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Health Savings Accounts: The Fundamentals

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OVERVIEW — *This paper explores the fundamentals of health savings accounts (HSAs). While not intended to be an exhaustive review of these accounts, it describes their intellectual and legislative origins and the mechanics of how they work, explores the early returns on how they are faring in the insurance market, and identifies major issues and controversies that they raise. The paper looks specifically at the basic rules for HSAs and the requirements for health insurance that qualifies as a high-deductible health plan (HDHP) for HSA purposes. Also considered are issues related to provider payments under HSAs and the administration of the benefit and the accounts. At the broader level of the health care system, the paper examines how HSAs may affect the employer-based system and whether they may help to increase the number of Americans with health insurance coverage.*

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Health savings accounts (HSAs) represent the latest in an attempt by the federal government to encourage the development of a new approach to health insurance. HSAs dominate the news about emerging trends in the insurance market, and even a few governors are looking to integrate them into their state Medicaid programs. HSAs are also central to the Bush administration's proposals to expand health insurance to individuals and small employers, control health care costs, and provide for more affordable health insurance options, goals that critics claim are unrealistic. Indeed, few topics in health policy today attract as much fervor on the part of proponents and opponents as HSAs.

An HSA is a personal savings vehicle that allows individuals to set aside funds on a tax-free basis to pay for health care expenses not covered by third-party insurance. To be eligible to make tax-free contributions to an HSA, an individual must be enrolled in a high-deductible health plan (HDHP) that meets specific requirements.¹ The combination of the HSA and the high-deductible insurance is intended to provide financial protection against high medical expenses for individuals while retaining incentives for individuals to be prudent purchasers of health care services.

HSAs and their associated HDHPs are part of a family of health insurance products that many refer to as "consumer-directed" or "consumer-driven" health care. While HSAs may be a type of consumer-directed health plan, or CDHP, not all such plans are HSAs. What CDHPs generally have in common, however, is a high-deductible health insurance product combined with a personal health care savings account. Also key to consumer-directed health care is providing consumers with access to information on health and the health care systems. (Since this paper addresses HSAs specifically and not the broader issue of consumer-directed health care, it focuses on the combination health account–health plan and not on the other components of the consumer-directed approach to health care. For ease of presentation and unless otherwise specified, *HDHP* in this paper refers only to the high-deductible health insurance plans that meet requirements relating to HSAs, while *HSA* refers to both the tax-favored accounts and the HDHPs with which they are associated.)

THE ORIGINS OF HSAs

Precursors

There has been an ongoing debate in the health policy community about the role played by third-party insurance coverage in driving up the costs of health care. Many analysts believe that such coverage is a major contributor to health care costs' rising at rates that exceed general inflation. In their view, conventional health insurance policies, with low deductibles and modest cost-sharing requirements, largely insulate policyholders from the true cost of care. Backed by a key finding of the RAND health insurance experiment of the 1970s—that increases in enrollee cost-sharing are associated with reductions in medical care utilization—analysts of this perspective have advocated for high cost-sharing benefit designs and, most especially, for cost-sharing requirements for routine services.²

In the opposing camp are analysts who tend to emphasize two other key findings of the RAND experiment—that enrollee cost-sharing can discourage appropriate as well as inappropriate utilization of services and that lower-income individuals are especially likely to forego necessary services if faced with cost-sharing responsibilities. These analysts point to the difficulty of designing an insurance program or policy that achieves the right incentives for consumers who have different abilities to pay and vary significantly in their need for medical services.³

These opposing viewpoints have played out both in the private and public insurance markets at different times in different ways. In the private market, insurers have largely responded to employer and consumer preferences. Although high-deductible policies have been available in the market for a long time, the vast majority of policies—especially in the employer group market—have favored relatively low deductibles and coinsurance.

The development of comprehensive health benefits requiring low patient cost-sharing has, in fact, been encouraged by federal tax policy. Health benefits received as an employee fringe benefit are exempt from federal income and payroll taxes. Individual out-of-pocket spending on health care, on the other hand, is tax deductible only to the extent that total health expenses in a year exceed 7.5 percent of adjusted gross income. Sums above that threshold can be deducted only by individuals who file itemized tax returns. Various mechanisms for providing workers with tax-free funds to pay for health care through employee benefits have developed, including cafeteria plans with flexible spending arrangements and health reimbursement arrangements, which are described below.

In 1996 and 1997, Congress changed federal tax policy, extending the same tax benefits enjoyed by comprehensive employer health plans to an approach that combined high-deductible (“catastrophic”) insurance with tax-favored, personal health savings accounts. This was done by establishing favorable federal tax status for a type of personal account called a medical

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savings account (MSA) that would be available as an option both to active workers and to Medicare beneficiaries.

Heavily promoted by some insurers and conservative think tanks,⁴ MSAs for the private insurance market were included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) on a demonstration basis. To enroll in an MSA, an individual had to be self-employed or an employee covered by a qualified high-deductible health insurance plan established by his or her small employer (defined as having on average 50 or fewer employees). A fixed limit was imposed on the number of MSAs that could be established⁵ and the authorization for their favorable tax treatment was set to sunset for any new MSAs opened after December 31, 2000.

Congressional support for MSAs was also sufficient to win their inclusion on a demonstration basis for Medicare beneficiaries as part of the 1997 Balanced Budget Act (BBA) makeover of Medicare's private plan options (Medicare+Choice, or M+C).⁶ Like the HIPAA MSAs for the non-Medicare market, the Medicare MSAs were authorized for a capped number of enrollees and on a time-limited basis (originally no new enrollments would be permitted after 2002 or after the number of enrollees reached 390,000). Medicare beneficiaries were to have the option of electing as an alternative to the traditional Medicare benefits a privately sponsored high-deductible health plan coupled with a government contribution into an MSA.

Although many expected that these changes in law would give rise to a robust MSA market, MSAs never gained much popularity. There was no interest at all on the part of private health plans to offer MSA plans under the M+C program. And MSA policies for the self-employed and small-group market met with little enthusiasm in the marketplace. Although opponents pointed to the low enrollment numbers to argue that consumers did not want these types of policies, proponents argued that the many federal requirements relating to the benefit design and the time-limited nature of the HIPAA and BBA demonstrations discouraged insurers from marketing MSAs, and employers and Medicare beneficiaries from seeking them.⁷ And while proponents in Congress succeeded in extending the life of private-market MSAs through successive legislation, their numbers remained relatively small through the end of December 2003.⁸ After December 31, 2005 (recent law extended them once again),⁹ no new MSAs may be opened and contributions are allowed only for those individuals who had previously contributed to one or who work for an employer already offering them. In all, only about 140,000 MSAs have been established since their inception.¹⁰

With the return of double-digit annual increases in private insurance premiums beginning in 2001,¹¹ high-deductible health plans that could be paired with personal health savings accounts began to attract more attention from employers seeking to limit their costs for health benefits.¹² Because such

plans also tended to permit a greater choice of providers than traditional managed care plans, especially health maintenance organizations (HMOs), they were also viewed by some as a better way to structure insurance plans. A number of entrepreneurs entered the market touting CDHPs. These new consumer-driven products married high-deductible insurance and personal health savings accounts with sophisticated Internet-based systems for providing enrollees with information about their health plan choices, provider networks, and even treatment options. Slowing the adoption of these options, however, was uncertainty about how the personal health savings accounts, known under a number of names,¹³ would be regarded by the Internal Revenue Service (IRS). In 2002, the IRS did issue guidance clarifying how certain of these accounts (health reimbursement accounts) would be treated (see below).

Legislation Authorizing HSAs

In the 108th Congress, Republicans pressed for more favorable tax treatment of personal health savings accounts. They were successful in winning House passage of two new forms of tax-favored accounts in the House version of what would be enacted as the Medicare Prescription Drug, Improvement, and Modernization Act (MMA): (a) the HSAs discussed in this paper and (b) health security savings accounts (HSSAs). Compared with the HSAs contained in the final MMA conference agreement, HSSAs would have been available to a larger number of taxpayers, provided for high-deductible health insurance plans with more modest deductible amounts, and permitted significantly higher contributions to the tax-favored accounts. Opposed by moderate Senate Republicans and congressional Democrats, the HSSAs were dropped from the legislation.¹⁴ HSAs, however, were included in the final law and became effective beginning in 2004. (Medicare MSAs were also authorized for the new version of the Medicare+Choice program called Medicare Advantage. These are not discussed in this paper.)

THE MECHANICS OF HSAs

HSA accounts are similar in structure and concept to individual retirement accounts (IRAs). Individuals who meet specific qualifications may establish HSA trust or custodial accounts with banks and other financial institutions approved by the IRS. Money may be deposited into the accounts by the individual, an employer, or anyone else on behalf of the individual, although the combined contributions may not exceed certain annual contribution limits. Qualified individuals must establish their own accounts; joint HSA accounts are not allowed, even for individuals enrolled in a single-family HDHP (although the HSA contribution limits are higher for individuals with HDHP family coverage). The total contribution for spouses who both have an HSA and are enrolled under one family HDHP is limited to the amount of the HDHP deductible. The couple

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can divide their contribution however they wish and make deposits into the separate accounts or all into one account. If either spouse is 55 or older, that spouse can also make an additional “catch-up” contribution to his or her account. Dependent children may not have their own HSAs, but their medical expenses may be reimbursed from a parent’s HSA (see below).

Funds deposited in HSAs by individuals or employees may be claimed by the account holder as deductions from adjusted gross income, regardless of whether or not the taxpayer files an itemized return (referred to as an “above-the-line” deduction). Deposits by employers on behalf of employees, including employee contributions made through salary reduction, are excluded from income and wages for federal employee income and payroll taxes and, depending on state law, may also be exempt from state taxes (see below for discussion of state laws relating to HSAs). Account earnings accumulate on a tax-free basis.

