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ISSUE BRIEF

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FAQs on HSAs

Frequently Asked Questions on Health Savings Accounts

Health Savings Accounts (HSAs) were created by a provision in the Medicare Modernization Act of 2003 to allow individuals to set aside tax-advantaged money to pay for health expenses. HSAs must be paired with a qualified high-deductible health plan (HDHP) that meets requirements set forth by the Department of the Treasury. Taken together, HSAs and qualified HDHPs are a type of consumer-driven health plan. In 2007, qualified HDHPs must have deductibles of at least \$1,100 for individuals and \$2,200 for families. The maximum HSA contribution is \$2,850 for individuals and \$5,650 for families, even if the deductible is lower. These amounts are adjusted annually for inflation based on the Consumer Price Index.

There are many questions regarding who is signing up for HSAs and why they are choosing this type of plan, whether HSAs will have an effect on rising health care costs, and how the traditional health insurance market will be affected. While extensive data still does not exist, the most complete illustration of trends, with respect to HSAs, can be found in health insurance studies on HSAs and related products. This issue brief utilizes this available data to provide an actuarial perspective on a number of key questions related to HSAs.

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General

1. What types of Consumer-Driven Health Plans (CDHPs) are there?

CDHP is a general term typically used to describe the combination of a high-deductible health insurance plan and a health care spending account. The catastrophic component is intended to cover high-severity, low-incidence health services. The health care spending account is commonly used to cover high-incidence low-severity health services, such as office visits.

A Health Savings Account (HSA) is a specific type of health care spending account, created by a provision in the *Medicare Modernization Act of 2003* (MMA) to allow individuals to set aside tax-advantaged money to pay for health expenses. HSAs must be paired with a qualified high-deductible health plan (HDHP) that meets requirements set forth by the Department of the Treasury. HDHPs and HSAs can be obtained through either the individual or the employer group insurance markets. If HSAs are obtained through an employer, both the employer and employee can contribute, but the funds remain with the employee.

Aside from HSAs, there are other types of tax-advantaged health care spending accounts. Health Reimbursement Accounts (HRAs) can be provided by employers in conjunction with high-deductible plans and are used to pay for eligible health expenses defined by the employer. Unlike HSAs, only employers can contribute to HRAs. The funds in an HRA can accumulate and roll over to cover health expenses in subsequent years, but the funds typically remain with the employer at termination. Having an HRA could affect HSA eligibility.

Medical Savings Accounts (MSAs), another type of health spending account, were created as part of the *Health Insurance Portability and Accountability Act of 1996*. MSAs were available to those with an HDHP who were either self-employed or in firms with 50 or fewer employees. In these plans, either the employee or employer could contribute. The funds, however, were the property of the individual, regardless of who funded the accounts. As of Dec. 31, 2005, no new MSAs have been issued, although those already in existence can continue or they can be rolled over to an HSA.

Flexible Spending Accounts (FSAs) offer tax-advantaged health care spending accounts for workers with traditional health plans, as they do not require that workers be covered by an HDHP. Workers can set aside a portion of their salary to pay for qualified medical expenses. These funds do not roll over between years. As with HRAs, having an FSA could affect HSA eligibility.

2. What are the motivations of HDHP/HSA purchasers? What are the potential drawbacks?

Reasons for purchasing HSA-qualified HDHPs are as varied as the purchasers themselves and depend on many factors, including the options available to them; understanding of the healthcare system and its costs; financial and tax status; and health status. Primary motivations include the following:

LOWER COST

If an employee has the option to purchase a health plan with catastrophic coverage while saving out-of-pocket expenses on premiums, the HSA may be a viable option. HDHP/HSA options offered through an employer are typically priced significantly lower than other plans offered. In addition, individuals who do not have employer-provided health benefits may find the premiums for traditional plans in the individual market financially out of reach, but may be able to afford an HDHP. However, the traditional market has seen substantial movement to traditional plans with high-deductible designs similar to HDHP designs. In these cases, there is not much difference in premium levels.

Note however, that individuals who purchase HDHPs solely on the basis of lower premium costs may be less likely to contribute to an HSA (although some may have employer-funded HSAs), and they may be more likely to be unable to afford the up-front deductibles.

RETIREMENT SAVINGS

HSAs allow individuals to save money for retirement while saving taxes on their current income. Unlike other

retirement savings vehicles, the expectation is that these funds, and the investment income they earn, will be exempt from taxes when they are withdrawn and used in retirement—as long as they are used for qualified medical expenditures. While it is unlikely that the accumulations in these accounts will be sufficient to provide fully for health-related retirement needs alone, they can reduce the savings needed from other, less tax-advantaged, retirement savings vehicles. Individuals utilizing HSAs for retirement savings purposes are likely to purchase the highest deductible they are comfortable with, given their financial and health status, up to the applicable HSA deduction limit. They are also likely to fully fund the HSA.

