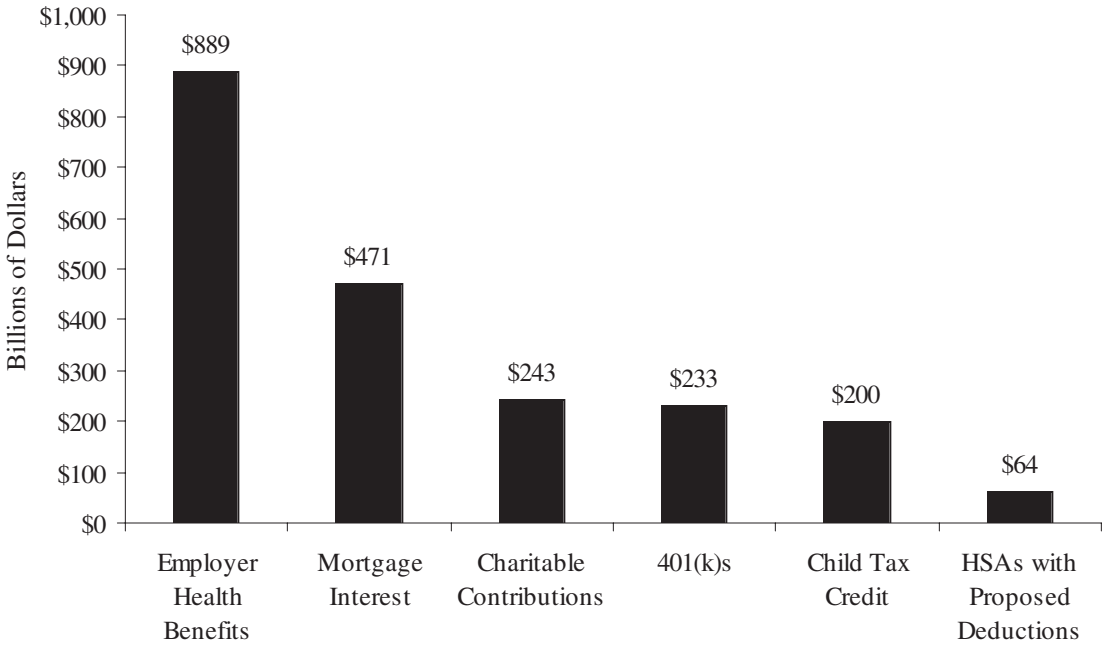
The financial condition of the federal Medicare program is also relevant. Current revenue sources cannot finance all the benefits that Medicare has promised to current and future retirees. As of 2006 Medicare carries an unfunded liability of $70.8 trillion. In other words, if the federal government were to deposit funds in an interest-bearing account to cover all of Medicare's future deficits, it would have to deposit $70.8 trillion.[93] As a point of reference, that is about five times the size of the U.S. gross domestic product. Filling this shortfall would require an immediate and permanent tax increase equal to 25 percent of wages, which is so large as to be politically infeasible.[94]

In short, cuts in Medicare benefits are inevitable. Given that inevitability, Congress should be doing everything it can to encourage current workers to save for their health care needs in retirement. The quickest way to do that is to make HSAs more appealing by allowing them to be combined with any type of insurance and to increase HSA contribution limits. The revenue loss to the government would be a fraction of the amount that Americans would have available in their HSAs to pay for their present and future medical needs.

Are HSAs Unpopular?

Critics have pointed to survey research suggesting that HSAs are thus far unpopular with consumers. Supporters counter that the number of people covered by HSA-compatible insurance tripled from one million to more than three million between March 2005 and January 2006. That is a less than perfect measure of HSA growth or popularity. First, that survey counted only people with HSA-compatible insurance, not those

Figure 4
Projected Federal Revenue Losses from Bush HSA Proposals and Other Items, 2007–2011



Source: U.S. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007*, February 6, 2006, Table 17-3, "Effect of Proposals on Receipts," pp. 265, 296, http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf.

who have actually coupled that insurance with an HSA. Second, it is unclear how many of those three million "covered lives" chose HDHPs themselves and how many had an HDHP chosen for them. Those who purchased HSA-compatible insurance for themselves in the individual market appear to account for fewer than half of the three million covered lives. It is certain that some portion of the remainder had HSAs thrust upon them by their employers.[95]