HSA funds may be invested in a number of IRS-approved investments, such as bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds. They may not be invested in life insurance contracts or in collectibles (for example, stamps, art, or gems), although investment in certain types of bullion or coins is allowed. The HSA trust or custodial agreement may restrict the investments that are permissible for that account. The IRS has also identified certain prohibited transactions involving HSA funds (for example, sale or exchange of property).¹⁵ HSA trustees or custodians may charge fees for administration of the accounts. Such fees do not count towards the annual contribution limits if paid directly instead of by withdrawal of funds from the account.

HSA fund balances may build from year to year; there are no “use or lose” requirements. Even if an individual is no longer eligible to make HSA contributions, any funds deposited in the account while he or she was eligible remain available to use on a tax-free basis for qualified medical expenses. Thus, HSAs provide a form of portable health benefits that follow an individual, regardless of changes in employment or insurance status.

Eligibility

Individuals are eligible to deposit money on a tax-free basis in an HSA if they are covered under a qualified HDHP and are not covered under other health insurance,¹⁶ (including enrollment in Medicare). As noted above, individuals claimed by taxpayers as dependents (for example, children) may not set up their own HSAs, although their health expenses may be reimbursed from the HSA of the person claiming them as a dependent (for example, a parent). There is no requirement that an individual have earned income to qualify for an HSA, nor are there any income limits on who can set one up. Eligibility is determined as of the first of each month; therefore, someone enrolling in an HDHP after the first day of a month becomes eligible to make HSA contributions beginning with the next month.

HSA Contributions

In general, annual contributions are limited by law to the lesser of the amount of the deductible in the HDHP in which the individual is enrolled¹⁷ and the maximum individual or family HSA contribution for the year. In 2004, the maximum contributions were \$2,600 for an individual and \$5,150 for a family. These amounts are adjusted annually for inflation (rounded to the nearest \$50). In 2005, the maximum contribution amounts are \$2,650 for an individual and \$5,250 for a family.

To encourage saving for health expenses after retirement, individuals eligible to make HSA deposits who are age 55 and older are allowed to make additional catch-up contributions. Catch-up contributions are limited to \$500 for 2004 and \$600 for 2005. The catch-up contribution limit increases by \$100 each year through 2009 and then remains at \$1,000 each year after 2009.

Contribution limits for both the regular HSA and catch-up contributions are calculated on a monthly basis. Individuals may contribute up to one-twelfth of the annual contribution maximum for each month that they are eligible during a year. Thus, an individual who is eligible for six months could make contributions of up to one-half of the annual limit. Contributions need not be made each month; they may be made at any time up to the filing date for the tax year. Table 1 presents some examples of HSA contribution amounts.

If more money is deposited into an HSA than is allowed under law (referred to as *excess contributions*), the amount that exceeds the limit is subject to a 6 percent excise tax penalty each year until the money is withdrawn. The penalty may be avoided, however, if the excess amount and any earnings on it are withdrawn before the federal income tax filing date.¹⁸ Individuals may have more than one HSA, but the annual contribution limits apply to the aggregate deposits in all HSA accounts.

TABLE 1
Examples of 2005 HSA Contributions

Scenarios	Maximum Annual HSA Contribution	Maximum Annual "Catch-Up" Contribution
35-year-old individual enrolled in a qualified \$5,000-deductible HDHP from 3/15 through 12/31/2005.	\$1,987.50 (9 months of eligibility/ \$2,650 maximum allowed)	None (not eligible because individual is under age 55)
54-year-old individual enrolled in a qualified \$5,000-deductible HDHP through employment from 1/1 through 12/31/2005. Family coverage. Turns 55 in June 2005.	\$5,000 (amount of HDHP deductible)	\$300 (6 months of eligibility for catch-up contributions)

Use of HSA Funds

Funds withdrawn from an HSA are not taxed if they are used to pay qualifying medical expenses for any beneficiary of the account to the extent the expenses have not been reimbursed by insurance or otherwise compensated. The definition of qualifying medical expenses generally includes those items and services allowed under section 213(d) of the Internal Revenue Code.¹⁹ Items and services that qualify as medical care under section 213(d) are more extensive than those generally covered under health insurance policies and include, in addition to medical, dental, and vision services, such things as attending medical conferences on a family member's chronic illness, transportation for medical services, smoking cessation and weight loss programs, and special education for learning disabilities. There is one major exception: while health insurance premiums are allowed under section 213(d), HSA funds may not be withdrawn and used tax-free to pay health plan premiums. Payment for premiums for certain types of insurance is allowed, however, including continuation coverage (for example, COBRA premiums),²⁰ qualified long-term care policies, (as defined in section 7702B(b) of the Internal Revenue Code); health insurance purchased while receiving federal or state unemployment compensation; and, for Medicare beneficiaries, any insurance other than Medicare supplemental policies. (Thus, for example, funds in HSAs that were established prior to becoming Medicare-covered could be used to pay premiums for Part B and the new prescription drug benefit.)

The trustee or custodian of an HSA is not responsible for determining whether or not the funds are being used for qualified medical expenses. The only requirement of the trustee or custodian is that he or she not accept contributions that exceed the annual limits. An exception is provided for rollover deposits from other HSA accounts of the individual. Account owners have free access to the accounts, and oversight of the use of funds is the responsibility of the IRS. Trustees or custodians are allowed to impose reasonable restrictions on the frequency of withdrawals from the HSA as well as on minimum withdrawal amounts.

HSA funds that are withdrawn and used for other than qualified health expenses must be included in gross income for tax purposes and are subject to a 10 percent penalty tax. The penalty is waived, however, in cases of disability or death or for individuals age 65 and over.

Upon the death of an HSA owner, the account balance transfers to the designated beneficiary. A spouse may continue to use the funds as an HSA. For other beneficiaries, the account balance is taxable as individual income. If no beneficiary is designated, the HSA balance becomes part of the estate and is taxable as income to the deceased on the final tax return. The amount is reduced by any qualified medical expenses incurred by the deceased individual prior to death and paid within one year of the death.

HDHPs

To qualify as a high-deductible health plan for purposes of an HSA, a health plan must meet certain requirements. The HDHP must provide general medical benefits. Coverage for only a narrow range of services, such as a dental or vision plan, would not qualify. The coverage must impose a minimum annual deductible and also provide catastrophic coverage after out-of-pocket expenditures reach a specified level. The minimum annual deductible amounts, specified in the law for 2004, are \$1,000 for an individual or \$2,000 for family coverage. These amounts are indexed to change by the rate of inflation each year, rounded to the nearest \$50. In 2005, the rounding results in the minimum deductible amounts' remaining at \$1,000 individual and \$2,000 family.²¹

Generally, family plans have embedded deductibles applying to individuals within the family that are less than the aggregate family deductible. For example, a plan may have a family deductible of \$2,000 but an embedded individual deductible of \$1,000 per family member. In such a case, the plan would begin paying benefits for each individual family member who incurs \$1,000 in spending and would pay benefits for all family members once the \$2,000 deductible had been met. To qualify as an HDHP for HSA purposes, the plan cannot have an embedded individual deductible that is less than the minimum required family deductible (that is, \$2,000 in 2005). So a plan with a \$2,000 family deductible and \$1,000 embedded individual deductible would not qualify as an HDHP, but one with a \$4,000 family deductible and an embedded \$2,000 individual deductible would qualify.

In order not to discourage individuals from receiving preventive services, the law provides for certain of these services to be exempt from application of the deductible, at the discretion of the HDHP sponsor. IRS guidance identifies preventive care as services that are not intended to treat an existing illness, injury, or condition and provides a list of preventive care benefits for which the deductible need not apply: periodic health evaluations (including diagnostic tests and procedures ordered for routine examinations), routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight loss programs, and certain screening services.²² The definition also includes treatment that is incidental or ancillary to a preventive care service, such as removal of polyps during a screening colonoscopy. Emergency services are not considered preventive and thus would be subject to the deductible. The IRS allows medications to be considered preventive care only when taken by a person to prevent disease or a recurrence of disease. (Some are advocating that the HSA law and regulations be changed to allow all medications to be exempted from the deductible, a step they see as necessary to ensuring compliance with medications and to simplifying the administrative difficulties posed by allowing only drugs provided for certain circumstances to qualify.)

HDHP policies must also have catastrophic coverage that pays all costs for covered services once an annual spending threshold for copayments,

coinsurance, and deductibles has been incurred by the enrollee (or family). The out-of-pocket threshold can be no more than \$5,000 for an individual or \$10,000 for a family. These amounts are also indexed to rise each year for inflation (see Table 2). In 2005, the out-of-pocket limits may be no higher than \$5,100 for an individual or \$10,200 for a family. The rules regarding out-of-pocket limits apply only to expenditures for benefits covered by a plan and not to all out-of-pocket medical expenses an HSA owner may incur during a year.

TABLE 2
Maximum HSA Contributions, Out-of-Pocket Limits,
and Deductibles, 2004 and 2005

	Amount Effective in 2004	Indexed Amount for 2005
Annual Contribution Limit	\$2,600 individual \$5,150 family	\$2,650 individual \$5,250 family
“Catch-Up” Contribution Limit (age 55+)	\$500	\$600
HDHP Maximum Out-of-Pocket Spending Limit	\$5,000 individual \$10,000 family	\$5,100 individual \$10,200 family
HDHP Minimum Annual Deductible	\$1,000 individual \$2,000 family	\$1,000 individual \$2,000 family

Because there is no direct relationship between the health care items and services covered under an HDHP and those that may be reimbursed from the HSA, most HDHP enrollees will likely have medical expenses that do not count towards the HDHP out-of-pocket limit. For example, HDHP premiums do not qualify, nor do amounts expended for items and services not covered by the plan, such as certain vision and dental services. If an HDHP does not cover eyeglasses, then the cost of eyeglasses would not count towards the plan’s out-of-pocket limit (although the eyeglasses could be purchased with funds from the HSA). In addition, any amounts for services obtained from providers that do not have a price agreement with the insurer (indemnity plans or out-of-network services) that are above what is allowed by the plan for “usual, reasonable, and customary” charges would not count towards the out-of-pocket limit. (This issue is discussed in greater detail below.)