Reliance on an HSA to help fund retirement needs is somewhat problematic, however, in that it assumes that the individuals will not need to access these funds prior to retirement. This will likely be the case only if they are fortunate enough to be generally healthy throughout their pre-retirement years and/or are able and willing to pay for un-reimbursed medical expenses with other funds.

CURRENT TAX SAVINGS

Individuals without an employer-provided health plan generally must pay for any out-of-pocket health expenditures and health insurance premiums with after-tax dollars. Retirees, even those with employer-provided coverage, must also pay for health expenditures with after-tax dollars. An HSA can be used to provide tax subsidies for out-of-pocket health expenditures channeled through the HSA. The HSA provisions that allow individuals to fund the account after incurring medical expenses (provided the person is covered by an HDHP at the time of such expense) facilitates the use of pre-tax dollars, even for those who do not pre-fund their HSAs. This approach requires accurate recordkeeping and a good understanding of the applicable tax provisions. There are also legislative proposals that would allow pre-tax premium contributions for HDHPs in the individual market. At this time, however, these plans are paid for with after-tax dollars unless the individual is self-employed.

OUT-OF-POCKET PROTECTION

By law, HDHPs must provide a safety net against catastrophic health care expenses. Other low cost health insurance plans may be available, depending on the state of residence and employer offerings, but often they have low maximums for specific services and/or total payment limits on an annual or lifetime basis. Preferred-provider (PPO), point-of-service (POS), and health maintenance organization (HMO) plans may contain numerous copayments that typically do not count toward out-of-pocket limits. This is especially true for prescription drug coverage. Thus, plan participants may be subject to high out-of-pocket costs, even with relatively low deductible plans. HDHPs may be a preferable alternative to employees looking to cap their exposure to out-of-pocket expenditures. However, for low-income individuals, and especially families, the maximum out-of-pocket exposure may still be too high for HDHPs to be viewed as a viable option.

HDHP/HSA Enrollment Information

3. To what extent are CDHPs and individual accounts, such as HSAs, being offered by employers?

In general, employers can offer two types of CDHPs. They can offer qualified HDHPs, with or without an HSA. (In this issue brief, a “qualified HDHP” is a high-deductible health plan qualified under MMA to enable an individual to create an HSA.) Alternatively, they can offer other relatively high-deductible plans with a Health Reimbursement Arrangement. If an HSA is offered through an employer, both the employer and employee may contribute to the account, but all funds remain the property of the employee. With an HRA, however, only the employer can contribute to the account, and funds are the property of the employer.

The share of employers offering a CDHP, although still relatively low, has been growing, and more employers expect to offer CDHPs in the future. According to Mercer’s *2006 National Survey of Employer-Sponsored Health Plans*, the likelihood of an employer offering either type of CDHP increases with the size of the employer (Table 1). In 2006, 37 percent of employers with 20,000 or more employees offered CDHPs, up from 22 percent in 2005. Only 6 percent of employers with fewer than 1,000 employees offered CDHPs in 2006, up from less than 4 percent in 2005.

Table 1
Percent of Employers Offering a CDHP, by Employer Size

Number of Employees	2005	2006	Very likely to offer in 2007
10–499 employees	2%	5%	N/A
500–999	4	6	10%
1,000–4,999	4	12	15
5,000–9,999	10	18	21
10,000–19,999	19	21	22
20,000 or more	22	37	39

N/A: not available

Source: Mercer Health & Benefits, *2006 National Survey of Employer-Sponsored Health Plans (2007)*

Note: CDHPs include qualified HDHPs as well as HRA-based plans.

According to a 2005 Mercer survey, the type of CDHP offered was related to the size of the employer. However, the 2006 survey indicates that HSAs have caught up with HRAs in terms of popularity for both small and large employers. Among large employers, there is an almost even split between the percentage offering HSAs and HRAs. For small employers, a slightly higher percentage offer HSAs. By year-end 2007, this margin is expected to increase in favor of HSAs.

4. What has been the enrollment experience so far with HSAs? How many people have signed up and where are they obtaining their coverage?

