GBPI
Georgia Budget and Policy Institute
Georgia Budget Analysis
Thoughtful Analysis...Responsible Policy
100 Edgewood Avenue, Suite 1040, Atlanta, Georgia 30303 • ph: 404-420-1324 • fax: 404-420-1329 • www.gbpi.org
Contact: Alan Essig, *alangbpi@bellsouth.net*

Reforming Healthcare Brief #1:

Taking a Closer Look at Health Savings Accounts

By Tim Sweeney

Introduction and Background

In 2004, approximately 45.5 million non-elderly Americans, including nearly 1.5 million Georgians, went without health insurance. These figures represent approximately 18% of all Americans under 65 and nearly 19% of non-elderly Georgians.[1] One factor that most certainly affects the number of uninsured Americans, and Georgians, is the rate at which employers sponsor health insurance. In 2000, approximately 69% of all firms, and 57% of firms with fewer than 10 employees, offered health insurance; in 2005 these percentages had dropped to 60% and 47%, respectively.[2] As a result of fewer firms offering coverage, the percent of Americans covered through employer-sponsored plans has fallen from 66% in 2000 to 61% in 2005.[3]

Probably the largest reason for these declining coverage rates has been the high cost growth for health insurance. While overall inflation over the last 6 years has ranged from 1.6% to 3.5%, annual health insurance premium increases have ranged from 8.2% to 13.9%, with only 2 years of less-than double digit growth (8.2% from 1999 to 2000 and 9.2% from 2004 to 2005).[4] Small employers may feel healthcare cost increases more acutely, though large employers also have a difficult time dealing with the rapidly increasing cost of health insurance for their employees.[5] Furthermore, because of the unique reliance on employers to provide health insurance in the U.S., phenomena that reduce employer rates of coverage have a significant impact on the overall healthcare landscape.

Uninsured individuals generally have less access to healthcare services and have poorer health status compared to persons with insurance. When uninsured individuals do seek and receive care, it is more likely to be uncompensated, and is often delivered in expensive settings such as emergency rooms. Insured individuals see increased healthcare costs as a result of these costs associated with the growing uninsured population. One recent study estimates that insured families in Georgia pay an additional $746 per year (over 7% of annual health insurance premiums) to offset the costs of care for the uninsured.[6] In response to these issues, employers are making significant changes to the types of insurance policies they offer, and governments at every level (state, local, and federal) are pursuing policies to both encourage certain behaviors in individuals and employers as well as to address these issues directly.

This paper will be the first in a series examining the recent increases in healthcare costs, corresponding declines in employer-sponsored insurance and increases in the uninsured population, and policies the federal, state, and local governments are currently examining and pursuing to address these problems. This brief will examine Health Savings Accounts (HSAs) and the corresponding High Deductible Health Plans (HDHPs) that were created in 2003 and their currently preferred tax status at the federal level. Future papers will examine Medicaid/SCHIP/State-only coverage expansions, pay-or-play laws, small business pools and buy-in to state employee health plans, and non-traditional healthcare arrangements some employers are gravitating to in attempting to reduce their healthcare spending. These papers will provide background on what these policies seek to accomplish, how they can or cannot be implemented, and to which populations they provide the most or least benefits.

While HSAs and HDHPs are some of the fastest growing health insurance products, especially in the individual insurance market, their further expansion raises several concerns. Widespread adoption of these arrangements could lead to some unintended "adverse selection" problems, and there is not yet convincing evidence that they will have a significant effect on overall healthcare costs or the uninsured.

HSA / HDHP Overview

HSAs are tax-free investment accounts that can be used only in conjunction with qualifying HDHPs. Individuals can make tax-free contributions into an HSA, an account with various investment options, and can use the HSA to pay for out-of-pocket healthcare expenses. Unlike other pre-tax investment accounts, neither the investment earnings nor any withdrawals for healthcare expenses are taxed.

