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An Updated Analysis of Health Savings Accounts and Consumer Directed Health Plans

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An Updated Analysis of Health Savings Accounts and Consumer Directed Health Plans

This brief examines three recently released reports focusing on Health Savings Accounts (HSAs) and Consumer Directed Health Plans (CDHPs). Among other findings, these reports lead us to the following conclusions:

- HSAs and CDHPs are primarily beneficial to higher-income, healthier individuals who use these accounts as a tax-shelter. Additional tax-incentives for these products are not going to help address Georgia's increasing uninsured population.
- Enrollees in CDHPs often put off recommended healthcare services due to the cost, and most enrollees are in plans that do not adequately incentivize preventive care.
- HSAs and CDHPs fail to address the root causes of increasing healthcare costs in the U.S. and additional tax incentives that favor these products at the expense of traditional, comprehensive health insurance products are misguided.

As the number of individuals without health insurance continues to rise both nationally and in Georgia and as overall healthcare costs increase, groups across the political spectrum are searching for healthcare reform solutions to address these two connected issues.

One proposal receiving considerable attention in Georgia is the concept of "consumer directed healthcare." At both the state and federal level, some lawmakers are pushing for more tax-breaks targeting HSAs and High Deductible Health Plans (HDHPs), which combine to form a "Consumer Directed Health Plan" and are the centerpieces of this concept. The two main assertions made by CDHP supporters are that 1) these products will be attractive to currently uninsured individuals and thus will significantly lower the number of individuals without health insurance, and 2) these products will reduce unnecessary healthcare utilization and incentivize consumers to live healthier lives and use more preventive care.

Before enacting additional tax-cuts, however, these products need to be examined as to whether they can actually address either of these significant healthcare issues: access to care and proper use of care.

To this end, this brief will examine three recently released reports with various findings that show the many flaws in these "consumer directed healthcare" proposals. These reports find further evidence that HSAs are more attractive to higher income and healthier consumers, that the accompanying HDHPs do not encourage proper healthcare utilization, and that these products are not effective tools to target the uninsured. Because HSAs are relatively new products, data on these arrangements is limited.

HSA and HDHP Refresher:

(In March 2006, the GBPI released a report titled "Taking a Closer Look at Health Savings Accounts" which includes a more in-depth analysis of HSAs and HDHPs. For a further explanation of HSAs and HDHPs please see that report.)

HSAs are tax-free investment accounts that one may only open if also participating in a qualifying HDHP. Deposits may be made to the account tax-free, interest accrues tax-free, and withdrawals for healthcare expenses can be made tax-free.

In order to open an HSA, individuals must participate in a qualifying HDHP. In 2007, federal rules specify that such plans must have a deductible of at least $1,100 for individuals and $2,200 for a family plan, though plans may have higher deductibles. Federal laws cap deposits into HSAs at $2,850 annually for individuals and $5,650 for families (in 2007). HDHPs must incorporate maximum annual (in-network) out-of-pocket spending limits, and for 2007 the limits are $5,500 for individual plans and $11,000 for family plans.

HDHPs are allowed to offer limited first-dollar coverage for some preventive services; however, individuals and families are generally completely financially responsible for services prior to reaching the annual deductible. In many cases out-of-network services do not count toward the annual deductible, and after reaching the deductible, consumers are generally still responsible for co-payments and/or coinsurance until the annual out-of-pocket maximum is reached. Because out-of-pocket costs are higher in HDHPs than in more traditional, lower-deductible plans, monthly premiums for HDHPs are generally lower than for more comprehensive insurance plans.

When combined, the HSA / HDHP arrangement is often referred to as a Consumer Directed Health Plan (CDHP).

This brief examines three recent reports and how their findings compare to claims made by HSA and CDHP advocates.

Furthermore, the brief will also explain why the assertion that simply limiting the demand for healthcare services will address overall healthcare costs rests on the faulty assumption that over-utilization of healthcare services is a significant driving factor in recent healthcare cost increases. The factors influencing healthcare cost growth are far more complicated and will not be addressed by HSAs and CDHPs.

Finding 1: HSAs/CDHPs are more attractive to individuals and families with higher incomes

One of the most discussed issues surrounding HSAs and CDHPs is whether or not they are broadly appealing enough to benefit a variety of individuals. In particular, there has been much debate about whether they will be attractive to lower-income consumers, who make up the largest portion of the uninsured in Georgia. While HSA advocates claim otherwise, surveys and reports examining income data of HSA participants have consistently shown that individuals and families who open HSAs have higher incomes compared to either the general population or to comprehensive insurance enrollees. Two reports released in late 2006 again illustrate that these products are generally chosen by individuals and families with higher than average incomes.