According to America's Health Insurance Plans (AHIP), 4.5 million people were covered by qualified HDHPs in January 2007, an increase of nearly 1.4 million from January 2006 (table 2).¹

Table 2
Qualified HDHP Plan Enrollment, by Market Type

	March 2005	January 2006	January 2007
Individual Market	556,000	855,000	1,106,000
Group Market			
Large group	162,000	679,000	2,044,000
Small group	147,000	510,000	1,057,000
Unknown group size	<u>88,000</u>	<u>247,000</u>	<u>291,000</u>
Total group	397,000	1,436,000	3,392,000
Unknown Market Type	77,000	878,000	34,000
Total	1,031,000	3,168,000	4,532,000

Source: AHIP Center for Policy and Research, "January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans," April 2007.

People are obtaining their health coverage from both the individual market as well as the group market. Initially, the individual market was the predominant source of qualified HDHP coverage. The group market has experienced higher growth rates, however, and has surpassed the individual market as the leading source of qualified HDHP coverage.

AHIP also finds that one quarter of all new individual policies sold are qualified HDHPs. This compares to 17 percent of new policies in the small-group market and 8 percent of new policies in the large-group market.

5. Who is purchasing qualified HDHPs and opening HSAs? What are the socioeconomic characteristics of the early adopters? What was their prior insurance status?

Several studies have examined preliminary enrollment data to determine the characteristics of HSA/HDHP enrollees:

AGE

The evidence on the age of qualified HDHP enrollees compared to those in traditional plans is mixed and utilization of these types of accounts seems to be spread throughout the age bands. A survey by the Blue Cross and Blue Shield Association showed that enrollees in qualified HDHPs are of all ages.²

A CIGNA study of CDHP plans found that on average, members with qualified HDHPs are younger than those enrolled in traditional plans (33 years old versus 36 years old, respectively).³ In the Federal Employees Health Benefit Plan (FEHBP), the average age of enrollees in qualified HDHPs (46 years) is slightly younger than the average age of those enrolled in all plans (47 years).⁴

A study by eHealthInsurance, however, found that enrollees in qualified HDHPs are older than other enrollees, with an average age of 38 among qualified-HDHP policyholders compared to an average age of 33 among other policyholders.⁵ Preliminary enrollment data from Humana, Inc. also indicate that individuals with HSA accounts (average age 40) are slightly older than enrollees in a traditional PPO (average age 39).⁶

Differences in the findings across studies may reflect differences in the specific plan designs, target populations, and marketing approaches. Differences could also be attributed to whether the studies analyze the profiles of employees/subscribers (which would include only the policyholder) or members/covered lives (which would include the policyholder and dependents).

INCOME

The average income of those with an HSA-qualified plan tends to be slightly higher than the average income of those who are not in an HSA-qualified plan. The United States Government Accountability Office (GAO) found that federal employees who chose HDHPs had higher salaries compared to the average salary of all federal employees. For instance, 43 percent of federal employees who enrolled in HDHPs had salaries of \$75,000 or more, whereas only 23 percent of federal employees enrolled in all FEHBP plans had salaries of \$75,000 or more.⁷

An Employee Benefit Research Institute (EBRI)/Commonwealth Fund study indicates that the income distribution of individuals with HDHPs (defined as not having a savings account component) and CDHPs (defined as HDHPs with an associated savings account) is fairly similar to that of those with traditional comprehensive plans. However, there is some evidence that those with very high incomes (greater than \$150,000) are more likely to choose a CDHP.⁸

Similarly, preliminary enrollment data from Humana, Inc. indicates that higher paid employees are more inclined to enroll in an HDHP/HSA than lower paid employees. Among employees with an annual income of \$50,000 or more, 60 percent select an HDHP/HSA plan, and 40 percent select a PPO plan. Among employees with an annual income of less than \$50,000, 40 percent select an HDHP/HSA plan, and 60 percent select a PPO plan.

FAMILY COVERAGE VS. INDIVIDUAL COVERAGE

Preliminary enrollment data from Humana, Inc. suggests that individuals with an HSA account are more likely to choose family coverage than those in traditional plans. Among those with an HSA account, 62 percent choose family coverage, compared to 50 percent of those in PPO plans, according to the study.⁹

PREVIOUS INSURANCE STATUS

According to AHIP, of the 1.1 million enrollees in qualified HDHPs in the individual market, 27 percent of new enrollees were previously uninsured.¹⁰ A Blue Cross Blue Shield survey indicates that twice as many individuals who were previously uninsured are covered by qualified HDHPs (12 percent) than by traditional health coverage (6 percent).¹¹

6. What are some of the key actuarial concerns regarding adverse selection related to HSAs and HDHPs, and what actions, if any, should payers take to address these concerns?