There are also no structural requirements for HDHPs. Closed-panel HMOs, preferred provider organization (PPO) plans (that is, plans that charge higher cost-sharing for using out-of-network providers), or fee-for-service indemnity plans can all qualify as HDHPs if they meet the minimum

requirements. If an HDHP is structured as a plan that has a network of contracted providers (for example, a PPO), some special rules apply. For example, a network plan may have an out-of-pocket limit for services obtained out-of-network that is higher than the maximum allowed under the HDHP rules, so long as the out-of-pocket limit applicable to in-network services meets HDHP requirements. Also, if a network plan has a separate deductible for out-of-network services, that deductible is not taken into consideration for determining the amount of contribution to the HSA. For example, an HDHP may have two deductibles: \$1,000 for in-network services and \$2,000 for all services, regardless of whether they are received in- or out-of-network. For the purposes of determining the maximum contribution to the HSA, the \$1,000 deductible is applied.

HSAs VERSUS OTHER HEALTH ACCOUNTS

Several other types of arrangements exist under federal tax law that allow individuals to set aside tax-free funds to use for medical expenses. These include flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs), and medical savings accounts. FSAs through employer cafeteria plans function in a similar manner to HSAs, but there are several key differences. Generally, FSAs allow individuals to elect to receive tax-free funds diverted from their wages (and supplied as an employer-provided benefit) instead of cash wages to use for qualified expenses, such as medical care or child care.²³ In general, however, there are five provisions that apply to health FSAs that do not apply to HSAs:

- Unused FSA contributions may not roll over from one year to another. To the extent they are not used, the funds revert to the employer.
- The entire amount of reimbursement must be available throughout the year.
- An employee may not take any unused amounts with them upon leaving employment during the year (although funds may remain temporarily available to pay for COBRA continuation coverage).
- The employer can further limit what qualifies as reimbursable expenses.
- The employer can require substantiation that the expense is reimbursable.

For example, an individual elects to have \$100 a month or \$1,200 a year withheld from salary to fund an FSA. The individual uses \$1,000 in January to pay for a qualified expense. If the individual then leaves the employer at the end of February, he or she would not have to reimburse for amounts used but not withheld from salary (that is, \$800) but also would not be able to take with them the \$200 that was available but not used.

Health reimbursement arrangements are another way that employers may provide tax-free funds to employees to use for health care expenses, in

addition to or in lieu of health insurance benefits. An HRA can be funded only by employer contributions (that is, employees cannot contribute on their own), are not portable from employer to employer, and cannot be used for nonmedical expenses. If the plan makes payments or provides other benefits that are not medical expenses, all amounts paid by the plan become taxable, including prior medical reimbursements.²⁴ The IRS guidance on HRAs allows the carryover of unused amounts to later years and use of HRA funds to reimburse employees for the purchase of health insurance. HRAs do not have to be associated with high-deductible health plans, although it appears that the typical HRA is coupled with a health plan that has a deductible exceeding the annual employer contribution to the HRA.²⁵

Finally, as noted above, the MSAs authorized under HIPAA in 1996 have been extended through December 31, 2005,²⁶ and will continue to exist only for those individuals who are “grandfathered” because they had or were employed by an employer who sponsored MSAs prior to the program’s termination. (In 2000, Congress renamed these accounts “Archer MSAs,” after Bill Archer, then chair of the House Ways and Means Committee.)

Table 3 highlights the major differences among HSAs, HRAs, FSAs, and MSAs.

TABLE 3
Major Features of Various Tax-Favored Health Accounts

Features	Health Savings Accounts (HSAs)	Archer Medical Savings Accounts (MSAs)	Health Reimbursement Arrangements (HRAs)	Flexible Spending Arrangements (FSAs)
Contributors	Individual without employer coverage; employer, employee, or both	Self-employed and employers with 50 or fewer employees; both employer and employee can contribute, but not in same year	Employer	Employee decides contribution amount up to certain limits; employer may fund without employee election or can match employee contribution
Required Enrollment in High-Deductible Plan	Yes	Yes	Determined by employer	No
Account Ownership	Individual	Individual	Employer	Employer
End-of-Year Rollover	Yes	Yes	Maybe (up to employer)	No
Authorization	Statute	Statute	Regulation	Regulation

HSAs AND STATE LAWS

HSAs are a federal health policy initiative. However, because health insurance regulation is primarily a state activity, the state role is significant for the implementation of the approach. The specific areas in which states are involved include those related to insurance regulation (for example, premium rates, solvency, benefit requirements, marketing, and consumer protections), state income tax policy, and state policies regarding state subsidies for health insurance.²⁷

While health insurance policies with high deductibles are currently marketed in the states, state rules regarding such policies may not allow the marketing of products that meet the specific requirements for HDHPs. For example, some states may require that certain benefits not be subjected to a deductible. Such benefits may not fall into the category of preventive benefits that are allowed to be exempt from the HDHP deductible under federal law. In addition, some state HMO laws limit the degree to which HMOs may impose high deductibles. Recognizing that these types of problems exist with some state laws, the IRS issued a notice of transitional relief that allows certain nonpreventive benefits to be exempt from the HDHP deductible if required by a state law that was in effect on January 1, 2004.²⁸ The transitional relief is available through calendar year 2005.

One of the key features of an HSA is the federal tax-free status of the deposits into the accounts. Many states link the computation of state income tax to federal tax calculations. Therefore, to the extent that federal HSA policy results in lower federal revenues, these states also stand to lose tax revenue. If these states do not wish to accommodate HSAs in their tax structure, they must enact changes in their income tax laws that would require individuals with HSAs to add the amount of HSA deposits and any earnings derived from them back into their income before computing their state tax. Conversely, states with tax policies that do not track federal tax calculations will have to decide whether or not to encourage HSAs by enacting legislation to allow state tax advantages for HSA deposits similar to those allowed under federal law.

Finally, states will have to decide if they wish to implement an HSA option for their state employee benefit plans, health insurance high-risk pools, or other state initiatives to subsidize health insurance coverage. Federal law does allow states to make HSA contributions a part of their high-risk pool strategy if the coverage meets HDHP requirements. Some states are moving toward changing their high-risk pool coverage so that it meets HDHP rules that allow them to implement HSAs.²⁹

HSAs IN THE INSURANCE MARKETPLACE: SOME EARLY RETURNS

Federal law facilitates HSAs, but their future will be determined by whether insurers and employers decide to offer them and whether employees and

State rules regarding health insurance policies with high deductibles may not allow the marketing of products that meet the specific requirements for HDHPs.

individuals decide to elect them. On the supply side, the market appears to be robust. On the demand side, the picture is less clear.

Qualified HDHPs and HSAs have been heavily promoted by the Bush administration (the president announced at a December 2004 White House Economic Conference that he has elected an HSA for his own health insurance)³⁰ and are highlighted on the Web sites of the Department of Treasury (www.ustreasury.gov) and the Small Business Administration (www.sba.gov). The trade association for the health insurance industry, America's Health Insurance Plans (AHIP), has initiated a Web site with a state-specific directory of HSA products to promote HSAs (www.HSADecisions.org). And insurers and other private-market entities, many of whom had lobbied Congress for the enactment of HSAs, quickly introduced to the market high-deductible products that could be coupled with HSAs.

Availability of HSA/HDHP Products

As of March 3, 2005, the AHIP's Web site listed 88 insurers (including managed care companies, indemnity insurers, and Blue Cross Blue Shield plans) offering HDHPs that qualify for HSAs. As of the same date, the *HSA Insider*, (a Web site promoting HSAs that is sponsored by an advocacy organization) listed 85 insurance companies that sold high-deductible health plans and 58 banks and trusts that provided HSA custodial and administrative services.³¹ Some insurers offered both HDHPs and HSAs. Insurer offerings varied with respect to which states and in which markets (that is, individual, small-, and large-group markets). Several of the nation's major insurers and managed care companies (for example, UnitedHealth Group and Aetna), indicated that they offer HDHPs and HSAs to self-insured, large employers on a national basis.

Another indicator of insurer response to HSAs is that nine out of ten HMOs and PPOs surveyed in 2004 reported that they intend to offer high-deductible health plans in tandem with a health savings or health reimbursement account within one year in the large-group employer market (firms of more than 250 employees). This is up from 29 percent in 2003.³² One of the nation's largest HMOs, Kaiser Permanente, in partnership with Wells Fargo Bank, began offering HSA-qualified HDHPs in January 2005 in both the employer and individual markets.³³

As discussed later, some vendors are marketing HSA packages in which they offer to health plans and employers HSA account services (administering the accounts, managing the investments) and health care debit cards. Such debit cards, which also are marketed to go along with other employee benefit accounts, such as FSAs and HRAs, can be used by plan enrollees to make distributions (payments) from their HSAs for medical expenses.³⁴

Response by Purchasers

As to the question of whether the HDHP products are actually being purchased and HSAs established, the evidence suggests a modest market response, at least so far. According to an AHIP survey of 29 of its member insurers actively marketing qualified HDHPs that accompany HSAs, about 438,000 consumers were covered by such insurance policies as of September 2004. Of that total, 346,500 were covered through non-group-market policies. The remaining 91,500 lives were covered through employers, with about 14 percent of the employer group policies covering workers in firms with 50 or more workers.³⁵

Because the IRS rules for HSAs were not published in time for many employers to incorporate them in their plan offerings for 2005, employer adoption of HSAs is expected to be more widespread in 2006. With a few major exceptions, results for the 2005 plan year are not fully known. Among the exceptions are the Federal Employees Health Benefits Program (FEHBP), which has made HSAs available to all participants electing HDHPs under the GEHA and Mail Handlers plans,³⁶ and Aetna, which is offering an HDHP/HSA product to participants in the FEHBP in a majority of states.³⁷

So far, employee election of the HDHP/HSA option appears to be modest. A survey by Hewitt of employer clients found that only 3 percent of employees offered an HSA for the 2005 plan year plan chose to enroll in it.³⁸ As of this writing, a more complete tally of employee election of HDHPs combined with HSAs is not available.