In order to obtain an HSA, individuals must enroll in a qualifying "high deductible health plan" (HDHP). Qualifying HDHPs must have deductibles of at least $1,050 for individuals and $2,100 for families (in federal tax year 2006), though these plans may have higher deductibles. While HDHPs may (but are not required to) offer limited first-dollar coverage for preventive care, individuals pay out-of-pocket for most of their medical care until they reach their yearly deductible. After reaching their deductible, the HDHP coverage begins, though individuals would still be responsible for any required co-payments and/or co-insurance when they receive services. Federal law establishes a cap on total in-network out-of-pocket medical costs at $5,250 per year for individuals and $10,500 per year for families.[7] Once the cap is reached, the participant's HDHP is responsible for all healthcare costs.

While individual contributions into HSAs are tax-free, federal law limits the yearly deposits into the account. In most cases, HSA deposits are capped at the level of their yearly deductible; however, HSA contributions cannot exceed $2,700 per year for individuals and $5,450 per year for families, even if the deductible is higher than these amounts.[8] As a result, as shown in *Table 1*, federal out-of-pocket expenditure limits exceed the maximum contribution to the HSA. At the end of the year, funds remaining in the HSA stay in the account, and the account holder can again deposit the maximum to the account in the following year. After age 65, funds may be withdrawn penalty free, though non-healthcare related withdrawals are subject to income taxes.[9]

Table 1 — Annual Requirements of HSAs & HDHPs

	Minimum Deductible	Max HSA Deposit	Max Out-of-Pocket
Individual	$1,050	$2,700 *	$5,250
Family	$2,100	$5,450 *	$10,500

* Annual HSA deposits may not exceed the HDHP's annual deductible. Regardless of deductible, deposits may not exceed amounts listed above.

Since the establishment of HSAs in the Medicare Modernization Act of 2003, there has been significant debate on the merits of these accounts. Proponents and opponents of these programs have very different views on the potential effects of greater use of HSAs and HDHPs on healthcare, the healthcare market in general, and healthcare consumers in particular. Specifically, there is disagreement around who benefits most from these programs, what effects these programs may have on comprehensive insurance plans, and whether they will address key issues in the health policy arena such as rising healthcare costs and rising rates of uninsurance. The following section will briefly examine some of the arguments for and against these programs.

Effects on Consumers & Existing Health Insurance Arrangements

One of the central points of discussion surrounding HSAs and HDHPs centers on who would primarily benefit from these plans. Proponents argue that the lower monthly premiums associated with HDHPs would be beneficial to lower-income individuals who have difficulty affording more comprehensive health insurance. Opponents, on the other hand, argue that the tax-free nature of HSAs will primarily benefit

Tax Benefits of HSAs Greater as Income Rises:

Because a family's marginal tax rate rises with income, the tax benefits of HSAs will be greater for families with higher incomes than for families with lower incomes. For example, a family of four with annual income of $120,000 will see substantial tax benefits from an HSA, while a family of four with income of $40,000 will see a much smaller benefit. The example below compares the tax benefits to these two families associated with a $4,000 deposit into an HSA.[10]

Family #1: Family of 4, $120,000 income
This family likely has a marginal tax rate of 25%, depending on other factors. At this marginal rate, Family 1 would realize tax savings of $1,000, as a result of a $4,000 HSA deposit. ($4,000 represents 3% of annual income).

Family #2: Family of 4, $40,000 income
This family likely has a marginal tax rate of either 10% or 15%, depending on other factors. At these rates, this family would realize savings ranging from $400 to $600. ($4,000 represents 10% of annual income).

In the above example, A family of 4 making $120,000 per year receives approximately twice the tax benefits as a family of 4 with income of $40,000 per year.[11] This example may even overestimate the savings of Family #2, as it assumes this family is able to save 10% of annual income, which may be unlikely. As income increases the tax benefits increase even more. A family of 4 making $300,000 per year would realize over $1,300 in tax benefits from the same $4,000 HSA deposit, roughly 3-times the savings of the lower-income family.

higher-income individuals, who would receive much greater tax benefits from these accounts than would lower-income individuals. Furthermore, lower-income families likely have much less ability to save and deposit significant funds into their HSA, as they are more likely to live on a tighter monthly budget, reducing their tax benefits even more.

Though HDHPs have lower monthly premiums than many comprehensive options, they also require greater out-of-pocket healthcare expenditures, which may be more difficult for lower-income individuals and families to afford. As shown above, however, the tax benefits for higher-income participants could be quite significant.