Adverse selection can occur when a buyer makes a purchasing decision based on knowledge that the seller does not have when setting the price. In a health insurance context, individuals generally have more knowledge than insurers regarding their future health care needs. As a result, the healthy will have financial incentives to select less generous plans with higher cost-sharing requirements but lower premiums. The less healthy will have financial incentives to select more comprehensive plans with higher premiums but lower cost-sharing requirements. In other words, lower-cost individuals would tend to choose plans with higher deductibles than higher-cost individuals.

This implies that consumer-driven health plans could actually benefit by favorable selection, that is, enrollment by healthier individuals. The potential for selection may actually increase as the trend toward consumer engagement will result in consumers becoming more knowledgeable about the financial impact of their decisions. However, there are limits to an individual's ability to adversely select. For instance, an individual's ability to predict his or her health care costs may not be much better than an insurer's ability, especially if the insurer uses individual medical underwriting. It can also be difficult to compare the financial implications of different plan designs. In addition, there may be deterrents to enrolling in a high-deductible health plan, even among healthy individuals. Some insureds may be comfortable with their current traditional plan design and be hesitant to switch to a high-deductible plan when it becomes available. Others may be deterred if their employer does not contribute to the HSA.

Nevertheless, there is the potential for at least some degree of selection with regard to plan choice when high-deductible plans are offered. Insurers and/or payers can mitigate the financial impact of selection in several ways. Rather than offering a choice among plans, an employer could offer one plan only. If offering multiple choices, premiums could be structured to account for the expected selection. Alternatively, plan design differences between different plan choices could be reduced. For instance, a \$500 difference in deductible levels between two plan choices will generate less selection than a \$3,000 difference.

HSA Funding and Spending

7. Who can put funds in HSAs and what are the eligibility requirements? Are employers putting money into employees' HSAs? If so, how much? How much money are employees putting into HSAs?

To be eligible to contribute to an HSA, an individual must be covered by a qualified HDHP and must not be covered by other health insurance that is not an HDHP. The HDHP can be an employer-sponsored plan, or it can be purchased in the individual market. There are no income eligibility requirements, and money contributed to an HSA can come from employment income or from any other source. To receive the full tax benefits of HSA contributions, individuals must make their contributions through pre-tax payroll deductions or they must claim and deduct any post-tax contributions on their federal income tax return. Both an employer and an employee can contribute to an HSA, but the funds in an HSA remain with the employee.

The GAO examined early HSA experience by collecting data from Internal Revenue Service (IRS) tax records as well as from national health benefit surveys and three large employers.¹² The GAO study found that, based on IRS data, about 55 percent of HSA-eligible plan enrollees reported HSA contributions in 2004, with an average contribution of \$2,100 among contributors. This figure could understate individual contributions to HSAs because it does not include any made through payroll reductions. On the other hand, it could overstate contributions because it will include those made on behalf of others. The GAO study also found that about two-thirds of employers offering HSA-eligible plans contributed to their employee's HSAs in 2005; the average contribution reported to the IRS in 2004 was \$1,064. However, GAO noted that contribution amounts could vary widely by employer.

Table 3 presents more HSA contribution information from three studies on employer-group coverage, conducted by the Kaiser Family Foundation, Mercer Health and Benefits, and Humana. The results vary, not only regarding average contributions, but also on the share of employers who contribute to their employees' HSAs. The studies found that between 57 and 70 percent of employers contribute to their employees' HSAs. Among those who do contribute, the Kaiser study found that average employer contributions are \$988 for single coverage and \$1,632

for family coverage. Humana found a similar amount for family coverage (\$1,644), but a much lower amount for single coverage (\$588). The Mercer study provided information on median contribution amounts rather than average amounts, and perhaps as a result, reported lower results than either Kaiser or Humana. According to the Mercer data, the median employer HSA contributions for single and family coverage are \$500 and \$800, respectively. This suggests that employer contribution amounts are skewed toward higher contributions, which would increase the average contributions relative to the median contribution amounts. However, other factors may explain the different contribution amounts between the various studies, including different types and/or sizes of employers examined.

Table 3
Average Annual HSA Contributions

	<i>Coverage Type</i>	Kaiser Study	Mercer Study	Humana Study
Employer Contributes to HSA				
Employee contribution	<i>Single</i>	N/A	N/A	\$672
Employer contribution		\$988	\$500*	\$588
Employee contribution	<i>Family</i>	N/A	N/A	\$1,176
Employer contribution		\$1,632	\$800*	\$1,644
Employer Does Not Contribute to HSA				
Employee contribution	<i>Single</i>	N/A	N/A	\$1,332
	<i>Family</i>	N/A	N/A	\$3,336
Percentage of Employers Contributing to HSA		63%	57%	70%

* Median contributions for large employers (average contributions were not available); N/A not available
Sources: Kaiser Family Foundation/Health Research & Educational Trust. *Employer Health Benefits 2006 Annual Survey* (2006); Mercer Health & Benefits, *2006 National Survey of Employer-Sponsored Health Plans* (2007); and Humana, Inc. *Health Savings Accounts Study* (2007).