The small employer market is expected by many to respond especially favorably to the introduction of HDHP/HSA products. Small employers (generally defined as fewer than 50 employees), to the extent that they provide coverage at all, tend to be more sensitive to the price of insurance than larger firms. At a time when annual premium increases hover in double digits, small employers should be receptive to plan designs offering relatively lower premiums, as it is hoped high-deductible health plans will. And while the rules related to FSAs and HRAs have limited small employer participation, these drawbacks do not apply to HSAs.³⁹ This said, it should be noted that even double-digit increases in premiums in the recent past have not led significant numbers of small employers to change health plans. Such inertia can result from many factors, including the administrative burdens involved in changing plans and employee resistance to switching health care providers.⁴⁰ The Bush administration has proposed to give eligible small business owners a refundable tax credit for contributions they make to their employees' HSAs as a way of encouraging more small business adoption of HSAs.⁴¹

The jury is still out on the extent to which early employer adopters have found that HSAs have saved them money; the experience is too new and limited. Mercer reports that employers offering health plans with high deductibles and HRAs (not HSAs) in 2004, on average, saved money but

So far, employee election of the HDHP/HSA option appears to be modest.

so too did PPO plans with high deductibles that were not combined with personal accounts.⁴² Humana, Aetna, and Definity Health have released data indicating that HRAs are associated with reduced costs, but the findings are not definitive. Adjustments were not made to reflect benefit cut-backs or shifts of employees between options from one year to the next. Moreover, one or two years of experience are not sufficient to determine whether savings are sustainable; a plan's claims experience tends to deteriorate over time. Additionally, enrollees in high-deductible plans may have been foregoing important medical services, which could lead to higher-cost interactions with medical providers in the future.⁴³ Proponents would argue, however, that HRAs are not HSAs. In their view, HSAs include more incentives to produce cost savings. Their ability to produce savings for employers is discussed below in the section on implementation and policy issues.

Looking Ahead

As an indicator of potential employer interest in HSAs, one can look at the many national surveys of employer attitudes toward HSAs and HDHPs. These show varying results, ranging from minimal to substantial interest.⁴⁴ Somewhere between 6 percent and 26 percent of all employers are at least giving serious thought to offering HDHPs within the next two years.⁴⁵ A higher percentage report being somewhat likely to do so. A Mercer Human Resources April 2004 survey found that very large employers (20,000 or more employees) and very small employers (10 through 49 employees) will be the first to offer them: 81 percent and 78 percent, respectively, are very or somewhat likely to do so by 2006. The extent to which these employers intend to contribute to HSAs for their employees is harder to discern. Mercer found that nearly 40 percent of employers did not plan to make any contribution to the HSA. About a fourth (24 percent) said they would contribute \$500, 17 percent said they would contribute \$1,000, and 5 percent said they would contribute \$1,500. Only 6 percent would contribute the maximum permitted (in 2004) of \$2,600. For 77 percent of employers, their HSA contribution amount was lower than the deductible amount they selected; for 13 percent, it was the same; and for 10 percent, it was higher (despite the fact that the contribution is limited to the lesser of the plan deductible or an amount set by Treasury each year).⁴⁶

Representative national surveys of employee attitudes toward HDHPs and HSAs are not yet available, and the results of public opinion surveys are somewhat mixed. A national survey of public attitudes towards health care after the 2004 presidential election found little enthusiasm for HSAs. In general, respondents said that they would get less care with them, although enthusiasm was higher among the youngest respondents.⁴⁷ Another survey found that although most people were unaware of the new law relating to HSAs, enthusiasm for personal health accounts was high, again especially on the part of younger respondents.⁴⁸

A more comprehensive look at consumer attitudes about the nation's health care system indicates that high-deductible plan designs are not favored by a majority of Americans and that many are worried that such plans could adversely affect their health. The addition of personal health accounts, however, helps to increase their appeal. The Employee Benefit Research Institute (EBRI) 2004 survey of consumer confidence in the health care system found that while more Americans than previously surveyed were dissatisfied with the costs of health care, many "are not eager to switch to a system that assigns them more responsibility for their health care costs."⁴⁹ Almost two-thirds of respondents said that it would make no difference in their use of health care services if they knew their full price, not just what they pay. More than a quarter of survey respondents believed that health care would deteriorate if they paid for more of their health care costs directly instead of through an insurance company.

Results of the EBRI survey also suggest that a majority of consumers do not actively seek the added decision-making responsibilities associated with consumer-directed health plans. Two-thirds of respondents said they simply follow whatever counsel they receive from medical professionals rather than researching medical implications further. But when respondents were asked explicitly about their interest in high-deductible plans combined with savings accounts, public opinion was more favorable. A majority of respondents (including insured and uninsured persons) indicated being somewhat, very, or extremely interested in high-deductible plans, with interest increasing if such plans were combined with portable savings accounts and with employer contributions. Interest was generally about the same or even higher on the part of uninsured respondents. Survey respondents in excellent or very good health were more likely than those in poorer health to indicate interest in these plans.⁵⁰

IMPLEMENTATION AND POLICY ISSUES RELATED TO HSAs

Opinions about HSAs within the health policy community are polarized and intensely held. Proponents believe that because these products require consumers to take more responsibility for paying for their health care than conventional insurance products, they will help stem the rise in health care costs. Since consumers will think twice before spending their own money, either out-of-pocket or from their HSAs, proponents maintain, they will have an incentive to choose generic drugs, seek out lower cost health care providers or even negotiate directly with their physicians and other providers over the price of the service, and demand more quality and price information from providers. This consumer involvement will encourage providers to compete on the basis of price, drive down overutilization, and reduce the amount of unnecessary services that are provided. They also argue that the availability of the high-deductible health plans and their lower premiums will encourage more employers and individuals to purchase and retain health insurance, thus improving health insurance coverage rates.

Opinions about HSAs within the health policy community are polarized and intensely held.

Opponents of HSAs view them more as a blunt instrument than a well-placed scalpel in reducing medical services—and one that will further fragment the health insurance risk pool. In their view, to the extent that these products actually discourage consumer demand for medical services, they discourage appropriate as well as inappropriate care. When people are sick, opponents argue, they typically do not have the time, energy, or inclination to shop for a physician or hospital based on price, even if such price information were to become more widely available. The prudent and empowered *consumer* envisioned by HSA proponents is, in the opponent's view, an inherently disadvantaged *patient* who cannot be expected to enter into medical care transactions in the same way as they would the purchase of an automobile. They are also skeptical that consumers of HSAs will have much negotiating clout. Unless there are large numbers of people with HSAs and providers are required to make their prices public, consumers are likely to remain as “price takers” and not “price negotiators” when it comes to medical services.⁵¹ Perhaps of greater concern to many opponents of HSAs, however, is the accounts' potential to attract younger and healthier individuals, leaving more conventional insurance plans with an increasingly sick and expensive pool of risks. Should this occur, the result could be greater numbers of under- and uninsured.

Whether HSAs succeed in helping to tame rising health care costs or merely rearrange who bears these costs remains to be seen. The evidence remains incomplete and too preliminary to draw conclusions. A number of issues and concerns that relate to this type of health insurance product, both in terms of these products as a form of health insurance for individuals and in terms of their possible effects on the entire health insurance system in the United States remain to be answered.

HSAs and Health Care Costs

Can HDHPs combined with HSAs produce significant reductions in health care spending? While HDHPs may reduce a small fraction of spending by the vast majority of people with health insurance who never reach the deductible, they seem unlikely to reduce the overall level of expenditures very much. This is because, in any pool of insured individuals, the vast majority of health expenditures are, in fact, incurred by a small fraction of people. For example, among the adult population with employment-based health benefits, the average individual total spending on health care was \$2,454 in 2001. About one-quarter of the population incurred expenses above the average, but this group accounted for 80 percent of total spending.⁵² It is doubtful that health care costs would moderate much if the 25 percent of the population accounting for most of the spending all had high-deductible health plans and HSAs.⁵³

While the rules governing HDHPs do not preclude the use of utilization management tools (for example, the HDHP can offer a network of preferred providers, require preauthorization for certain services, and encourage less costly alternatives), the plan still must pay 100 percent for all

ADVANTAGES OF HSAs

- Provide financial incentives to:
 - Be prudent in seeking care.
 - Negotiate prices with providers.
 - Stay healthy.
- Give consumers greater choice in types and quality of care.
- As a result of lower-cost high-deductible plans, allow coverage of more people.
- Ensure portability.
- Have tax-free savings potential.

CONCERNS ABOUT HSAs

- Contain financial incentives to delay needed care.
- Shift costs to sicker individuals.
- Lack incentives for prudence once catastrophic limit is reached (100% coverage after limit is reached).
- If inadequately funded, may result in more provider bad debt.
- Segment insurance risk, possibly increasing the number of uninsured.

items and services covered by the plan once the annual out-of-pocket limit is reached. Therefore, at that level, there is no longer a financial incentive for the consumer to be prudent and, in fact, the reverse incentive exists to consume as much as possible before the next year's deductible takes effect. Of course, this rule could be changed to permit more cost-sharing after the enrollee exceeds the deductible, but that is also true for more traditional benefit designs. The extent to which such increased cost-sharing results in inadequate insurance, especially for lower-income enrollees, then becomes an issue.