The most dramatic finding was made in a report issued by the U.S. Government Accountability Office (GAO). In this report, the GAO used data from the Internal Revenue Service (IRS) to compare the incomes of tax filers who reported HSA contributions to tax-filers who did not report such contributions. According to 2004 IRS data, tax-filers reporting HSA contributions had an average income of approximately $133,000, more than two-and-a-half times the average income for all tax-filers ($51,000). Additionally, the GAO stated that while 51 percent of HSA contributors had incomes over $75,000, only 18 percent of all tax-filers had income above $75,000.[1]

Equally as important as the income differences between HSA owners and tax-filers as a whole, though certainly less dramatic, are comparisons between CDHP participants and individuals purchasing other insurance products. Another recent study examining CDHPs and found that about 45 percent of CDHP enrollees had incomes above $75,000 per year, while only 30 percent of those enrolled in other health insurance products had incomes above that level.[2] This comparison is particularly important because it examined individuals with different kinds of private health insurance, rather than both insured and uninsured individuals; thus, it would likely control for some other factors that produce income differences. The fact that income differences still exist when looking only at insured individuals strengthens the assertion that HSA and CDHP products are indeed more desirable to those with higher incomes.

Finding 2: HSAs/CDHPs are more attractive and beneficial to healthier consumers

Another finding of recent studies that further limits the likely effectiveness of CDHPs on a broad level is that they are generally much more appealing to healthier, well-educated consumers. One report, in particular, compared CDHP enrollees to insured, non-CDHP enrollees.

As *Table 1* shows, CDHPs generally attract healthier and well-educated enrollees. At the same time, they appear to be rather unattractive to individuals with chronic conditions, as CDHP enrollees are twice as likely to report that they would switch plans if they developed a chronic condition requiring more care.[3]

Table 1 **Kaiser Report Compares CDHP Enrollees to Non-CDHP Control Group**

	CDHP Group	Non-CDHP
Enrollees who reported being in excellent or good health	64%	52%
Enrollees reporting at least 1 chronic condition	23%	35%
Enrollees reporting that they would likely switch plans if they developed a chronic condition	30%	15%
Enrollees who graduated college	57%	35%

As will be discussed later, healthcare spending is especially concentrated among those with chronic conditions. As a result, the fact that CDHPs don't adequately address the needs of these higher-cost individuals could significantly limit the effectiveness of these products on a broad scale.

Finding 3: CDHP enrollees often forgo healthcare services due to cost

While the first two highlighted findings focus on the characteristics of those individuals who benefit from, and thus participate in, CDHPs, the behavior of these individuals is also significant. While proponents of CDHPs argue that the plan's financial incentives will reduce unnecessary utilization of healthcare services, studies are showing that they lower rates of utilization for desired services as well.

For example, one report found that CDHP participants were more likely than enrollees in other types of insurance products to put off a variety of healthcare services due to the costs of the services. CDHP members were more likely to put off obtaining a prescription (26 percent to 15 percent), more likely to skip a recommended test or treatment (25 percent to 15 percent), and more likely to report that they needed care but did not get it (23 percent to 11 percent).[4]

Finding 4: CDHPs do not adequately incentivize preventive care

While federal law allows high-deductible plans to cover some preventive care without making such care subject to the plan's deductible, in practice this often does not occur. One study actually found that more than 50 percent of CDHP participants were enrolled in plans that made preventive services subject to the plan's overall deductible.[5] Structuring healthcare plans in this fashion motivates the exact opposite behavior than what should be encouraged.

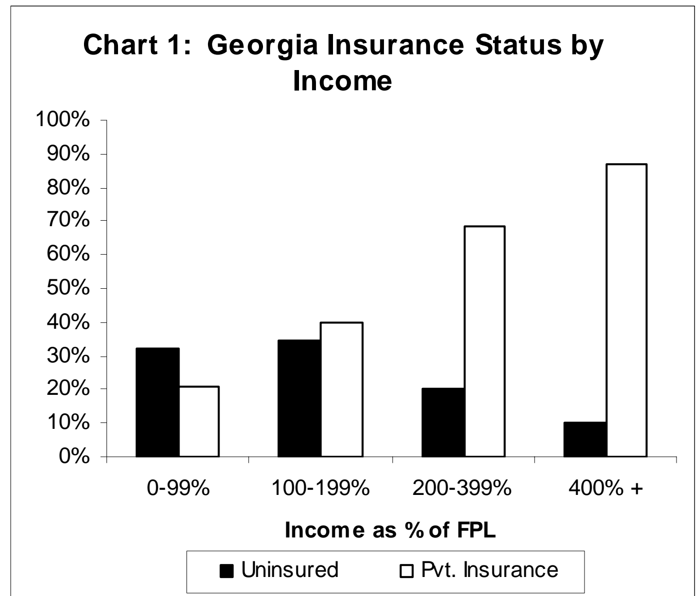
If preventive care is subject to the plan's deductible, individuals would be financially responsible for the entire cost of such care. As a result, many individuals and families would likely put off such care due to financial constraints. One survey examining CDHP enrollees found evidence of this behavior, as CDHP participants were less likely to have visited doctor's office in the previous year for a checkup (63 percent) than were enrollees in the non-CDHP control group (74 percent).[6]