Overall, consumer satisfaction surveys have so far produced mixed results. A survey by the Employee Benefits Research Institute and the Commonwealth Fund found that individuals with comprehensive third-party coverage were significantly more satisfied than were those with HSAs and similar high-deductible plans.[96] Likewise, a survey by McKinsey & Company found that fewer than half of consumers were as happy with HSAs as they had been with their previous traditional plans. Part of their dissatisfaction stemmed from a lack of price information with which to comparison shop.[97] Other surveys report different findings. A survey by the Blue Cross Blue Shield Association found that individuals with HSA-compatible insurance were consistently more satisfied with their coverage than those in traditional plans.[98]

There are good reasons not to draw any firm conclusions based on current survey research. First, the available surveys do not directly measure satisfaction among HSA holders. So far, there are relatively few HSA enrollees. Consumers with HSAs are therefore typically lumped in with those who are qualified to open an HSA but have not done so, or others with similar consumer-directed plans. As a result, none of the surveys measures consumer satisfaction with HSAs alone, or at their full potential. Second, some dissatisfaction inevitably stems from unfamiliarity. Consumers with HSAs and similar coverage have had much less experience with

None of the available surveys measures consumer satisfaction with HSAs alone, or at their full potential.

HSAs will have to reach a critical mass in the marketplace before they can be expected to effect a systemic change like widespread transparent price competition.

those options, because those options have been in existence for only a few years.[99] This source of dissatisfaction can be expected to dissipate over time.

Finally, HSAs may be unpopular for reasons that should not sway policymakers. HSAs are intended to be disruptive, which will inevitably cause dissatisfaction in some corners. We should expect that consumers who lose the cross-subsidies they used to receive (i.e., the "professors" in the above example) will be dissatisfied. To wit, the EBRI survey found the difference in out-of-pocket expenses was the source of the greatest gap in satisfaction between people in HSA-like plans and traditional plans.[100] We should also expect that as HSAs give consumers greater control over their health care dollars, uncompetitive providers will express their discontent. One analysis predicted that the growth of HSAs would cause a "major disruption in the health care industry."[101]

Yet these sources of dissatisfaction are not an indictment of HSAs. HSAs are designed to eliminate inefficiencies and hidden cross-subsidies. If that causes some dissatisfaction, it means that HSAs are achieving their purpose, not that they should be abandoned. If we stop robbing Peter to pay Paul, Paul's dissatisfaction should not persuade us to change course.

Nonetheless, HSA supporters should be very concerned about the frustration HSA holders feel with (1) the lack of information to help them be cost conscious consumers and (2) the complex rules and restrictions that come with HSAs.[102] HSAs will have to reach a critical mass in the marketplace before they can be expected to effect a systemic change like widespread transparent price competition. Currently, only about 1 percent of privately insured individuals has HSA-compatible coverage. Some observers project a large boost in HSA enrollment in 2006.[103] But as of February 2006, 45 percent of American adults had never heard of HSAs, and only 29 percent even claimed to know what an HSA is.[104] Moreover, without a broad base of political support, HSAs could be undermined by legislative or regulatory efforts. The quickest and surest way to build that critical mass and a political constituency for HSAs would be to allow them to be coupled with any type of health insurance.

Some degree of complexity is inevitable so long as HSAs enjoy special tax status. To obtain tax breaks, enrollees must contend with nettlesome contribution limits and account for all their HSA withdrawals. Until all health-related tax breaks can be eliminated (as suggested above), such complexity is inevitable. Yet the complications added by the rigid HDHP requirement are not inevitable. To open an HSA, millions of Americans would have to give up their current health insurance. HSA supporters can and should make HSAs simpler by removing that requirement.

None of the consumer satisfaction surveys tells us what we need to know most: the types of insurance and medical care consumers would choose if they controlled *all* their health care dollars and *all* their health care decisions. To find those answers requires expanding HSAs and removing all restrictions on HSA holders' insurance choices.

Conclusion

Health savings accounts are an important step toward restoring market forces and reducing government involvement in the health care sector. Proponents expect that HSAs will make medical markets more efficient by encouraging patients to be more parsimonious consumers. There is some evidence that this is happening.

Many of the criticisms that have been lodged against HSAs are unfounded. However, not all criticisms can be easily dismissed. HSAs are not a panacea, and the rules governing them make them less appealing than they could be, particularly to sick or low-income individuals. Those rules should be relaxed with an eye to letting individual consumers control all of their health care dollars and decisions.