HSAs could be problematic for individuals with chronic illnesses or disabilities. In particular, healthier individuals with fewer healthcare needs would benefit greatly by having unspent HSA balances remain in their account, allowing them to build significant tax-free assets. Individuals with higher costs due to a chronic illness or disability, however, would be more likely to exhaust their HSA each year, leaving them no balance to retain and no ability to build up their HSA. Because of these concerns, it is likely that individuals with chronic illnesses, mental, physical, and developmental disabilities, and other high-cost medical conditions would be less likely to utilize HSA/HDHP programs and would be at a disadvantage if employers chose to only offer these programs.

If the healthier, and wealthier individuals who would benefit most from HSAs and HDHPs leave the traditional insurance market for HSAs and HDHPs, an "adverse selection" problem will occur leaving mostly sicker, higher-cost individuals in the comprehensive healthcare programs. Such a situation could drive up the cost of comprehensive coverage significantly, and therefore make it less likely that employers would continue to offer such coverage and more difficult for individuals to afford.

Early Data on HSA/HDHP Participants

In general, the availability of data to evaluate the conceptual arguments presented above is very limited. Furthermore, the enrollment data currently available focuses primarily on the individual, non-group health insurance market (direct purchase) and often does not include employer-sponsored health insurance. This direct-purchase market is only a small percentage of the overall health insurance market, as it insures less than one-in-ten Americans and only represents about 13.6% of the private health insurance market.[12]

Studies estimate that between 29-40% of HSA-eligible health plan purchasers in the direct-purchase insurance market have incomes below $50,000 per year.[13] When compared to other data examining consumers in the direct purchase market, however, this data may tell a different story. For instance, 2004 U.S. Census data shows that about 54% of direct-purchase consumers have (household) incomes below $50,000.[14] Therefore, when compared to the individual health insurance market as a whole, it appears that HDHP purchasers are actually less likely to have incomes below $50,000. The fact researchers primarily cite direct-purchase health insurance consumers shows that at this early stage there is not significant data to dismiss the "adverse-selection" fear of some health policy experts.

Two recent surveys have tried to measure the health status of higher-deductible health insurance participants compared to participants in more comprehensive insurance.[15] One survey by the BlueCross & Blue Shield Association concludes the health status between HDHP and non-HDHP participants are identical. This assertion may be premature, however, as this survey lumps individuals in employer sponsored insurance and in the individual (direct-purchase) market together. This aspect of the survey is problematic because individuals in the employer-sponsored insurance market generally have

lower health status than those in the direct purchase market.

Another survey by the Employee Benefit Research Institute (EBRI) and the Commonwealth Fund, however, found that participants in Consumer Directed Health Plans (CDHPs) (which the survey defined as HDHPs with HSAs) had better self-reported health status than participants in comprehensive insurance plans. Additionally, the EBRI study found that individuals with employer-sponsored HDHPs reported lower health status than individuals who purchased HDHPs in the individual market, which is consistent with general perceptions regarding the health status of the employer and direct-purchase markets.[16]

Both of these studies have flaws, and do not include all of the information necessary to reach firm conclusions about what *will* happen if HSAs and HDHPs become more widespread. As these two somewhat contradictory surveys show, additional studies examining the behavior of sicker and healthier persons when presented with similar options will be needed to more fully measure whether "adverse-selection" will result from HDHP/HSA expansion. Additional studies performed in 1990's (prior to the creation of HSAs) concluded that widespread use of programs similar to HSAs would have a high risk for adverse selection. Policymakers should consider these concerns as policies to further encourage the use of HSAs and HDHPs are considered.[17]

Increasing Costs and the Uninsured

Healthcare spending in the U.S. has increased rapidly in recent years, and at $5,267, per capita healthcare spending in 2002 was over 50% higher than any other country (Switzerland was 2nd highest, at $3,446).[18] At the same time, however, approximately 46 million Americans, and nearly 1.5 million Georgians, are without health insurance and these numbers continue to rise.[19] Increasing health insurance costs put significant financial pressure on employers who provide insurance to employees, while at the same time declining rates of employer-sponsored health insurance puts increasing pressure on public insurance programs such as Medicaid. Whether HSAs and HDHPs will help address the issues of increasing costs/spending and growing numbers of Americans without insurance are central to the evaluation of these proposals; again, supporters and critics disagree.