This leads to a related question: If HSAs are unlikely to reduce much health care utilization, especially utilization above the deductible, will they encourage more prudent purchase and effective use of health care services? While patient cost-sharing provides an incentive for individuals to be prudent in their use of health services, it may also discourage them from seeking services for prevention and early detection of disease.⁵⁴ For this reason, the law allows (but does not require) HDHPs to exclude preventive services from application of the deductible. However, the problem of providing a disincentive for seeking services and obtaining early diagnosis and treatment of conditions remains, which could result in the need for more expensive interventions and perhaps poorer health outcomes.

This possibility is one reason that enrollees, especially those with more modest resources, need to build a balance of funds in their HSAs. Fundamental to the theory behind HSAs as a form of health insurance is the tax-free status of the HSA, which provides individuals with the same tax advantages that they would have if they had comprehensive employer-sponsored coverage with little in out-of-pocket liability. The individual is protected from medical expenses through the combination of the HDHP and money in the HSA. Under a number of circumstances, however, it is possible that individuals with HSAs would not have much money accumulated in their accounts and would remain exposed to liability for the amount of the high deductible. This may not be a serious problem for those with high incomes but could be very significant for lower- and middle-income individuals and families.

Individuals or families that already experience high medical costs are likely to expend the funds in their HSAs every year and never have an opportunity to build up any account balances. Another factor that may discourage accumulation of HSA funds is that HSA funds may be used for a broad array of medical items and services, much broader than the benefits that are generally included under typical health insurance plans, including HDHPs. For example, vision and dental services are often not covered or are covered separately from general medical insurance (such as an HDHP). An individual with an HSA will have the advantage of using HSA funds to pay for expensive services such as orthodontia or lasik surgery that are typically not covered under general health insurance policies, much in the same way funds in FSAs are used. An individual or family may use up an HSA balance on these types of discretionary expenditures each year. And

Individuals or families that already experience high medical costs are likely to expend the funds in their HSAs every year.

if their HDHP does not include coverage of such discretionary services, their expenditures on these services do not qualify as out-of-pocket expenses for purposes of their HDHP catastrophic limit, and they remain financially exposed for the HDHP deductible costs of a medical situation requiring expensive inpatient and/or outpatient treatments. Some large employers have addressed this issue by offering an FSA along with an HSA. The FSA may be used to pay for health care items and services that are not benefits covered by the HDHP, thus allowing the HSA funds to accumulate and remain available to cover the HDHP deductible expenses.

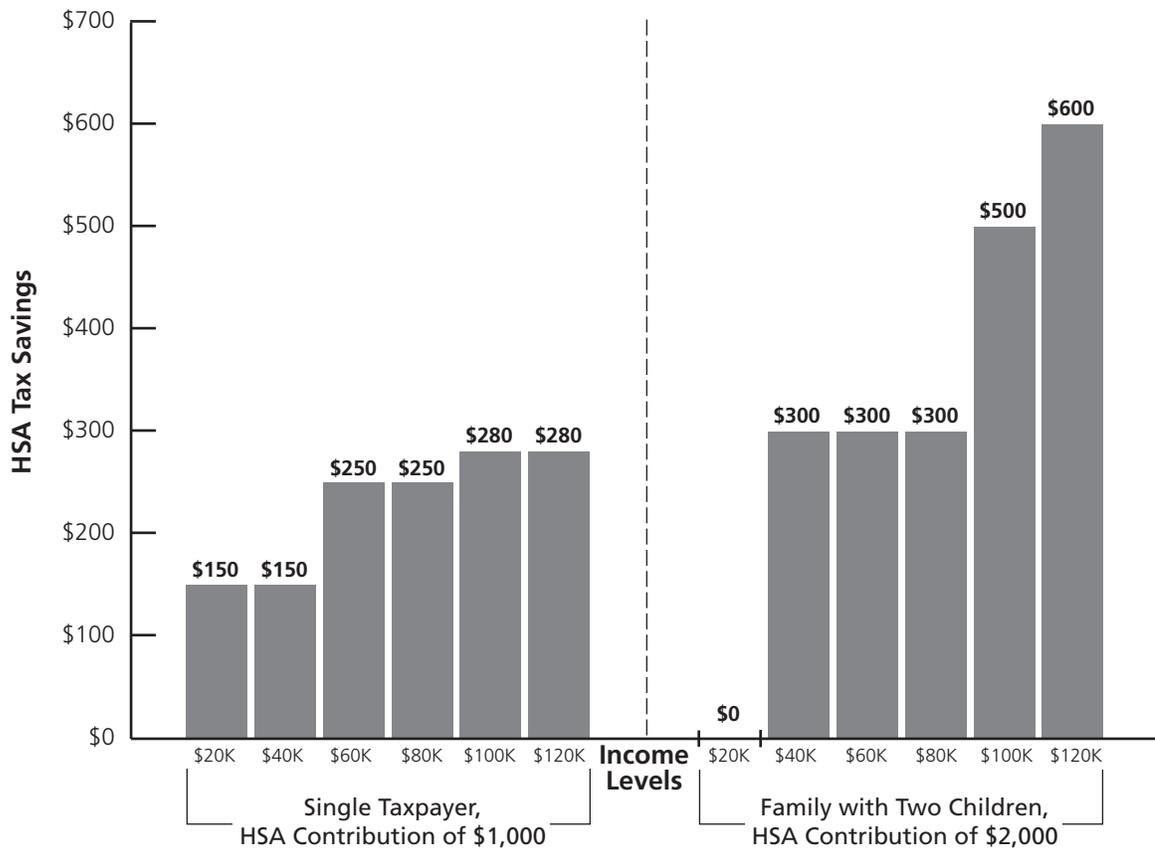
Another issue relates to the rules for contributing to an HSA. An individual may purchase an HDHP and open an HSA account. However, the law allows HSA contributions to be made up to the tax filing date for the year. Thus, individuals may delay or avoid making deposits into their HSAs, figuring that if they become ill during the year they will be able to deposit funds and access them on a tax-free basis. In such cases, funds will not accumulate in the HSAs to protect the individuals from significant medical expenses in the future.

For individuals who remain relatively healthy and manage to accumulate funds in their HSAs, such accounts could be an important part of planning and saving for later-life health needs such as long-term care. However, for the under-65 population, the tax consequences and penalties on unqualified distributions are not severe. Some may be willing to incur the income tax and 10 percent penalty on the funds to use them for nonmedical purposes.⁵⁵ And even those over age 65, who might be viewed as more likely to want to accumulate savings for future health care expenses, may be tempted to use their HSA balances for nonmedical purposes because the withdrawal penalty is waived and, even though amounts used for nonqualified purposes are subject to taxation as income, retired individuals usually have a lower marginal income tax rate.

HSAs may be, in fact, most attractive to high-income people and those with low expected health expenses. The benefits of tax exemption are highest for those in the highest marginal tax brackets and are of little value to those who have minimal tax liability. Those with higher incomes are also more likely to be able to afford to pay out-of-pocket those expenses incurred below a high deductible. As shown in Figure 1 (see following page), a family with two children and an income of \$60,000 making an annual HSA contribution of \$2,000 would save \$300 in federal taxes, whereas a family with \$120,000 in income, making the same HSA contribution, would save twice as much. The difference in tax savings would be somewhat less for taxpayers filing as individuals in these same income categories and making a \$1,000 annual HSA contribution. It should be noted that if contributions to an HSA are made by an employer, however, all workers in all income ranges reap the advantage of having the contribution exempt from payroll taxes.

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FIGURE 1
HSA-Derived Federal Income Tax Savings at Various Income Levels
for a Single Taxpayer and for a Family with Two Children



Source: U.S. Department of the Treasury, "HSA Tax Savings: Reduction in Federal Income Tax from HSA Contributions in 2005, Illustrative Examples," www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa-examples.pdf.

Provider Reimbursement

Another issue for individuals with HSAs concerns the prices charged by providers for services. Proponents of HSAs believe that HSAs may help control health care spending because patients who are "spending their own money" will be more prudent about seeking health care and will be more conscious of prices for services. This will lead to bargaining with providers or encouraging providers to compete for patients by lowering their rates. While there is some skepticism about the ability of individuals to bargain effectively with providers, at the very least, proponents argue, the

combination of HSAs and more informed and prudent purchasers will result in greater price transparency and competitive pressure to lower prices.

In cases in which an individual purchases an HDHP that has an associated network, such as a PPO or an HMO, the plan will have negotiated provider payment rates with network providers. In these cases, individuals will get the negotiated price unless they choose to use non-network providers.

It is when obtaining services from providers who do not have negotiated rates with the HDHPs that problems may arise. These are issues that are applicable not only to HSAs but also to any non-network type of health insurance. Non-network providers are free to charge whatever they wish for their services. In these cases, most HDHPs will base reimbursement on “usual, reasonable, and customary” (URC) amounts charged by network providers. Amounts that exceed those on which the plan bases its reimbursement remain the responsibility of the individual and may be paid from HSA account balances. These additional amounts paid out-of-pocket by the enrollee will not be counted toward either the HDHP deductible or the annual out-of-pocket limit and, once the catastrophic out-of-pocket limit is reached, the amount covered by insurance will again be the URC amount, not amounts in excess of that.

For example, an individual has surgery and is charged \$5,000 by the doctor. The URC for the service is only \$4,000. In this case the enrollee is liable to pay \$5,000, but the plan will count only \$4,000 towards the out-of-pocket limit for the year. If the individual has reached the out-of-pocket threshold, the plan will pay \$4,000 and the individual will be liable for the remaining \$1,000.

The paperwork involved in trying to sort out the correct applicable charges (that is, whether there have been negotiated rates that are lower than the provider’s “retail” rates) can be confusing and time-consuming.⁵⁶ In some cases, individuals may pay more than they are liable for because they are not aware that lower rates have been negotiated by their plan. These problems may be overcome if the patient sends all medical bills to his or her insurance company to have it determine the amount of patient liability and waits to make payment until notified of the amount.