Whatever the strengths and weaknesses of HSAs, they are now a reality and appear to be

growing. Nonetheless, it is important to build a constituency for preserving and expanding HSAs in order to forestall legislative or regulatory efforts to undermine them. The most important thing Congress could do to encourage HSA growth would be to allow HSAs to be coupled with any type of health insurance. That would allow millions of Americans to open HSAs without giving up the coverage they now have. Further, Congress should allow workers to take the full amount of their health benefits as a cash deposit in their HSAs, and then allow workers to use those funds to purchase health insurance of their choosing from any carrier they wish. Those steps would give workers ownership of every one of their health care dollars, solidify support for HSAs, and truly put consumers in the driver's seat.

Notes

1. See, for example, John C. Goodman and Gerald Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington: Cato Institute, 1992); and Victoria Craig Bunce, "Medical Savings Accounts: Progress and Problems under HIPAA," Cato Institute Policy Analysis no. 411, August 8, 2001, http://www.cato.org/pubs/pas/pa411.pdf.

2. For a fuller discussion of the problems created by excessive health coverage, see Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute, 2005).

3. This introduction to HSAs is not meant to be comprehensive. The U.S. Department of the Treasury has a highly useful guide to HSAs on its website at http://www.treas.gov/offices/public-affairs/hsa/faq.shtml.

4. Figures are for 2006 and are indexed for inflation annually.

5. The amount allowed for catch-up contributions rises by $100 annually until it freezes at $1,000 in 2009.

6. Vishal Agrawal et al., "Consumer-Directed Health Plan Report—Early Evidence Is Promising: Insights from Primary Consumer Research," McKinsey & Company, June 2005, p. 4, http://mckinsey.com/clientservice/payorprovider/Health_Plan_Report.pdf. See also Paul Fronstin and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefits Research Institute Issue Brief no. 288, December 2005, p. 1, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2005.pdf.

7. Jeff Lemieux, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans," America's Health Insurance Plans Center for Policy and Research, March 9, 2006, p. 2, http://www.ahip.org/content/default.aspx?docid=15302.

8. Katy Henrickson, Bradford J. Holmes, and Eric G. Brown, "Will Health Plans Profit from HSAs? Forecast of Health Savings Account Assets and Transactions," Forrester Research, April 7, 2005, http://www.forrester.com/Research/Document/Excerpt/0,7211,36469,00.html.

9. Aamer Baig, Jeff Nuckols, and Amy Dawson, "Seizing the HSA Opportunity," *DiamondCluster International Insight*, August 2005, pp. 3–4, http://www.diamondcluster.com/Ideas/Viewpoint/PDF/HSA%20DiamondCluster%20Single.pdf.

10. See Cannon and Tanner, pp. 65–73; and Michael F. Cannon, "Combining Tax Reform and Health Care Reform with Large HSAs," Cato Institute *Tax & Budget Bulletin* no. 23, May 2005, http://www.cato.org/pubs/tbb/tbb-0505-23.pdf.

11. See, e.g., Elana Schor, "Dems Try to Do to HSAs What They Did to Social Security Plan," *Hill*, February 8, 2006, http://www.hillnews.com/thehill/export/TheHill/News/Frontpage/020806/hsa.html.

12. See, e.g., John Breaux et al., dear colleague letter re "Medical Cost Containment Act (S. 2873)," September 8, 1992, author's files.

13. See, e.g., Harry Reid et al., "Democrats Call on Bush to Offer Real Healthcare Reform in State of the Union," news release, January 27, 2006, p. 3, http://help.senate.gov/Min_press/2006_01_27.pdf.

14. "A number of CDHP [consumer-directed health plan] sponsors have used demographic data to suggest that these plans have not disproportionately attracted low-risk members. . . . We found that although demographic data did not reveal favorable risk selection in the [CDHP], better measures of risk based on prior use and prior cost unanimously indicated risk segmentation taking place." Laura Tollen, Murray N. Ross, and Stephen Poor, "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.," *Health Services Research* 39, no. 4, Part II (August 2004): 1167–87, http://www.cmwf.org/usr_doc/hsr_39_4p2_1167_Tollen.pdf.

15. Gary Claxton et al., *Employer Health Benefits: 2005 Annual Survey* (Washington: Kaiser Family Foundation/Health Research and Educational Trust, 2005), pp. 96–97, http://www.kff.org/insurance/7315/upload/7315.pdf. The figures reported are average premiums and are only suggestive of the actual premium savings that HDHPs offer.