Instead, preventive health maintenance activities should have very few barriers to their use. Because these are the services that help keep individuals healthy and less in need of higher-cost services at a later date, health plans should incentivize preventive care. Unfortunately, most CDHPs disincentivize use of proper preventive healthcare services.

What do these findings mean?

HSAs not an effective tool to target the uninsured

While HSA supporters argue that these products will solve the problem of the uninsured, recent survey findings indicate that this may not be the case. Due to the tax-benefits of HSAs, these products are especially attractive to higher-income households, which are more likely to have health insurance to begin with. As Chart 1 shows, uninsured rates are much higher for Georgians with lower incomes, while the percentage of Georgians with private insurance increases with income.[7] For adults in Georgia, the situation is even worse, as the uninsured rate for adults with incomes below 200 percent of the Federal Poverty Level (FPL) is approximately 44 percent.[8] Furthermore, while only 27 percent of Georgia adults have incomes below 200 percent of FPL, nearly half of all uninsured adults have incomes below this level.[9] Because CDHPs are not especially attractive, or even financially viable, for Georgians with lower incomes, it is very unlikely that these products will motivate currently uninsured individuals and families to buy health insurance.



Critics of HSAs have been claiming this relationship since the inception of the federal income tax breaks for these accounts, and data is now becoming available to support their claims. One study focusing on enrollees found that CDHP participants were less likely to be previously uninsured when compared to purchasers of other health insurance products. In particular, 24% of the survey respondents in traditional, comprehensive insurance products reported that they were previously uninsured, while only 10% of CDHP enrollees reported being uninsured prior to purchasing the product.[10]

HSA-supporters have often made claims that these products would be broadly appealing to those without health insurance. In order to support these claims, many groups cited data on *HSA-eligible* health plans, without taking into account whether enrollees actually opened an HSA. Also, some industry-cited statistics only examined the individual insurance market (rather than including employer sponsored plans), which is thought of as a lower-income market to begin with. As additional data emerges from independent studies that examine purchasers of the HSA as well as the accompanying high-deductible plan, it becomes apparent that the tax-advantages of the HSA

motivate those with higher incomes to purchase these products. At the same time, lower-income individuals without the means to open the HSA, and who are more likely to be uninsured, are less likely to benefit from the financial benefits of these accounts.[11]

Now, HSA supporters are calling for additional tax incentives on the purchase of the accompanying HDHPs (tax-breaks already exist for the HSA). Supporters fail to recognize, however, that tax incentives are not as significant to lower-income consumers who are most likely to be uninsured. Therefore, simply increasing tax benefits for one particular type of health insurance coverage is unlikely to motivate most of the uninsured population. Furthermore, the fact that lower-income individuals and families could have a difficult time affording the high out-of-pocket costs associated with these plans makes additional tax-cuts targeted at HDHPs even more problematic.

HSAs are not likely to reduce healthcare costs by incentivizing healthy behavior

While HSA advocates contend that making consumers directly responsible for the financial costs of healthcare will incentivize better, more cost conscious use of healthcare services, studies do not necessarily support these claims. While the up-front financial cost of services does appear to reduce healthcare utilization in CDHP participants, studies are showing that consumers are not simply reducing "over-consumption" of services, but rather they are limiting consumption of all healthcare services. As data presented earlier in the brief discussed, CDHP participants were less likely to visit a doctor for a "check-up" and were also more likely to forgo recommended or needed care, when compared to participants in other health insurance plans.

Furthermore, CDHP enrollees are no more likely than members of other health insurance arrangements to report that their health plan encourages them to adopt a healthier lifestyle (72 percent of CDHP participants agreed with that statement, while 73 percent of the non-CDHP group agreed).[12]

"Consumer driven" solution rests on faulty assessment of healthcare spending

While recent studies examining HSAs and CDHPs help illustrate that these products often fail to accomplish their goals, further analysis shows that these products rest on an incorrect assessment of what behaviors drive healthcare spending growth in the U.S. Currently, the inherent assumption in "consumerism" is that unnecessary healthcare costs are currently driving U.S. healthcare trends. As a result, the theory suggests that placing financial incentives to limit healthcare consumption will more properly align demand with need, thus reducing healthcare spending. This assumption, however, is not correct.