A development that attempts to address many of these HSA issues is the use of debit cards that some institutions are providing with HSAs. The cards may be administered in-house or in partnership with a financial institution. In addition to the convenience of using the HSA-supplied debit card to pay medical expenses, the HSA holder is provided an accounting of the expenses without having to keep numerous receipts. An issue that arises, however, is making sure that the debit card purchases are all qualified medical expenses. For example, what if an individual purchases a prescription at a drug store along with other items that are not qualified medical expenses? The debit card statement would not provide an itemized list of the purchase; therefore, it would be up to the individual to maintain documentation of the items. And, if HSA funds were used to purchase

nonqualified items, he or she could be subject to taxation and penalties on the amounts involved for the nonqualified purchases.

As the market for HSAs evolves, products are being developed to respond to some of these administrative issues. For example, Humana offers a Visa-branded debit card that also serves as the insurance identification card. The card provides access to the enrollee's benefits and eligibility information.⁵⁷ Other HSA sponsors are exploring similar approaches. Some cards will reject purchases that are not qualified HSA expenses, thus mitigating the documentation issue discussed above and providing employers with some assurance that HSA funds are being used as intended for health care expenses.

Still another approach that some insurers are using involves having enrollees authorize the insurance company to make deductions directly from their HSAs.⁵⁸ While this approach may simplify administration, it also raises the obvious issues related to allowing another entity to have access to one's bank account.

Provider Bad Debt

Some health care providers view HSAs with concern because of their perceived potential to increase bad debt or the cost of bad debt collections. For example, some in the hospital community worry that hospital charges below the insurance deductible are more likely to go unpaid, especially in the near term before HSA participants have had time to accumulate large HSA balances and in the case of the very high-deductible plans. Also, collections from individuals as opposed to insurers will be more labor intensive and thus more expensive, although this concern may eventually subside as health care debit cards that are issued to many enrollees of HDHPs become more prevalent.⁵⁹ The concern about bad debt resulting from HDHPs has even been flagged by some investment analysts who predict an erosion of hospital profits and a downturn in hospital stock prices as investors lose faith in their performance.⁶⁰ High-deductible plans may also become a fertile ground for hospital lawsuits, increasing the already sizable amount of litigation over the adequacy of insurer reimbursements.⁶¹

Physicians and other medical professionals may be even more exposed to bad debt due to high-deductible health plans. Because their services typically cost much less than hospital services, more of their patients may be responsible to pay for services out-of-pocket because they have not yet reached their deductibles. If the HSAs are not adequately funded, there may be more default on payments. On the other hand, to the extent HSAs function as intended, especially if accompanied by a debit card, debt collection by professionals may be simplified and improved.

HSAs and the Employer-Based System

High-deductible health plans in combination with HSAs are being promoted by some on the basis that they expand provider choices for

Some health care providers view HSAs with concern because of their perceived potential to increase bad debt or the cost of bad debt collections.

individuals and give employees a wider choice of plan options. Another advantage, in the view of some, is that HSAs may be promoted by employers to their workers as a vehicle for helping them save for postretirement medical needs in the face of declining employer-sponsored coverage. But probably a more determinant factor in whether HSAs play an enduring role in the nation's health care system is whether they save purchasers, especially employers, money.

As noted above, employer interest in offering HDHPs is high, but less enthusiasm appears to exist on the part of employers for contributing to employees' HSAs.⁶² This suggests the need for assessing HDHPs as distinct products from HSAs. Also, because of the different implications for risk selection, it is important to distinguish between situations in which an employer elects to offer an HDHP in addition to other, more traditional, plan options from those in which an employer elects to offer an HDHP as a replacement to those options. Finally, there is the more complex question of whether HDHPs offered in conjunction with an employer contribution to an employee's HSA can result in cost savings.

Anecdotal evidence from insurers offering HDHPs indicates that premiums for these plans are currently being offered at some savings ("up to 40 percent" for small employers, according to AHIP).⁶³ Whether such lower premiums anticipate favorable risk selection or whether first-year savings are sustainable over the long run remains to be seen. To build enrollment, insurers may offer HDHPs to first-time customers at an attractive premium. However, renewal premiums may be less attractive as insurers seek to bring premiums more in line with actual experience. And that will depend on which employees enroll in HDHPs.

In those cases in which an employer offers only one health insurance product to its employees, HDHPs may save the employer money, at least over the short run, and will not encourage segmentation of the employer's risk pool, because everyone is in the same pool. A single plan option is unusual in large firms but common for small employers, especially those with fewer than 25 employees.⁶⁴

But even if segmentation is not a problem for the employer's own pool of insured individuals, critics of HDHPs worry that they will result in segmentation of the overall employer risk pool. If employers that migrate to HDHPs are largely those with the healthiest employees, more traditional insurance products will be left with the higher-risk groups, accelerating rate increases in the cost of traditional plan coverage.⁶⁵ This is especially of concern in the small-group market, where firms considered above average risk already face a difficult time finding affordable coverage. As discussed below, it is too early to tell whether such risk segmentation is occurring.

In the large employer market, most employers offer their workers a choice among several plan options, usually ranging from less to more tightly constrained provider networks.⁶⁶ In such a multiple-plan-option environment, the extent to which an HDHP saves the employer money will depend on

how the employer contribution is set, what the mix of plan options offered is, and how employees sort themselves out among the different health plans. If the employer simply offers the HDHP as another plan option and does not change the amount contributed to the other options, the employer is unlikely to save money. Under a scenario in which the employer also contributes to workers' HSAs, an HDHP/HSA option could even cost the employer more.

Employer cost savings are more likely, however, if the employer sets its total contribution, including any HSA contribution, to the lowest plan amount, which may be the HDHP. Depending on how employees sort themselves among the plan options, employer costs may, therefore, remain the same or even decrease from what they otherwise might have been. Increased employer costs for the HSA for healthy employees can be offset by reduced contributions for sicker employees remaining in the traditional plans. However, traditional plans may experience steadily increasing claims costs if their pool of employees becomes increasingly composed of individuals with above-average risks. Such adverse selection could drive up premiums to the point that they will be unsustainable.⁶⁷ Adverse selection against the traditional plans could be especially bad if employees are allowed to change health plans each year. In such cases, individuals enrolled in the HDHP could build up HSA balances, switch to a traditional plan in a year in which they anticipate significant medical expenses, and switch back to the HDHP in years when they anticipate few expenses.⁶⁸

Those concerned about adverse selection in a multiple-plan-option environment assume that high-deductible plans are most appealing to younger, healthier employees, with or without HSAs. This view is consistent with some survey data.⁶⁹ Early evidence on high-deductible plans, albeit not those authorized under the MMA, is less conclusive.

On the one hand, consumer-directed health plans were found to attract relatively healthy employees in a study of Humana, Inc.'s early experience in offering such plans to its own employees. Although there did not appear to be a difference in the age profiles of employees choosing such plans and those of employees who chose the more traditional HMO and PPO options, those who chose the CDHP options were found to be healthier on the basis of claims costs and use of health services. They also made somewhat higher salaries.⁷⁰

On the other hand, another set of studies found that the appeal of high-deductible health plans may be broader than just to younger and healthier individuals, thereby helping to reduce favorable selection. Stephen T. Parente and his colleagues analyzed the selection of a high-deductible plan in an employer setting in which employees could choose from a traditional HMO, a PPO, a tiered network product, and a high-deductible plan (a CDHP). They found that the high-deductible plan was not chosen disproportionately by the young and healthy but that it

The appeal of high-deductible health plans may be broader than just to younger and healthier individuals, thereby helping to reduce favorable selection.

did attract “wealthy” employees and those employees who found the broad availability of providers offered by that plan more appealing than the more restricted networks of the HMO and the PPO. The lower out-of-pocket premiums associated with the high-deductible plans was offered as the reason the less healthy selected such plans.⁷¹ Another study by the same researchers compared medical care costs and utilization in a CDHP to other health insurance plans offered by one large employer. After one year’s experience with the CDHP, enrollees in the CDHP had lower total expenditures than the enrollees in the other plans because of lower costs for physician visits and pharmaceutical use. But they also had “higher utilization of resource-intensive hospital admissions.”⁷²

Again, both sets of studies predate the HSAs established by the MMA. Research to determine whether the HDHP/HSA plans in multiple- and single-plan-option environments are giving rise to adverse selection and fragmentation of employer risk pools has yet to be carried out.

Another issue is whether HDHPs combined with HSAs could encourage some employers to drop group coverage and cash out health benefits. This possibility is viewed by some HSA critics as especially likely should the law be changed, as proposed by the Bush administration, to make premiums associated with individually purchased HDHPs deductible from income tax. (Presently, premiums paid for individual coverage cannot be deducted unless they, in combination with other nonreimbursed medical expenses, exceed 7.5 percent of the taxpayer’s adjusted gross income.) In their view, the resulting improved tax status of individual coverage could make such coverage more attractive to healthier and higher-income individuals. Small business owners, for example, would then have a more viable option for getting coverage from the individual market, reducing their incentive to continue providing group coverage for their employees in order to acquire it for themselves. And, even if only a few employees elected to opt out of a small-employer group, coverage might be jeopardized because the group might then fall below insurers’ participation requirements.⁷³

Effects on Health Insurance Coverage

Analysts disagree on the effect that HSAs will have on the number of uninsured. Many proponents of HSAs argue that their introduction to the market place will result in reductions in the number of uninsured because lower-cost HDHP health insurance products will be more attractive to small employers and people purchasing insurance in the nongroup market. Early anecdotal evidence indicates that HSAs are attracting some purchasers who report no recent prior health insurance coverage, but no systematically collected, independent evidence is available yet.⁷⁴ Proponents also believe HSAs will enable many employers to continue to offer health benefits at a time when rising health care costs might otherwise convince many to drop coverage. In addition, HSAs can be drawn on to

pay for health insurance continuation coverage (for example, COBRA)—helping to assure that more people retain group coverage when they experience a job loss or change in family status that would otherwise result in loss of insurance.