Notes: The chart reflects employer-group coverage only; it does not include data from the individual market.

The Humana study also included HSA contribution information for employees, including those who do not have an employer contribution. Perhaps not surprisingly, employees whose employers do not make an HSA contribution contribute more to their HSAs than do employees whose employers also contribute to their HSAs. For example, among those with single coverage, the average employee contribution among those whose employer also contributes is \$672, compared to \$1,332 for those whose employer does not contribute. It is also important to note that total HSA contributions are higher among employees whose employers do not contribute. Among those with single (family) coverage, average HSA contributions total \$1,260 (\$2,820) for employees whose employers contribute, compared to \$1,332 (\$3,336) for employees whose employers do not contribute. This does not necessarily mean that eliminating employer HSA contributions would result in increased employee HSA contributions, however. Workers whose employers do not contribute to their HSAs may be different from workers whose employers do contribute, perhaps by income or other characteristics.

8. What levels of basic deductibles have employers or employees favored when enrolling in HDHPs? What deductible levels are common in traditional health benefit plans?

In 2006, the minimum annual deductibles for qualified HDHPs were \$1,050 for single coverage and \$2,100 for family coverage. Table 4 shows that average deductibles exceed these requirements by a substantial margin. For instance, the Kaiser and Humana studies show average deductibles for single coverage at about \$2,000 and for family coverage at about \$4,000. These averages are higher than the average deductibles in traditional products. Although not included in the table, the Humana study also found that for single coverage, the average deductibles for employees in the traditional group market are \$1,574 for groups with two to 50 employees, \$1,400 for groups with 51-99 employees, and \$944 for groups with 100 or more employees. The Mercer study provided information

on median deductibles rather than average amounts, and reported lower deductibles than the Kaiser and Humana studies. Again, this could indicate that deductibles are skewed toward higher amounts.

Table 4
Average HDHP Annual Deductibles and Out-of-Pocket Maximums

	<i>Coverage Type</i>	Kaiser Study	Mercer Study	Humana Study
Annual Deductible	<i>Single</i>	\$2,011	\$1,500*	\$2,187
	<i>Family</i>	\$4,008	\$3,000*	\$3,929
Out-of-Pocket Maximum	<i>Single</i>	\$3,172	\$3,000*	N/A
	<i>Family</i>	\$6,017	\$6,000*	N/A

* Median deductibles and out-of-pocket maximums for large employers (average figures were not available)

Sources: Kaiser Family Foundation/Health Research & Educational Trust, *Employer Health Benefits 2006 Annual Survey* (2006); Mercer Health & Benefits, *2006 National Survey of Employer-Sponsored Health Plans* (2007); Humana, Inc. *Health Savings Account Study* (2007).

Notes: The chart reflects employer-group coverage only; it does not include data from the individual market.

In 2006, the maximum annual out-of-pocket amounts for HDHPs were \$5,250 for single coverage and \$10,500 for family coverage. The Kaiser and Mercer studies showed that average (and median in the case of the Mercer study) out-of-pocket maximums were well below these limits at about \$3,000 for single coverage and \$6,000 for family coverage.

9. How are individuals using HSAs? Are employees spending or saving the HSA funds?

Individuals with HSAs who do not incur out-of-pocket medical spending can leave their money in their accounts to accumulate from year to year. Individuals with out-of-pocket medical expenses can either withdraw money from their HSA to use toward that spending, or they can use money from outside their account and leave their HSA funds to accumulate. Money used from the account would be pre-tax money, and money used from outside the account would be post-tax money. One reason to use post-tax money for out-of-pocket medical expenses rather than withdrawing HSA funds would be to save the HSA for large claims that might arise in future years, or as a retirement savings vehicle. The latter will be discussed in more detail in the next section.

For individuals incurring health-related out-of-pocket costs, most appear to be applying their HSA funds toward the deductible. Individuals with relatively few claims under the deductible might have HSA funds to carry over to the following year.

A four-year study of 1.6 million Aetna members showed 52 percent of HSA account holders rolled over their entire fund in 2005 and 49 percent of those with HRAs rolled over some or all of their funds in the same year.¹³ According to the GAO, 45 percent of tax filers reporting an HSA contribution in 2004 also reported withdrawing funds that same year.¹⁴ It is likely too early to know, however, the long-term trends in HSA utilization behavior.