Instead, increases in the prevalence of treated disease appear to be the driving factor in overall healthcare spending growth in the last 15 years. One study in particular, examining growth in private health insurance spending from 1987-2002, contained several relevant findings. For example, this study found that the top twenty medical conditions accounted for 67 percent of private insurance spending growth over this time period.[13] Furthermore, increases in the treated prevalence of the condition represented more than half of the spending increase for sixteen of the twenty conditions (and more than 79 percent of the increase for eleven conditions).[14]

In Georgia, approximately 75-80 percent of healthcare spending is linked to chronically ill patients.[15] At the same time, chronically ill patients receive less than 60 percent of all clinically recommended medical care.[16] Combined with the above findings, these statistics suggest that solutions seeking to address increases in healthcare spending need to focus on reforms that target persons with chronic conditions, who are the largest consumers of healthcare in the U.S. and in Georgia. "Consumer driven" healthcare does not do this.

Instead, CDHPs place additional barriers to those seeking care, which could further limit the amount of recommended care individuals receive. Limiting healthcare services for those with chronic conditions may actually exacerbate current problems, especially if additional financial constraints further reduce utilization of recommended care. Solutions wishing to address overall healthcare spending in the U.S. must take into account the current healthcare spending realities. "Consumer driven" solutions, which essentially amount to enacting tax cuts and implementing higher cost-sharing in the form of deductibles that seek to reduce healthcare utilization, instead rest on a fundamental misunderstanding of the current healthcare situation in the U.S.

Conclusions:

From the state's low rankings in health status indicators to the growing uninsured population, Georgia faces critical health issues that can, and should, be addressed. The assertion that HSAs and "consumer directed" health plans can be the cornerstone to solutions addressing these problems,

however, is unproven. Furthermore, because these products fail to adequately target currently uninsured individuals and those with chronic conditions who consume the most healthcare services, enacting additional tax-incentives for these products in particular would be a misguided use of resources.

Instead, the state could invest resources in ways that expand health insurance coverage to the roughly 300,000 children and 1.4 million adults in Georgia without insurance.[17] Additionally, the state could examine ways to change the healthcare system to make sure individuals with chronic conditions receive adequate health maintenance services and healthy individuals receive proper preventive medicine.

Finally, should state policymakers insist on using the tax code to motivate the purchase of private insurance, such tax-incentives should be available to purchasers of all types of health insurance products, not simply high-deductible plans. Incentivizing only the purchase of high-deductible policies at the expense of traditional, comprehensive plans is neither fair tax policy nor good healthcare policy. Furthermore, the costs of enacting additional tax-incentives needs to be considered in the context of the actual effectiveness of the incentives as well as how these costs compare to other policy options, such as directly subsidizing health insurance costs for low income individuals and families.

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] "Consumer Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans. United States Government Accountability Office, August 2006. Report # GAO-06-798. www.gao.gov/cgi-bin/getrpt?GAO-06-798

[2] National Survey of Enrollees in Consumer Directed Health Plans, Kaiser Family Foundation November 2006. http://www.kff.org/kaiserpolls/upload/7594.pdf

[3] Ibid

[4] Ibid

[5] The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans. Paul Fronstin, Employee Benefit Research Institute and Sara R. Collins, The Commonwealth Fund. EBRI Issue Brief No. 300, December 2006. http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-20061.pdf

[6] National Survey of Enrollees in Consumer Directed Health Plans, Kaiser Family Foundation November 2006.

[7] "Sources of Health Insurance Coverage in Georgia 2005," Tabulations of the March 2006 Annual Social and Economic Supplement to the Current Population Survey by William S. Custer, Ph.D, and Patricia Ketsche, PhD. Center for Health Services Research, Robinson College of Business, Inst. of Health Administration at Georgia State University

[8] Ibid

[9] Ibid. Of the slightly more than 1.4 million adults in Georgia without health insurance in 2005, more than 680,000 (48%) had incomes below 200% FPL

[10] EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006. Fronstin and Collins

[11] While low-premium, high deductible health plans may be affordable for some low-income consumers unable to afford comprehensive insurance plans, individuals who purchase these plans without the means to open an HSA may be left very vulnerable to high medical costs.

[12] National Survey of Enrollees in Consumer Directed Health Plans, Kaiser Family Foundation November 2006.

[13] What Accounts for the Rise in Healthcare Spending in Georgia?" A presentation by Dr. Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management of the Rollins School of Public at Emory University. http://www.gbpi.org/pubs/specialreport/20070104_thorpe.pdf

[14] Ibid

[15] Ibid

[16] Ibid

[17] "Sources of Health Insurance Coverage in Georgia 2005," Custer and Ketsche