<u>Healthcare Costs and Spending:</u>
Because these proposals place more financial responsibility on healthcare consumers, proponents of HSAs and HDHPs contend that these arrangements will reduce healthcare costs and spending. Additional individual financial responsibility, supporters argue, will provide incentives for healthcare consumers to make better healthcare purchasing and lifestyle decisions in order to reduce their healthcare spending. Opponents disagree, however, noting that individuals would likely forgo needed healthcare services (in addition to unnecessary ones) and that individuals with chronic conditions would be especially vulnerable to higher out-of-pocket costs. Furthermore, if consumers forgo seeking medical care because they cannot afford the out-of-pocket costs, these consumers may get sicker and require more expensive care at a later date. This concern is greatest with regards to lower-income individuals, who may be more likely to over-ration their healthcare consumption if they are unable to afford the out-of-pocket costs. The EBRI study found that about one-third of people in HSAs and HDHPs reported delaying or avoiding care due to cost, twice the rate in comprehensive plans. The percentage rises to half for households with incomes below $50,000.

A majority of U.S. healthcare costs are due to especially high-cost individuals. In fact, the 1% of the population that consumes the most healthcare services accounts for approximately 22% of total health spending; the top 10% of consumers account for nearly 64% of healthcare spending.[20] Based on total U.S. healthcare spending of approximately $1.7 trillion in 2003, this 10% of the population incurs annual costs of over $35,000 per person, per year.[21] On the other hand, the bottom 50% of population (in terms of healthcare spending, not income) accounts for less than 4% of total health spending, meaning that these individuals incur an average $500 in overall healthcare costs per year.[22] Put another way, 95 percent of medical expenditures by insured working-age households are above the minimum HSA deductibles.[23]

Even if HSAs and HDHPs significantly reduce healthcare spending of this half of the U.S. population, this behavior change would have little effect on overall healthcare spending. At the same time, once consumers exceed the minimum deductibles, they will face the same incentives they currently see under more traditional insurance; and once their out-of-pocket maximum is reached ($5,250 for individuals) there is no incentive to limit healthcare spending. Therefore, these accounts would likely have little or no effect on the healthcare costs of the 10% of the population that incurs nearly two-thirds of all U.S. healthcare costs.

Because a relatively small portion of the population accounts for a relatively high concentration of medical costs (and conditions), many individuals pay more into the "healthcare system" than they receive from it. This is the underlying theory behind a "social insurance"

HSAs and HDHPs in Practice: Statistics on Employer Implementation and Examples

While HSA qualified HDHPs are some of the fastest growing health insurance products, they are still fairly rare in the employer sponsored insurance market. The Kaiser Family Foundation's 2005 Employer Health Benefits Survey found that only 2.3% of firms offering health insurance offered an HSA qualified HDHP and that only about 810,000 workers participated in such a plan. Furthermore, only 15% of workers offered both an HSA-eligible HDHP and a comprehensive health plan chose the HDHP (while about half of HSA eligible HDHP enrollees were not offered another health insurance option). These plans will likely become more prevalent in the coming years, however, as about one-quarter of the firms not offering such a plan reported they are "somewhat likely" to do so in the next year (2005) and 2% reported that they were "very likely" to do so.

The Kaiser report also shows that so far, employers offering these plans are contributing similar amounts to employee coverage as they do for traditional plans. The survey also found, however, that one-third of employers offering these plans did not make any contributions to the HSA portion of the arrangement.

While these options are still fairly new to the employer insurance market, the federal government is now offering HSA eligible HDHPs, as are several state employee health plans – including the state of Georgia. While the federal and state plans may be more generous than most private employer plans, they are worthwhile to examine as a brief case study on how these plans are structured. Beginning January 1, 2006, participants in the Georgia State Health Benefit Plan (SHBP) now have the option to select an HSA-qualified HDHP. For in-network services, the deductible on the HDHP the SHBP is offering is $1,100 for individuals and $2,200 for families. At $45/month for individuals and $146/month for families, the HDHP monthly premiums are less expensive than the other options offered ($71-$77 and $175-$217 for HMO and PPO plans for individuals and families, respectively). By joining the HDHP, state employees will be able to open HSAs, though the nearly $30 per month an individual would save compared to the HMO/PPO options would only translate to an HSA deposit of $360 per year, about one-third of the HDHP's annual deductible. Also, most private institutions offering HSAs charge origination and maintenance fees associated with the operation of the account; SHBP participants in these plans would be responsible for these fees.