10. How effective is the current HSA structure likely to be for accumulating sufficient amounts to fund retirement health care expenses?

An HSA can be used to accumulate money for retirement health care needs, but it is unlikely to be the sole source of funds for a majority of out-of-pocket expenses during retirement. There are two reasons that sufficient amounts are unlikely to accumulate in HSAs—health care utilization in retirement is usually higher than during the working years, and HSA account balances are likely to be used before retirement.

First, since health care utilization increases with age, out-of-pocket expenses remain high, even after Medicare eligibility at age 65. The Medicare program covers only about half of enrollee expenditures, leaving enrollees responsible for a large share of costs. For instance, EBRI estimates that the average couple retiring today at age 65 is estimated to need as much as \$295,000 for health-related expenses if they live to an average life expectancy.¹⁵ If the

couple were to live to age 95, costs could exceed half a million dollars. In contrast, typical HSA annual contributions are only a fraction of health care costs in a single year of retirement, even assuming that investment earnings on the HSA savings keep pace with health care spending growth. In addition, HSAs cannot currently be used to purchase health insurance before Medicare eligibility or for Medicare supplement coverage after Medicare enrollment, although insurance is an efficient way of reducing the financial risk of difficult to manage health costs. For a retirement period of 15 years or longer, there is only a small likelihood of accumulating sufficient funds in an HSA to pay the entirety of retirement health care costs.

The second reason for the difficulty in accumulating sufficient HSA account balances is that the savings are likely to be accessed during the working years, leaving less than the full savings for retirement. Those who do not access the funds before retirement will do so for one of two reasons—they are healthy or they think there is a tax advantage to using the HSA funds during retirement rather than before. Those who are healthy during their pre-retirement years are likely to have longer lives in retirement and thus their savings will need to cover a longer period of health care needs. Those influenced by tax policy would seem to be betting that their tax rates would be higher in retirement than before. Most retirement planning assumes the opposite.

There is much uncertainty in attempting to assess the effectiveness of HSAs as a retirement savings vehicle. Any modeling of how funds will be accumulated over the years and then spent down is challenged by the change in health care utilization over a lifetime and the effect of health care inflation and changing technology. A major variable in the evaluation of how much will be saved before retirement and spent after retirement is determining the age at retirement. A person retiring at age 65 will have a longer accumulation period, and probably a shorter retirement period, than someone retiring at age 55. Anyone retiring before Medicare eligibility also faces much higher out-of-pocket costs in their first retirement years if they have no or less generous health coverage than while working. Finally, while some retirees will have health coverage continued by employers, this may be less likely for future retirees who have been offered HSAs for the 15 or 20 years before retirement and assumed to have time to accumulate a significant savings account balance.

11. What are individuals spending the HSA funds on (e.g., pharmacy, medical, vision, dental, etc.)?

Individuals with HSAs can use those funds toward the copayments or deductibles of their HDHP. They can also use their HSA funds toward qualified expenses that are not covered by their HDHP. Data are not yet available on how individuals are using HSA funds; however, data from HRA utilization may be illustrative:¹⁶

- | | |
|--------------------------------------|-----|
| ■ Medical (copays, deductibles, etc) | 57% |
| ■ Pharmacy copays | 16% |
| ■ Vision | 13% |
| ■ Dental | 14% |

Impact on Health Costs

12. How will HSAs/HDHPs affect health care costs? Can they lower cost growth? Will there be behavioral changes associated with HSAs/HDHPs? Are these behavioral changes due to more information or increased employee cost sharing?

Although HSAs have not been in the marketplace long enough for a thorough actuarial study, many studies have evaluated the effect of consumer-driven health plans on costs by examining HRA plans. The effect of HSAs on health care costs will likely be similar to those of HRAs. It is possible that HSAs will lower cost growth by more than HRAs given the additional tax incentives and true individual ownership of the HSA funds. Several studies have examined preliminary evidence on how CDHPs will affect health costs and the findings suggest that health costs under HSA/HDHP plans could be lower than those under more traditional plans.

Humana has examined more than three years of data on its HRA offerings. It studied a group of enrollees both before and after implementing an HRA, and compared health costs for those choosing an HRA to those for enrollees

remaining in traditional HMO and PPO plans.¹⁷ The results indicate that health costs among HRA enrollees increased by 5 percent less than the costs for enrollees remaining in traditional plans. Approximately one-third of the savings results from additional employee cost sharing. Two-thirds of the savings result from behavior changes, due to both financial incentives and additional information given to employees. The results show a clear shift from inpatient surgeries to outpatient surgeries among HRA enrollees. The actual cost per service for inpatient surgeries increased, which is consistent with an appropriate movement of less intense services to an outpatient basis. Notably, preventive services increased under the HRA plans, likely due to better communications to plan participants or enrollees.