16. Phil Ellis, "Do Health Accounts Promote Better Spending?" slide presentation to the American Enterprise Institute, June 29, 2005, http://www.aei.org/docLib/20050628_Ellis.pdf.

17. Health expenditures were based on the actual claims experience of 600,000 workers at a Fortune 500 company. Matthew J. Eichner and David A. Wise, "Little Saving and Too Much Medical Insurance: Medical Savings Accounts Could Help," in *Personal Saving, Personal Choice*, ed. David A. Wise (Stanford: Hoover Institution Press, 1999), pp. 86–92.

18. Joseph P. Newhouse et al., *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1996), p. 197.

19. Ibid., p. 210.

20. Ibid., p. 243.

21. Emmett B. Keeler et al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association* 275, no. 21 (June 5, 1996): 1666.

22. See Sherry A. Glied and Dahlia K. Remler, "The Effect of Health Savings Accounts on Health Insurance Coverage," Commonwealth Fund Issue Brief no. 811, April 2005, pp. 5–6, http://www.cmwf.org/usr_doc/811_Glied_effect_hlt_savings_accounts_coverage.pdf; and Dwight McNeill, "Do Consumer-Directed Health Benefits Favor the Young and Healthy?" *Health Affairs* 23, no. 1 (January–February 2004): 186–93, http://content.healthaffairs.org/cgi/reprint/23/1/186.pdf. This study simulated the distributional effects of health reimbursement arrangements (HRAs), which are similar to HSAs. HRAs combine (usually high-deductible) insurance with a line of credit for out-of-pocket medical expenses. Unused credit rolls over from year to year but is forfeited when an employee changes jobs. HRAs do not give workers ownership of those funds as HSAs do. Nonetheless, scholars have studied HRAs for insights into the likely effects of HSAs. This paper refers to HRAs as "HSA-like" plans, or "similar coverage."

23. Stephen T. Parente, Roger Feldman, and Jon B. Christianson, "Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting," *Health Services Research* 39, no. 4, Part II (August 2004): 1107, http://www.cmwf.org/usr_doc/hsr_39_4p2_1091_Parente.pdf.

24. Bob Lyke, Chris Peterson, and Neela Ranade, "Health Savings Accounts," Congressional Research Service Report for Congress no. RL32467, updated March 23, 2005, pp. 24–25, http://www.belmont.edu/hr/CRSReportforCongress.pdf.

25. See, e.g., Reid et al., p. 3.

26. See Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79, no. 2, Papers and Proceedings of the Hundred and First Annual Meeting of the American Economic Association (May 1989): 177–83; Jonathan Gruber, "Health Insurance and the Labor Market," in *Handbook of Health Economics*, vol. 1A, ed. Anthony J. Cuyler and Joseph P. Newhouse (Amsterdam: Elsevier, 2000): 690–95; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," NBER Working Paper no. 11160, February 2005, p. i, http://www.nber.org/papers/w11160; Dana Goldman, Neeraj Sood, and Arleen Leibowitz, "Wage and Benefit Changes in Response to Rising Health Insurance Costs," NBER Working Paper no. 11063, January 2005, p. 1, http://www.nber.org/papers/w11063; and Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999), pp. 69–70.

27. Bureau of Labor Statistics, Office of Compensation Levels and Trends, "Employment Cost Index: Constant Dollar Historical Listing," April 29, 2005, tables 2a, 5a, 8a, ftp://ftp.bls.gov/pub/suppl/eci.ecconst.txt.

28. Marilyn Moon, Len M. Nichols, and Susan Wall, "Medical Savings Accounts: A Policy Analysis," Urban Institute, March 1996, p. 14, http://www.urban.org/uploadedPDF/msa.pdf; and Kenneth E. Thorpe, "Medical Savings Accounts: Design and Policy Issues," *Health Affairs* 14, no. 3 (Fall 1995): 258, http://content.healthaffairs.org/cgi/reprint/14/3/254.pdf, citing American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," Public Policy Monograph 1, May 1995, p. 9.

29. Stephen T. Parente et al., "Assessing the Impact of Health Savings Accounts on Insurance and Coverage Costs," unpublished manuscript, December 2005, p. 10.