Participants in the HDHP will be responsible for paying their medical costs with funds from their HSAs or with other out-of-pocket contributions until they reach their annual deductible. The one exception to this is in regards to "wellness and preventive healthcare" and annual gynecological exams, which the plan will cover up to $500 worth of care prior to consumers reaching their deductible. The coverage HDHP participants receive after reaching the annual deductible is fairly consistent with the coverage of the HMO/PPO plans offered by SHBP. The plan will cover about 90% of the cost of physician services, hospital inpatient or outpatient services, testing and lab services, dental/vision services, and behavioral health services, leaving the consumer responsible for a 10% coinsurance payment. The annual out-of-pocket maximum for the HDHP is $1,700 for individuals and $2,900 for families, however, compared with $1,100 and $2,200 for the PPO option and $1,000 and $2,000 HMO plans.

In general, the HDHP options offered by Georgia's SHBP may be much more attractive to employees who expect to utilize only small amounts of healthcare services in a given year and those with higher-incomes, as the tax-benefits of the HSAs will be more pronounced for these individuals. If too many low-utilizers abandon the HMO and PPO options for the HDHP option, the pool of funds available in the SHBP to pay the healthcare costs of high-need individuals could shrink – driving up the comprehensive insurance rates for these consumers. While the catastrophic coverage contained in the HDHP option will protect individuals from exorbitantly high medical expenses, individuals with unexpected medical costs could very easily see their monthly premium savings (only $360) eaten up as they expend funds to reach their deductible.

model of healthcare. While very few individuals with high healthcare needs would be able to pay for their care with their own money, pooling the health insurance premiums of thousands or millions of customers gives insurance companies the resources to serve individuals with greater healthcare needs. If "low-cost" individuals simply took their contributions out of the "system," there would be fewer consumers to spread the costs between, likely driving up the costs for those individuals with the greatest healthcare needs. Such a scenario could push more and more people onto public programs – such as Medicaid – to receive higher-cost medical services, and could make comprehensive insurance more unaffordable.

Increasing Uninsured Population:

In addition to the growing costs and spending trends surrounding healthcare, another important health policy issue is the growing number of individuals without health insurance: the uninsured. Proponents of HSAs and HDHPs argue that the lower monthly premiums associated with these plans will be especially attractive to individuals and families who have no employer coverage, are currently priced out of the traditional insurance market, and do not receive public health insurance programs (such as Medicaid). In short, supporters contend that these programs will be an effective tool to reduce the number of people without health insurance. While these programs may have a modest effect on the number of uninsured, these policies are very expensive ways to help a fairly small number of the uninsured. Furthermore, as most of the uninsured are lower-income individuals, and as lower-income individuals would not benefit greatly from the tax-benefits of these programs, it is unlikely that HSAs and HDHPs will be especially attractive to uninsured

individuals. Studies recently cited by HSA proponents that conclude otherwise have focused only on the direct-purchase health insurance market, making their results much less compelling.[24]

Conclusions

The increased incentives that the federal government is placing on HDHPs by the creation of HSAs could have significant effects on the overall health insurance market. If healthier, wealthier, and younger consumers leave traditional insurance arrangements for these tax-preferred options, comprehensive insurance plans could be left with higher-cost individuals, making them much more difficult to afford. If such an "adverse-selection" scenario does occur, and comprehensive plans become more expensive as lower-cost persons leave for HSAs, employers may have difficulty offering their employees comprehensive insurance options. Such a scenario could be especially problematic for persons with chronic conditions, disabilities, and other high-cost medical conditions, who could see higher out-of-pocket costs associated with HDHPs.