A CIGNA study comparison of the health costs of its more than 40,000 CDHP members (both HSA- and HRA-based plans) to those remaining in its traditional plans showed significant savings among CDHP members.¹⁸ The increase in health costs for those who had switched to CDHPs was 12 percent less than those remaining in traditional plans. The trends were not significantly different between HSA and HRA based plans.

A study of United Healthcare's 30,000 members with CDHPs (both HSA- and HRA-based plans) and 73,000 traditional plan members indicated that the medical cost growth for CDHP members is lower than that for traditional products, even after adjusting for health status.¹⁹ In the first year of membership in a CDHP, the study indicates that consumers change behavior, in particular by using fewer services. Utilization growth for CDHPs increases in the second year, but still remains lower than that of traditional plans. Other behavior changes for those in CDHPs include increased use of web tools and generic drugs.

A four-year study of 1.6 million Aetna members showed that employers offering Aetna HealthFund's consumer-directed plan experienced savings compared to other products the employer offered.²⁰ Fully replacing other plans with the consumer-directed plan had the most significant savings, with an average medical cost trend of 1 percent over three years, meaning medical spending increased only 3 percent between 2002 and 2005. Employers who offered an HDHP/HRA option plan effective in January 2003 experienced an average medical cost trend of 6.7 percent over a three-year period.

Research by McKinsey & Company suggests that CDHP consumers are more value conscious, pay more attention to wellness and prevention, and "reported behavioral changes that could significantly reduce not only the short-term rise in medical costs but also long-term medical cost trends."²¹ This same report noted that CDHP consumers were not satisfied with the extent of health care-provider information available to them. As better information on provider prices and quality become accessible, positive behavior changes should be enhanced—particularly among HDHP/HSA participants.

Taken together, these studies provide evidence that health costs are lower for CDHP-type plans than for traditional plans. It is not clear, however, whether these cost savings will result in a long-term reduction in health care-cost growth rates or are more one-time in nature, meaning future cost growth will be similar between CDHP plans and traditional plans. The data from United Healthcare suggest that the impact on cost growth will diminish, at least somewhat, over time. On the other hand, increasing the availability of cost and quality information to enrollees could increase and extend the impact of CDHP plans on health care costs and cost growth.

It is also somewhat unclear how health spending will be affected for individuals who exceed the deductible. There is not yet been enough data to examine whether any behavior changes of individuals continue after they reach their deductible. This consideration will become more important over time as enrollees accumulate larger HRA and HSA balances.

Other

13. How will HSAs/HDHPs impact health care providers?

There are four main areas where providers may see a change including the availability of information for consumers, payment of claims, bad debt, and patient relations.

CONSUMER INFORMATION

Providers will find they are increasingly subject to pricing transparency and information-sharing requirements. The information insurers provide to consumers about cost and quality will vary to the extent it is timely, accurate,

fair, and consistent between insurers. The industry has yet to establish standard cost and quality definitions. Thus, providers face the risk of potentially inconsistent or conflicting information appearing on insurers' websites.

- **Quality:** Insurers may rely on quality measures that are convenient to obtain and universal across facilities. Inconsistencies may occur based on different quality criteria and different methods of risk adjustment, assuming the insurer risk adjusts the measures.
- **Costs:** Insurers may define costs based on billed charges, actual cost structure, or contracted allowed charges. The various definitions would produce distinctly different comparative results between providers. The provider's ranking will also depend on the volume of admissions and case mix, as well as where insurers draw the distinctions between high, average and low cost.
- **Timing of Information:** The time period may vary when cost and quality measures are defined, which may affect the performance rating of a provider. In most cases there will be a lag between current information and the data used by members to make their decisions. For example, quality measures would be inaccurate if a hospital purchases a world-class oncology practice early in the year, and quality measures are based on data from the past calendar year.

PAYMENT OF CLAIMS

Consumer-directed products are typically accompanied by higher levels of member cost sharing and a greater number of payment sources from which that responsibility may be met. Under a consumer-directed product, cost sharing is typically determined after a complex adjudication process and providers will be paid from a combination of the catastrophic insurance plan, HSA account, and the member themselves. Providers may find that they will be required to provide more detailed information to insurers and it will take longer to get paid for their services. Both of these propositions introduce challenges to providers concerned about timely payment.