30. This is not conjecture. See, e.g., Newhouse et al., p. 356.

31. Martin Feldstein, "Rethinking Social Insurance," Presidential Address for the American Economic Association, January 2005, *American Economic Review*

95, no 1 (March 2005): 7, http://www.nber.org/feldstein/aeajan8.pdf.

32. Bowen Garrett, "Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001," Kaiser Commission on Medicaid and the Uninsured, report no. 7116, July 26, 2004, pp. 14, 19, 22, http://www.kff.org/uninsured/upload/Employer-Sponsored-Health-Insurance-Coverage-Sponsorship-Eligibility-and-Participation-Patterns-in-2001-Full-Report.pdf.

33. See, e.g., Sherry Glied, *Revising the Tax Treatment of Employer-Provided Health Insurance* (Washington: AEI Press, 1994), pp. 6–8.

34. Ibid.

35. Pauly and Herring, pp. 69–70.

36. Bradley C. Strunk, Paul B. Ginsburg, and John P. Cookson, "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," *Health Affairs* Web Exclusive, June 21, 2005, p. W5-292, http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.286v1.pdf.

37. Mark Pauly et al., "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs* 18, no. 6 (November–December 1999): 28–44, http://content.healthaffairs.org/cgi/reprint/18/6/28.pdf.

38. Jonathan Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Center for Budget and Policy Priorities, February 15, 2006, p. 5, http://www.cbpp.org/2-15-06health.pdf.

39. Lemieux, pp. 4–5.

40. "Health Savings Accounts: The First Six Months of 2005," eHealthInsurance, July 27, 2005, p. 11, http://www.ehealthinsurance.com/content/ReportNew/072705HSA6mosReportFinal.pdf.

41. Personal correspondence with Sherry Glied, March 14, 2006, author's files. See generally Kathryn Klein, Sherry Glied, and Danielle Ferry, "Entrances and Exits: Health Insurance Churning, 1998–2000," Commonwealth Fund Issue Brief no. 855, September 2005, http://www.cmwf.org/usr_doc/klein_855_entrancesexits_ib.pdf.

42. Maureen Sullivan, "Health Savings Accounts—the Consumer Perspective," Blue Cross Blue Shield Association, September 28, 2005, p. 6, http://bcbshealthissues.com/events/consumer/sullivan_presentation.ppt.

43. Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," p. 2.

44. Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," U.S. Census Bureau Current Population Reports no. P60-229, August 2005, p. 60, http://www.census.gov/prod/2005pubs/p60-229.pdf; and author's calculations.

45. Claxton et al., p. 17.

46. Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," p. 2.

47. "Your World with Neil Cavuto," transcript, *FOXNews.com*, January 31, 2006, http://www.foxnews.com/story/0,2933,183446,00.html ("This is a partial transcript . . . that was edited for clarity.")

48. Bunce, pp. 8–9, 34.

49. See, for example, Milton Friedman, "How to Cure Health Care," *Public Interest* 142 (Winter 2001): 8–9, http://www.thepublicinterest.com/archives/2001winter/article1.html; Feldstein; and Vernon L. Smith, "Trust the Customer!" *Wall Street Journal*, March 8, 2006, p. A20.

50. Fronstin and Collins, p. 1; and Beth Fuchs and Julia A. James, "Health Savings Accounts: The Fundamentals," National Health Policy Forum Background Paper, April 11, 2005, p. 19, http://www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf.

51. Fronstin and Collins, p. 1.

52. Newhouse et al., p. 356.

53. Ibid., pp. 208–11.

54. It is important to note that Newhouse et al. argue that this finding was not a result of chance (pp. 197–201).

55. Newhouse et al., p. 197.

56. Ibid., p. 210.

57. Dana P. Goldman et al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *Journal of the American Medical Association* 291, no. 19 (May 19, 2004): 2349, http://jama.ama-assn.org/cgi/content/abstract/291/19/2344. The authors note, "Other studies have found mixed evidence on this issue."

58. "All HDHPs offered preventive care cost sharing for in-network providers that was the same or lower than the traditional plans. In addition, while all HDHPs covered preventive services before the

deductible, those services were not always covered before the deductible by the traditional PPO plans." U.S. Government Accountability Office, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," GAO-06-271, January 31, 2006, p. 15, http://www.gao.gov/new.items/d06271.pdf.