At the same time, higher-income individuals and families will realize the bulk of the tax-benefits of HSAs for two reasons. For one, these individuals and families receive much higher tax savings on their HSA deposits. Secondly, higher-income consumers have significantly greater ability to save, meaning they will be more likely to build significant balances in their HSAs to take further advantage of the tax benefits in place. For these reasons, HSAs could simply turn into a tax-shelter for higher-income individuals, while lower-income families see very little tax benefits, but instead must pay for more healthcare costs out-of-pocket.

Furthermore, even though consumers utilize healthcare at varying rates, overall healthcare spending is not generally driven by individual decisions. Consumers cannot determine which tests they need or the best course of treatment to seek; consumers instead must rely on professional medical advice. Even HSA proponents acknowledge the lack of information and resources available to assist consumers in making important healthcare decisions. The little information available is also difficult to obtain, and without significant improvements in the available resources, consumers would be forced to either make decisions without being properly informed, or continue to rely on medical professionals in the manner they do in the current system. Coupled with the higher out-of-pocket costs, this lack of obtainable information may be a significant reason why customer satisfaction is lower with these plans than with traditional, comprehensive insurance products.[25]

Policymakers on both the state and national level are considering further expansions to the tax-benefits already enjoyed by HSAs and HDHPS. The President has proposed expanding the federal tax incentives, and legislation has been introduced in Georgia (HB 1254) to make the monthly premiums paid for HDHPs tax-deductible. Much like the existing tax benefits for these arrangements, the proposals to expand the tax-incentives continue to primarily benefit upper-income consumers and will likely do very little to address the growing costs of insurance and the growing number of Americans without health insurance. Instead, they could exacerbate the adverse selection risks already in play and make comprehensive health insurance policies even more difficult for employers and employees to afford. Some studies even suggest that increasing the tax-benefits of these programs could increase the number of uninsured Americans.[26] Due to the many concerns regarding HSAs and HDHPs that this brief raises, policymakers should be wary of implementing additional tax-subsidies for these products. In future papers, we will examine other options available that are more likely to address the growing uninsured population and the increasing cost of health insurance.

The Georgia Budget and Policy Institute (GBPI) is an independent, nonprofit, non-partisan organization engaged in research and education on the fiscal and economic health of the state of Georgia. The GBPI provides reliable, accessible and timely analyses to promote greater state government fiscal accountability as a way to improve services to Georgians in need and to promote quality of life for all Georgians.