Other analysts, however, believe that the effect on the rate of uninsurance is likely to be modest at best, and at worst, could increase the number of uninsured. Most of the uninsured are linked to workers who are not offered insurance by their employers or who cannot afford to pay their share of the group premium. A smaller number of uninsured are unable to find affordable coverage in the nongroup market because of their age or health status. The majority of uninsured are in the lower tax brackets, for which the tax incentives of HSAs are modest at best. Thus, unless HDHPs/HSAs are offered at premiums sharply below the going rates for traditional insurance, they will not induce many of those currently uninsured to buy them. And, if they become a magnet for the healthier members of the community, they could drive up the costs of more traditional products, resulting in a higher rather than a lower number of uninsured.⁷⁵

FINAL OBSERVATIONS

HSAs are new and the issues are still evolving. Some of the problems and concerns that have arisen in the context of HDHPs and HSAs may be resolved through incremental changes in public policy or as the market adapts to the product. Unknowable at this juncture is whether HSAs are a flash in the pan, whether they will remain just one of a variety of health plan options available, or whether they will become a predominant form of health insurance coverage for those under age 65. The evidence to date on HSA market penetration is such that proponents can argue that the product is catching fire and opponents can claim that the consumer response is lukewarm at best. What is clear is that HSAs are likely to dominate the political agenda for some time to come, especially in the form of proposals to make them more attractive to the individual and small-employer markets and as at least one form of health plan eligible for any new health insurance tax credit that may be enacted for the uninsured.

ENDNOTES

1. In addition, the person cannot be covered by other health insurance, be enrolled in Medicare, or be claimed as a dependent on someone else's tax return.
2. Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs*, 23, no. 6 (November/December, 2004): 107–113. For more details on the RAND experiment, see W. G. Manning, J. P. Newhouse, N. Duan, E. B. Keeler, A. Leibowitz, and M. S. Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, 77, no. 3 (June 1987); and K. N. Lohr, R. H. Brook, C. J. Kamberg, G. A. Goldberg, A. Leibowitz, J. Keesey, D.

Reboussin, and J. P. Newhouse, "Use of Medical Care in the Rand Health Insurance Experiment," *Medical Care*, 24, no. 9 (September 1986): S72-S87.

3. Joseph P. Newhouse, principal investigator for the RAND experiment, says that effective cost containment requires modern managed care tools to manage the cost per case coupled with high deductibles for nonpoor policyholders. Newhouse, "Consumer-Directed Health Plans," 107-113.

4. Peter J. Ferrara, "More than a Theory: Medical Savings Accounts at Work," Cato Policy Analysis no. 220, Cato Institute, Washington, DC, March 14, 1995; John C. Goodman and Gerald L. Musgrave, *Controlling Health Care Costs with Medical Savings Accounts*, Policy Report no. 168, National Center for Policy Analysis, Dallas, January 1992. On the role of Golden Rule Insurance Company, see Marilyn Weber Sarafini, "Going for the Gold," *National Journal*, 27, no. 13 (April 1, 1995): 804-808.

5. The actual number of MSAs that were established never came close to the statutory limit of 750,000 accounts, even when previously uninsured individuals—not countable towards the limit—were considered. As noted later, the total number of tax-qualified MSAs established since their inception is about 140,000. See U.S. Internal Revenue Service (IRS), "Archer MSAs," announcement 2002-90; accessed November 28, 2004, at www.irs.gov/pub/irs-drop/a-02-90.pdf; and U.S. Department of the Treasury staff, personal communication with author, February 2005.

6. Under Public Law 105-33, a Medicare+Choice plan could be a medical savings account plan, defined as a plan that basically included Medicare benefits but only after the enrollee met a high annual deductible (\$6,000 in 1999) and an annual contribution to a Medicare+Choice medical savings account, which would have been made by the government.

7. For example, for the non-Medicare population, the high-deductible health plans that were required in conjunction with MSA contributions had to meet certain minimum deductibles that many viewed as too high. Moreover, because contributions to the accounts were limited to no more than 65 percent of the insurance deductible for self-only coverage and 75 percent of the deductible for family coverage, MSA policyholders were exposed to potentially significant out-of-pocket costs at least for the first year in which they were enrolled in the HDHP.

8. With passage of the Consolidated Appropriations Act of 2001 (P.L. 106-554), the MSAs authorized under HIPAA in 1996 were extended through 2002.

9. See §322 of P.L. 108-311, the Working Families Tax Relief Act of 2004, signed into law October 4, 2004.

10. U.S. Department of Treasury staff, personal communication with author, February 2005.

11. Health insurance premiums began a steady climb upward beginning in 1996 but reached double-digit growth between 2000 and 2001. Kaiser Family Foundation and Health Research and Educational Trust (Kaiser-HRET), *Employer Health Benefits: 2004 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation, 2004); accessed November 28, 2004, at www.kff.org/insurance/7148/index.cfm.

12. Increasing health care costs have led employers to increase employee cost-sharing through a variety of strategies. See Veronica Goff, "Consumer Cost Sharing in Private Health Insurance: On the Threshold of Change," National Health Policy Forum, Issue Brief 798, May 14, 2004; accessed December 18, 2004, at www.nhpf.org/pdfs_ib/IB798_CostSharing.pdf.

13. Different vendors referred to them by different names, including health savings accounts and personal health accounts.

14. Congress's Joint Committee on Taxation estimated that the HSSAs would cost about \$163 billion over ten years. U.S. Congress, Joint Committee on Taxation, "Estimated Revenue Effects of H.R. 2596," JCX-65-03, June 26, 2003; accessed November 28, 2004, at www.house.gov/jct/x-65-03.pdf. In addition to objecting to the high price tag for the HSSAs, opponents argued that they could weaken traditional employer-based coverage and shift a greater proportion of health care costs from firms to their employees. Edwin Park, Joel Friedman, and Andrew Lee, "Health Savings Security Accounts: A Costly Tax

Cut That Could Weaken Employer-Based Health Insurance,” Center for Budget and Policy Priorities, Washington, DC, revised July 8, 2003; accessed November 29, 2004, at www.cbpp.org/6-25-03tax.pdf. Iris J. Lav and Andrew Lee, “New Health Savings Security Accounts Could Reduce State Revenues by up to \$30 Billion over the Next Ten Years,” Center on Budget and Policy Priorities, Washington, DC, July 8, 2003; accessed November 29, 2004, at www.cbpp.org/7-8-03tax.htm.

15. IRS, “Notice 2004-2,” December 22, 2003.

16. Individuals may have certain types of insurance and still qualify for an HSA. Types of insurance that are allowed include coverage for specific diseases; vision, dental, and long-term care coverage; and drug discount cards or employee assistance benefits that do not provide significant medical coverage. Veterans may qualify for an HSA if they have not received veterans’ health benefits during the previous three months.

17. If the HDHP has an embedded deductible for one family member, the limit is the lower of the embedded deductible and the overall deductible for the policy.

18. The rules require that any income attributable to an excess contribution also be withdrawn from the account before the tax filing date for the year or it will be subject to the penalty. The same rules for computing net income for excess contributions to IRAs apply to HSAs (Treasury Regulation §1.408-11). The net income must be included in an individual’s gross income.

19. Generally, section 213(d) of the Internal Revenue Code allows individuals who file itemized tax returns to claim a deduction for medical and dental expenses paid for care for themselves, their spouse, or dependents to the extent that they exceed 7.5 percent of adjusted gross income.

20. Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, P.L. 99-272), employers with 20 or more employees are required to provide certain employees and their family members the option of purchasing continued health insurance coverage at group rates in the case of certain designated events. The major events include termination or reduction in hours of employment, death, divorce, eligibility for Medicare, or the end of a child’s dependency under a parent’s health insurance policy.

21. Because there was little time between enactment of the HSA law and implementation, the IRS delayed the effective date of some benefit requirements to January 1, 2006. This was done in order to allow health plans time to bring plan design into compliance with HDHP requirements and, in some cases, allow state legislatures time to revise state health insurance benefit laws that prohibit a high deductible from applying to certain benefits. See IRS, “Notice 2004-43,” June 25, 2004.

22. IRS, “Notice 2004-23,” March 30, 2004.

23. Elections must distinguish between amounts to be used for health and those used for child care.

24. IRS, “Revenue Ruling 2002-41,” June 26, 2002.

25. IRS, “Revenue Ruling 2002-41”; IRS, “Notice 2002-45,” June 26, 2002; and Bob Lyke, Chris Peterson, and Neela Ranade, *Health Savings Accounts*, RL372467, Congressional Research Service, Washington, DC, updated September 26, 2004.

26. Archer MSAs were extended in the Working Families Tax Relief Act of 2004 (P.L. 108-311).

27. For a discussion of state issues related to HSAs, see Mila Kofman, “Health Savings Accounts: Issues and Implementation Decisions for States,” *AcademyHealth, State Coverage Initiatives*, Issue Brief, V, no. 3 (September 2004).

28. IRS, “Notice 2004-43,” June 25, 2004.

29. Kofman, “Health Savings Accounts.”

30. At the White House Economic Conference in December 2004, the administration indicated interest in encouraging Medicare HSAs. “HSAs: A New Market under Construction, Maybe in Medicare Too,” *CQ Healthbeat*, December 17, 2004.