BAD DEBT

The increased cost sharing associated with these products raises the possibility for additional bad debt concerns for providers. Since reimbursement comes from multiple sources, providers should also account for a longer claims-adjudication timeline when planning their cash flow.

These issues may be of particular concern for physicians, because 1) the sheer volume of collections can quickly become unmanageable; 2) physicians are more likely than hospitals to be rendering services under an individual's deductible, which is the individual's direct financial responsibility; and 3) unlike hospitals, physicians groups tend to operate more like small businesses.

PATIENT RELATIONS

Many company/plan specific website tools provide average cost information by procedure, and are not necessarily based on the insurer's actual contracts. When individuals estimate their costs using these tools, they may get a very different answer than when they receive the actual bill. This may lead to members expressing concern over paying such a large differential versus expectation.

Providers should be prepared to face a new level of consumer involvement in the provision of their services. While it would be in violation of most managed-care contracts to individually negotiate service costs with members, providers will nonetheless get requests to waive out-of-pocket expenses and bargain on fees. The pressure members apply to providers will likely increase in this area and affect patient relations.

Summary

HSA's were enacted as part of the Medicare Modernization Act of 2003. According to a recent AHIP study, the number of people covered by HSA-eligible HDHPs in January 2007 was 4.5 million, an increase of over 1.3 million from January 2006. Although some qualified HDHP enrollees were previously uninsured, overall enrollment is still too low to have a substantial impact on the overall number of the nation's uninsured.

Preliminary evidence suggests that health costs are lower for CDHP-type plans than for traditional plans. How-

ever, it is too early to draw conclusions about whether these initial savings will lead to long-term reductions in health care cost growth or if future cost growth will equalize between CDHP plans and traditional plans. While some data indicate that the impact of CDHPs on cost growth could diminish over time, the increasing availability of cost and quality information to enrollees could increase the impact of CDHPs on cost growth. Policymakers should continue to monitor data on enrollment and spending in order to understand the full impact of HSAs, and other CDHP-type plans, on increasing health care costs.

ENDNOTES

¹ AHIP Center for Policy and Research. January 2007 Census Shows 4.5 Million People Covered By HSA/High-Deductible Health Plans, April 2007.

² Blue Cross and Blue Shield Association. Blue Cross and Blue Shield Association Consumer Survey Shows High Rate Of Satisfaction With HSAs, Cites Increased Reliance On Decision-Support Tools, September 2005.

³ CIGNA CDHP Experience Study. Consumer-driven Health Plans: Focus on Health Savings Accounts, as presented by David Tuomala at the American Academy of Actuaries Spring Meeting, 2006.

⁴ U.S. GAO. Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Account, January 2006.

⁵ eHealthInsurance. Health Savings Accounts January 2005 - December 2005, May 10, 2006.

⁶ Humana, Inc. It Works Study, 2007.

⁷ U.S. GAO. Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Account, January 2006.

⁸ Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. Issue brief No. 288, December 2005.

⁹ Humana, Inc. It Works Study, 2007.

¹⁰ AHIP Center for Policy and Research. January 2007 Census Shows 4.5 Million People Covered By HSA/High-Deductible Health Plans, April 2007.

¹¹ Blue Cross and Blue Shield Association. Blue Cross and Blue Shield Association Consumer Survey Shows High Rate Of Satisfaction With HSAs, Cites Increased Reliance On Decision-Support Tools, September 2005.

¹² U.S. GAO. Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans, GAO-06-798, August 2006.

¹³ The October 2006 Aetna study of consumer directed plans is available at http://www.aetna.com/news/2006/pr_20061001.htm.

¹⁴ U.S. GAO. Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Account, January 2006.

¹⁵ These results are confirmed by many actuarial studies and published papers, such as EBRI's issue brief 295, Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement (July 2006), which also notes that the maximum a person could save in an HSA account over 10 years is \$46,400. The EBRI issue brief is available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3650.

¹⁶ Humana, Inc. It Works Study, 2007.

¹⁷ Humana, Inc. It Works Study, 2007.

¹⁸ CIGNA CDHP Experience Study. Consumer-driven Health Plans: Focus on Health Savings Accounts, as presented by David Tuomala at the American Academy of Actuaries Spring Meeting, 2006.

¹⁹ Reden & Anders, CDHP Claim Experience Study, as presented by Brent Greenwood at the Conference of Consulting Actuaries annual meeting, October 2005.

²⁰ The Oct. 2006 Aetna study of consumer directed plans is available at http://www.aetna.com/news/2006/pr_20061001.htm.

²¹ McKinsey & Company. Consumer-Directed Health Plan Report – Early Evidence Is Promising, June 2005



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