[1] National and Georgia specific data from Census Bureau's March 2004 and 2005 Current Population Survey, compiled by Statehealthfacts.org. http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Georgia&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status
[2] Employer Health Benefit 2005 Annual Survey. Kaiser Family Foundation and the Health Research and Educational Trust. http://www.kff.org/insurance/7315/index.cfm
[3] "The Uninsured: A Primer." Kaiser Commission on Medicaid and the Uninsured, January 2006. http://www.kff.org/uninsured/upload/7451.pdf.
[4] Employer Health Benefit 2005 Annual Survey. Kaiser Family Foundation and the Health Research and Educational Trust.
[5] Even very large employers such as General Motors have difficulty dealing with rising healthcare costs. http://www.washingtonpost.com/wp-dyn/articles/A15828-2005Feb10.html; http://www.medicalnewstoday.com/medicalnews.php?newsid=23213;
[6] "Paying a Premium: The added cost of care for the uninsured." Families USA, June 2005. www.familiesusa.org
[7] There is no cap for out-of-network covered services or for services not otherwise covered under the insurance. Both the minimum deductible to qualify as an HDHP and the out-of-pocket spending caps represent tax-year 2006 rules; these figures are subject to inflation and will increase in 2007.
[8] Individuals over 55 may also make "catch-up" contributions of $700 in 2006 (limits are indexed and will increase in 2007). The President's FY 2007 Budget proposes expanding the HSA contribution limits to match the out-of-pocket maximum. This provision would significantly help upper-income consumers with the resources to make additional contributions.
[9] Funds withdrawn for non-healthcare purposes prior to turning 65 are subject to a 10% penalty in addition to income taxes.
[10] The example is based on data from the Employer Health Benefit 2005 Annual Survey, which found that the average family deductible (thus the maximum HSA deposit amount for a family) for employers offering HDHP/HSA plans was $4,070 in 2005.
[11] These calculations are based on the following marginal tax rates for a family of 4: 10% for taxable income from $0 - $14,600; 15% for taxable income from $14,600 - $59,400; 25% for taxable income from $59,400 - $119,950. This example is subject to change based on whether these families use a standard or itemized deduction, whether they are eligible for additional above-the-line deductions, or whether these families are eligible for tax credits such as the child care tax credit.
[12] U.S. census data from the Current Population Survey (CPS) 2005 Annual Social and Economic Supplement. http://pubdb3.census.gov/macro/032005/health/h02_001.htm
[13] These claims have been made, refuted, and discussed in several papers. "Consumerism in Healthcare: Early Evidence is Positive" and "Health Savings Accounts: A Survey of the Literature" Grace-Marie Turner, Galen Institute. http://www.galen.org/ccbdocs.asp?docID=823; http://www.galen.org/ccbdocs.asp?docID=862. "Administration Defense of Health Savings Accounts Rests on Misleading Use of Statistics" and "Latest Enrollment Data Still Fail to Dispel Concerns About Health Savings Accounts" Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities. http://www.cbpp.org/2-16-06health.pdf; http://www.cbpp.org/10-26-05health2.htm
[14] U.S. census data from the Current Population Survey (CPS) 2005 Annual Social and Economic Supplement, cited above.
[15] One survey conducted by the Employee Benefit Research Institute and The Commonwealth Fund http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2005.pdf; and another survey conducted by the Blue Cross and Blue Shield Association, http://bcbshealthissues.com/proactive/newsroom/release.vtml?id=179835
[16] 42% excellent or good health for employer sponsored group compared to 62% for individual purchasers.
[17] "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" Emmett B. Keeler, et. al., Journal of The American Medical Association, June 5, 1996, p. 1666-71; "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Len M. Nichols, et. al., Urban Institute, April 1996; and "Medical Savings Accounts: Cost Implications and Design Issues," American Academy of Actuaries, May 1995; "The Health Care Divide: Unfair Financial Burdens," Gail Shearer, Consumers Union, August 10, 2000 (relying on Lewin Group estimates).
[18] "Health Spending in the United States and the Rest of the Industrialized World," by Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner and High R. Waters. Health Affairs, July/August 2005. Volume 24, Number 4, pages 903-914.
[19] Data compiled by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey
[20] "Trends and Indicators in the Changing Healthcare Marketplace" a study by the Kaiser Family Foundation. Data from Section 1: Health Spending and Costs, Including Prescription drugs. http://www.kff.org/insurance/7031/ti2004-1-11.cfm
[21] 10% of the population in 2003 ≈ 29.1 million people. 64% of total healthcare spending ≈ $1.09 trillion. $1.09 trillion / 29.8 million ≈ $37,400 per person.
[22] Spending data from Kaiser study cited above. Calculations as follows: 50% of U.S. population ≈ 145.4 million people; 4% of healthcare spending ≈ $68 billion. $68 billion / 145.4 million ≈ $470 per person.

[23] "Most Households' Medical Expenses Exceed HSA Deductibles," Linda Blumberg and Leonard Burman. Tax Notes. August 16, 2004. http://www.urban.org/UploadedPDF/1000678_TaxFacts_081604.pdf

[24] Studies have focus mostly on the direct-purchase insurance market, which is generally thought of as a market of last resort, such as for adults who have lost their job and cannot afford COBRA. Many (possibly most) direct-purchase insurance consumers are likely to be uninsured prior to purchasing insurance, therefore these studies do not adequately address questions regarding whether HSAs are especially attractive to uninsured persons. Studies most often cited include: "Health Savings Accounts: The First Six Months of 2005," eHealthInsurance, July 25, 2005; "Quick Facts: Health Savings Accounts," Assurant Health, September 16, 2005; "Number of HSA Plans Exceeded One Million in March 2005," America's Health Insurance Plans, May 4, 2005.

[25] EBRI/The Commonwealth Fund. http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2005.pdf

[26] "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Jonathon Gruber MIT. Center of Budget and Policy Priorities, Feb 15, 2006. http://www.cbpp.org/2-15-06health.pdf