31. A small measure of the growth of the HSA market may be reflected in the fact that as of September 7, 2004, the "HSA Insider" Web site (www.hsainsider.com) listed 66 insurance companies and 24 banks/trustees. See Lyke, Peterson and Ranade, *Health Savings Accounts*, 15.
32. "Nine in Ten Health Insurers Expect to Offer High-Deductible Products, Survey Finds," *BNA Health Care Daily Report*, 9, no. 206 (October 26, 2004). The survey found that HRAs were currently more prevalent than HSAs but noted that HSAs are "expected to overtake HSAs in prevalence."
33. HMO plans have traditionally not imposed deductibles, in part to encourage enrollees to seek out primary care and preventive services. The new HSA products will be offered initially in Colorado, Georgia, and the Pacific Northwest. "New Kaiser Permanente Health Plans and Health Savings Accounts Offer Increased Access and Choice," press release, Kaiser Permanente, Oakland, CA, November 15, 2004; accessed December 2, 2004, at <http://newsmedia.kaiserpermanente.org/kpweb/newsannouncements.do>.
34. Christopher J. Gearon, "HSAs: Are they Really the Next Big Thing?" *Hospitals and Health Networks*, August 2004, 44–47.
35. Sarah Rubenstein, "Health Savings Accounts Offerings May Pick Up," *Wall Street Journal*, January 12, 2005; "AHIP Announces HSA Enrollment Numbers," *CQ Healthbeat*, January 12, 2005; and "Insurers Say HSAs Gaining Momentum; Others Cite Lack of Familiarity with Product," *BNA Health Care Daily Report*, 10, no. 9 (January 13, 2005).
36. Two nationwide plans available to all federal employees participating in the FEHBP.
37. U.S. Office of Personnel Management, "High-Deductible Health Plans (HDHP) with Health Savings Accounts (HSA)"; accessed December 2, 2004, at www.opm.gov/hsa/index.asp.
38. Hewitt, "More Employees Enroll in Consumer-Driven Plans for 2005," press release, February 9, 2005; accessed March 3, 2005, at <http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2005/02-09-05.htm>. Hewitt administers benefits for "more than 18 million employees and their families."
39. For technical reasons, owners of small businesses cannot participate in FSAs and HRAs. Also, many small businesses are organized as partnerships, S corporations, Limited Liability Companies or sole proprietorships. Partners, more than 2 percent owners of S corporations, members of an LLC, and sole proprietors are not considered to be employees for purposes of FSAs and HRAs. See Lyke, Peterson and Ranade, *Health Savings Accounts*, 15.
40. Paul Fronstin, "Health Savings Accounts and Other Account-Based Health Plans," Employee Benefit Research Institute, Issue Brief 273, September 2004.
41. The credit would apply to the first \$500 per worker with family coverage and the first \$200 per worker with individual coverage. Republican National Committee, "President Bush's Plan to Make Health Care More Affordable," fact sheet, September 2, 2004; accessed January 12, 2005, at www.gop.com/News/Read.aspx?ID=4605.
42. The average cost for a standard PPO with a deductible of \$1,000 or more was lower than that for the consumer-directed health plan combined with the HRA. Mercer Human Resource Consulting, "Consumer-Directed Health Plans Were Least Costly in 2004," press release, February 21, 2005; accessed March 1, 2005, at www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1170045.
43. Lyke, Peterson and Ranade, *Health Savings Accounts*.
44. This may, in part, be due to the fact that the different surveys reflect different employer sectors, with some seeking to get a representative sample of all but the smallest employers and some more focused on the large employer market. Nuanced differences in the survey questions may also explain some of the variation in results.
45. Kaiser-HRET, *Employer Health Benefits: 2004 Annual Survey*, 63.
46. Mercer Human Resources, *Survey on Health Savings Accounts*; accessed December 10, 2004, at www.mercerhr.com.

47. "Post-Election Health Care Poll: We're Worried and We Don't Know What to Do," *CQ Healthbeat*, November 10, 2004. The survey was conducted by Glen Bolger, a Republican pollster, and Geoff Garin, a Democratic pollster.
48. Destiny Health, a major player in the consumer-driven health plan market, sponsored a survey of 1,000 Americans that found that "while 66 percent of respondents were interested in having their own tax-free health savings account, barely half that number of respondents was at all familiar with the legislation [authorizing HSAs] itself. The numbers were even more dramatic among young people, aged 18 to 24. Within this group, 72 percent were interested in the idea, but only 18 percent knew any of the details." "Tidbits," *Managed Care on Line (MCOL)*, March 8, 2004; accessed November 20, 2004, at www.MCOL.com.
49. Ruth Helman and Paul Fronstin, "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey," Employee Benefit Research Institute, Issue Brief 275 November 2004. The survey (conducted by Mathew Greenwald and Associates) was conducted between June 21 and July 23, 2004, and is the seventh such annual survey. Results are considered representative of the population at large, plus or minus three percentage points.
50. Helman and Fronstin, "Public Attitudes."
51. As one reviewer of this paper noted, the uninsured have the most incentive to try to negotiate prices for physician and hospital care and yet they often end up paying the highest prices of all health care purchasers, as recent news stories have revealed.
52. Fronstin, "Health Savings Accounts."
53. Fronstin, "Health Savings Accounts."
54. For illustrations of how enrollees in HDHPs experience fewer physician visits, take medications less often than prescribed by a physician, do not follow up on physician recommendations, and otherwise fail to comply with physician orders, see Karen Davis, "High-Deductible Health Plans and Health Savings Accounts: For Better or Worse?" presentation to the National Academy of Social Insurance, January 27, 2005; accessed March 4, 2005, at www.cmwf.org/usr_doc/Davis_NASI_01-27-2005_FINAL_b&w.pdf.
55. Linda Blumberg, "Health Savings Accounts and Tax Preferences for High Deductible Policies Purchased in the Non-Group Market: Potential Impacts on Employer-Based Coverage in the Small Group Market," testimony to the Subcommittee on Workforce, Empowerment and Government Programs, Small Business Committee, U.S. House of Representatives, March 18, 2004, 8.
56. "Consumers, Firms Work Out Kinks in New Health Savings Accounts," *Wall Street Journal*, November 28, 2004.
57. "Health Insurers Use Debit Cards to Speed Consumer-Directed Offerings to Market," *Managed Care Week*, February 7, 2005.
58. "Consumers, Firms," *Wall Street Journal*.
59. Gearon, "HSAs," 44-47.
60. Bill Lewis, "Changing Market Saps Health of Hospital Stocks," *Tennessean*, November 15, 2004.
61. "Florida Hospital Sues HSA Plan to Collect Fees Company Claimed Were Not Reasonable," *BNA's Health Care Daily Report*, 9, no. 183 (September 22, 2004).
62. One reason that employers may not be enthusiastic about making contributions to an employee's HSA is that the employer cannot control how the funds in the HSA are spent. Because of the relatively modest tax penalty on distributions from the HSA for nonqualified uses, an employee may take the money and use it, for example, to buy a big-screen television. Because of this possibility, many employers would like to place a condition on HSAs that employer funds be used only for qualified health purposes. American Benefits Council staff, personal communication with author, February 2004.
63. Milliman Consultants, "Milliman Report Finds Nine out of 10 Health Insurers Will Offer a HDHP/HSA Option," press release, October 27, 2004; accessed December 20, 2004, at www.hsadecisions.org/news/article.asp?article_id=73.

64. In 2004, 73 percent of firms with fewer than 200 employees offered their covered workers only one plan. Kaiser-HRET, *Employer Health Benefits: 2004 Annual Survey*. This percentage would likely increase for very small firms.
65. 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): 1167–1187.
66. In 2004, 82 percent of covered workers in firms with 200 or more employees were offered a choice of two or more health plans. Kaiser-HRET, *Employer Health Benefits: 2004 Annual Survey*.
67. One could imagine moderating these effects by pegging the employer contribution to the average of the plan costs or even adjusting the contribution for the age or risk of the specific employee. But such a risk-adjusted contribution would reduce the amount of achievable savings for the employer and would lessen the appeal of HDHPs to healthier employees.
68. Since eligibility rules for HSAs apply to making tax-free account deposits, earnings on balances accrue tax-free and the funds remain available to use tax-free for qualified expenses, regardless of whether the account holder continues to be enrolled in an HDHP and eligible to make deposits.
69. When asked which of their employees would be most likely to participate in a high-deductible health plan and HSA, the majority of the employers surveyed (61 percent) by Mercer in April 2004 said it would be their higher-paid employees. Just 13 percent believed it would be their lower-paid employees. About 44 percent believed their healthiest employees would be the most likely to participate, although 28 percent believed that their least healthy employees would be most likely to participate. Mercer Human Resource Consulting, "U.S. Employers See a Role for Health Savings Accounts in Their Benefit Programs," April 27, 2004; accessed November 29, 2004, at www.mercerhr.com.
70. Tollen, Ross, and Poor, "Risk Segmentation."
71. Stephen T. Parente, Roger Feldman, and Jon Christianson, "Employee Choice of Consumer-Driven Health Insurance in a Multi-Plan, Multi-Product Setting," *Health Services Research*, 39, no. 4, Part II (August 2004):1091–1111.
72. Stephen T. Parente, "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.
73. Blumberg, "Health Savings Accounts." Others argue that the high cost of individually purchased health insurance, even with the improved tax treatment, makes this outcome unlikely. However, the Bush administration has also proposed the creation of health insurance purchasing pools that could make such coverage somewhat less expensive.
74. About one-third of the applicants to eHealthInsurance for HSAs indicated not being covered for the previous six months; Assurant reports that 43 percent of its HSA applicants indicated no prior coverage. The percentage of uninsured applicants who are actually covered under their HSA policies was not reported. Laura Trueman, "Health Savings Accounts Myth vs. Fact," Coalition for Affordable Health Coverage; accessed March 6, 2005, at www.regence.com/hsa/101/HSAWhitePaper.pdf.
75. Lyke, Peterson and Ranade, *Health Savings Accounts*.