59. The limits on out-of-pocket exposure in HAS-qualified HDHPs effectively constitute a maximum deductible. Thus "high-deductible health plans" might be more appropriately termed "high-but-not-too-high-deductible health plans," or HBNTHDHPs.

60. See, for example, the benefits structure of the federal Medicare program.

61. Claxton et al., pp. 82, 105.

62. See Cannon.

63. See, e.g., Reid et al., p. 4.

64. Dana Goldman and Jesse Malkin, "The HSA Mirage," United Press International, February 20, 2006, http://www.upi.com/HealthBusiness/view.php?StoryID=20060220-110738-4830r.

65. Keeler et al., p. 1670.

66. Jason Furman, "Expansion in HSA Tax Breaks Is Larger—And More Problematic—Than Previously Understood," Center on Budget and Policy Priorities, February 4, 2006, p. 5, http://www.cbpp.org/2-4-06tax.pdf.

67. To make this tax credit mirror precisely the tax benefit extended to employer contributions to an HSA, the president proposes to limit this credit "by the amount of wages in the [individual's] payroll tax base." U.S. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007*, February 6, 2006, Table 17-3, "Effect of Proposals on Receipts," p. 254, http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf.

68. John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web Exclusive, February 25, 2004, pp. W4-109, W4-110, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf.

69. Without any reduction in tax rates, eliminating health-related deductions would effectively be a tax increase.

70. "Health Savings Accounts: The First Six Months of 2005," eHealthInsurance, July 27, 2005, p. 4, http://www.ehealthinsurance.com/content/ReportNew/072705HSA6mosReportFinal.pdf.

71. Len M. Nichols, Marilyn Moon, and Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Urban Institute, April 1996, p. 28, http://www.urban.org/UploadedPDF/winlose.pdf.

72. Keeler et al., p. 1670.

73. See, e.g., Damon Darlin, "You Think 401(k)'s Are Hard to Manage? Try Health Accounts," *New York Times*, February 18, 2006.

74. David Kashihara and Kelly Carper, "National Health Care Expenses in the U.S. Civilian Non-institutionalized Population, 2003," Agency for Healthcare Research and Quality Statistical Brief no. 103, November 2005, p. 1, http://www.meps.ahrq.gov/papers/st103/stat103.pdf.

75. U.S. Centers for Medicare & Medicaid Services, "An Overview of the U.S. Healthcare System: Two Decades of Change, 1980–2000," CMS Chart Series, p. 6, http://www.cms.hhs.gov/TheChartSeries/downloads/us_health_chap1_p.pdf (accessed April 10, 2006).

76. See, e.g., John E. Wennberg, "Variation in Use of Medicare Services among Regions and Selected Academic Medical Centers: Is More Better?" Duncan W. Clark Lecture, New York Academy of Medicine, January 24, 2005, p. 6, http://www.dartmouthatlas.org/atlases/NYAM_Lecture.pdf.

77. Some portion of physician expenditures relates to care delivered in hospitals. U.S. Centers for Medicare & Medicaid Services, p. 6.

78. U.S. Government Accountability Office, pp. 6, 8.

79. U.S. Centers for Medicare & Medicaid Services, p. 4.

80. Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos behind a Veil of Secrecy," *Health Affairs* 25, no. 1 (January–February 2006): 62, http://content.healthaffairs.org/cgi/reprint/25/1/57.pdf.

81. See, e.g., Joel Millman, "How the Amish Drive Down Medical Costs," *Wall Street Journal*, February 21, 2006, p. B1, http://online.wsj.com/article/SB114048909124578710.html.

82. Darlin.

83. Lemieux, p. 3.

84. See, e.g., Millman, p. B1.

85. Reinhardt, p. 62. "A hospital's chargemaster is a lengthy list of the hospital's prices for every single procedure performed in the hospital and for every supply item used during those procedures."

86. Kate Schuler, "White House Looks to Price Transparency to Lower National Health Care Costs," *CQ Today*, March 13, 2006. "'It's going to be imposed upon you,' Hubbard said at a meeting last week of the Federation of American Hospitals."

87. Keeler et al., p. 1669.

88. Stephen T. Parente, Roger Feldman, and Jon B.Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization," *Health Services Research* 39, no. 4, Part II (August 2004):1189–1209, http://www.cmwf.org/usr_doc/hsr_39_4p2_1189_Parente.pdf.

89. Ellis, slide 3; and personal correspondence with Phil Ellis, June 29, 2005.

90. Agrawal et al., p. 4.

91. Expenditure data for 1997 from Alan C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, no. 7, Supplement (July 2003): III-53–III-64; inflated to 2006 dollars using growth in per capita national health expenditures from U.S. Centers for Medicare & Medicaid Services, Table 1, "National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960–2004," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, and "National Health Care Expenditures Projections: 2005–2015," January 2006, p. 4, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf.

92. U.S. Office of Management and Budget, Table 17-3, "Effect of Proposals on Receipts," p. 265. This revenue loss estimate is confined to the president's proposals that would reduce the federal tax code's distortion of taxpayers' health care decisions. HSA-related proposals that would add new distortions are excluded.

93. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington: Government Printing Office, 2006) pp. 65, 105, 116, http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf.

94. See Cannon and Tanner, p. 28.

95. At least one-third of the 500,000 or more individuals who get HSA-compatible insurance through a small employer appear to have no other options. Lemieux, p. 5. Fronstin and Collins, p. 9, find that "among individuals covered by an employment-based health plan, those in CDHPs or HDHPs were more likely than those with comprehensive insurance not to have a choice of health plan."

96. Fronstin and Collins, p. 1.

97. Agrawal et al., pp. 10–13.

98. Sullivan, pp. 7–9.

99. Fronstin and Collins, pp. 24–25.

100. Ibid., p. 10.

101. "The migration to lower premium, high-deductible health plans is certain to restrain payer revenue growth. . . . By our estimates, $200 billion of revenue will be in play as healthcare payers face a daunting challenge of holding on to their existing revenue streams while consumers, employers, and financial services firms stand to gain." Aamer Baig, Jeff Nuckols, and Amy Dawson, "Seizing the HSA Opportunity," *DiamondCluster International Insight*, August 2005, p. 4, http://www.diamondcluster.com/Ideas/Viewpoint/PDF/HSA%20DiamondCluster%20Single.pdf.

102. Ibid., pp. 7–8.

103. Fronstin and. Collins, p. 4.

104. Kaiser Family Foundation, "January/February 2006 Health Poll Report Survey: Selected Findings on 2006 State of the Union Address and Health Care (Toplines)," February 2006, p. 3, http://www.kff.org/kaiserpolls/upload/7460.pdf.

OTHER STUDIES IN THE POLICY ANALYSIS SERIES

568. **A Seismic Shift: How Canada's Supreme Court Sparked a Patients' Rights Revolution** by Jacques Chaoulli (May 8, 2006)

567. **Amateur-to-Amateur: The Rise of a New Creative Culture** by F. Gregory Lastowka and Dan Hunter (April 26, 2006)

566. **Two Normal Countries: Rethinking the U.S.-Japan Strategic Relationship** by Christopher Preble (April 18, 2006)

565. **Individual Mandates for Health Insurance: Slippery Slope to National Health Care** by Michael Tanner (April 5, 2006)

564. **Circumventing Competition: The Perverse Consequences of the Digital Millennium Copyright Act** by Timothy B. Lee (March 21, 2006)

563. **Against the New Paternalism: Internalities and the Economics of Self-Control** by Glen Whitman (February 22, 2006)

562. **KidSave: Real Problem, Wrong Solution** by Jagadeesh Gokhale and Michael Tanner (January 24, 2006)

561. **Economic Amnesia: The Case against Oil Price Controls and Windfall Profit Taxes** by Jerry Taylor and Peter Van Doren (January 12, 2006)

560. **Failed States and Flawed Logic: The Case against a Standing Nation-Building Office** by Justin Logan and Christopher Preble (January 11, 2006)

CATO INSTITUTE
1000 Massachusetts Ave., N.W.
Washington, D.C. 20001

Published by the Cato Institute, Policy Analysis is a regular series evaluating government policies and offering proposals for reform. Nothing in Policy Analysis should be construed as necessarily reflecting the views of the Cato Institute or as an attempt to aid or hinder the passage of any bill before Congress. Contact the Cato Institute for reprint permission. Additional copies of Policy Analysis are $6.00 each ($3.00 each for five or more). To order, or for a complete listing of available studies, write the Cato Institute, 1000 Massachusetts Ave., N.W., Washington, D.C. 20001 or call toll free 1-800-767-1241 (noon-9 p.m. eastern time). Fax (202) 842-3490 • www.cato.org

CATO INSTITUTE