Health Savings Accounts

Robert I. Field, JD, MPH, PhD

Health Savings Accounts (HSAs) offer a new paradigm for American healthcare finance. Instead of covering all healthcare needs, insurance under an HSA system responds only to catastrophic expenses. Routine costs are paid by the patients themselves out of special tax-advantaged funds. Because of the smaller role for insurance companies in the purchase of healthcare services, patients more closely resemble consumers of other kinds of good and services. HSA proponents see a system that begins to track a free market model with greater efficiency and responsiveness At the same time, however, opponents see an erosion of traditional insurance protections for those who are most sick and vulnerable.

The HSA concept received significant support from provisions contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the law that also established the Part D prescription benefit.[1] In particular, the MMA defined HSAs as a new kind of savings account, with special tax benefits that can be used for healthcare expenses that fall below an annual cap of a few thousand dollars. Expenses above the cap are covered by "catastrophic" health insurance that must be obtained in conjunction with the accounts. HSAs are successors to previous similar concepts in the form of Medical Savings Accounts (MSAs) and Health Reimbursement Accounts (HRAs). However, the HSA provisions of the MMA offer the most extensive and ambitious trial yet of patient-directed healthcare spending.

The premise behind HSAs is extremely controversial. While supporters envision greater patient empowerment leading to a more responsive "consumer-driven" healthcare system, opponents fear more ominous consequences. They see a system with significant benefits for healthier and wealthier patients at the expense of those with chronic illnesses and more limited financial resources. HSA opponents foresee gradual erosion of traditional insurance coverage, leaving many unable to afford basic medical needs.

Whatever the outcome of HSAs, the MMA guarantees them a trial run. Uptake in the market since the MMA's enactment, while still limited, has nevertheless increased substantially. As of January 2006, about 3.2 million people were enrolled, more than triple the number in March 2005.[2] Since financing determines the shape of any industry, HSAs could affect not only the health insurance industry, but also the entire healthcare system. Long-term adoption of HSAs on a wide scale also could have significant consequences for Medicare. It is important, therefore, to understand how HSAs work and where they might lead us.

The Structure of HSAs

Under the structure established by the MMA, individuals, their employers, or both can fund HSA accounts. Money that is deposited, along with investment returns on that money, are exempt from federal income tax, as would be the case for a tax-favored retirement account, such as an individual retirement account (IRA) or 401(k) plan. The maximum annual contribution may not exceed the lesser of the deductible of the accompanying catastrophic insurance policy or a ceiling that is adjusted each year for inflation. For 2007, the limits are $2850 for an individual and $5650 for a family. HSA funds can be used for any purpose that the Internal Revenue Service (IRS) determines through regulations to be health related.[3] The definition is quite broad and encompasses many personal care items and services, in addition to traditionally recognized expenses, such as physician visits, hospital stays, and prescription drugs. HSA funds may not be used for health insurance premiums, but they may be applied to the costs of long-term care insurance and related kinds of coverage.

The most significant feature of the MMA in facilitating HSAs is the provision for funds to be rolled over from year to year. Previous health-savings vehicles required that unused funds be for-

feited, and the next year's accounting begin anew. HSA deposits remain the owner's property, and can build up continuously until age 65. An account maintained over an entire career could grow to a considerable amount, provided that significant unreimbursed medical expenses do not arise. To further enhance individual control over HSA savings, the MMA places full ownership in the hands of the account holder, with portability from job to job. Previous vehicles were owned and administered by the employer and had to be left behind upon a change in employment.

To qualify for these advantages, an HSA must be purchased in conjunction with a catastrophic insurance policy. This coverage carries a high annual deductible, which is indexed to inflation, but initially set at a minimum of $1100 for an individual and $2200 for a family, so that it is reserved for a level of aggregate expenses that is considered "catastrophic."[3] These policies are often referred to as high-deductible health plans (HDHPs). A survey conducted in 2005 found that deductibles in actual HDHP policies averaged as high as $1870 for individuals and $3686 for families.[4] As an additional protection for those under this coverage, the 2007 total annual out-of-pocket healthcare spending for expenses within the deductible and for other unreimbursed medical costs combined may not exceed $5500 for an individual and $11,000 for a family. In addition, these policies are portable between employers, as well as exempt from medical underwriting of individual risks.

Patients meet their healthcare expenses with this combination of HSAs and HDHPs. At the start of each year, they pay for healthcare services first out of their HSA, until the insurance deductible has been met. If the account has not built up sufficient funds to satisfy the deductible, patients must make up the difference on their own. If a patient is fortunate enough to accumulate an account surplus over time, he or she is free to withdraw it for any purpose starting at age 65 or if disability occurs before age 65. Unlike tax-favored retirement accounts, no taxes are incurred on withdrawals, even those for non-healthcare expenses.[5]

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The Vision of HSAs

The proponents of HSAs envision a "consumer-driven" healthcare system.[6] This term, first coined by Harvard Business School Professor Regina Herzlinger, describes a system in which patients drive the market for healthcare goods and services, as do consumers in most other industries.[7] With ownership rights protected through rollover of account balances from year to year and portability between employers, the funds in HSAs represent a patient's own money. The incentive is to make purchases with these funds prudently, as it would be, for example, in buying a new car or a house. This will lead patients to consider price and quality and seek out the best value for the cost.

Patients face no such incentives when obtaining health care that is covered by insurance. The bill is paid by a third party—either a private insurance company or a government program, such as Medicare or Medicaid. Excess spending on unneeded or inefficient services impose no direct financial consequences on the patient. The only effect is a highly attenuated, upward pressure on premiums or taxes that is spread across a large pool of other people. The result is a phenomenon that economists call "moral hazard." People are likely to be less prudent about their behavior and less financially cautious in healthcare spending when a third party buffers them from the true cost. Moral hazard produces a system that rewards waste and inefficiency, which are both seen as common features of American health care.

Individual control of healthcare purchases is the foundation of consumer-driven health care, but an additional ingredient is needed to make the system work. Patients must have information to make rational purchasing decisions. health care is an extremely complex technical field. On their own, lay consumers would have difficulty in determining what services they need and what provider is best qualified to render them. If purchases are made directly, without the intervention of a managed care company or other financial intermediary, patients must have a means with which to sort out the

choices available in the market.

To this end, HSA proponents envision an explosion of accessible healthcare information. As a central part of fulfilling this need, physicians, hospitals, pharmacies, and others would post prices in a clear and transparent manner. Impartial assessors would issue report cards on healthcare providers that would summarize outcomes on key performance measures. Web sites and print publications would disseminate data on prices and quality in an accessible format to permit direct comparisons of marketplace competitors offering similar goods and services.

Informed patients directing their own healthcare spending would impose the discipline of the market on healthcare providers. Those who overcharge compared to competitors of similar capabilities and quality would see demand for their services shrink. Those who offer high value in terms of measurable quality outcomes for the price charged would see business expand and profits grow. Ultimately, the healthcare industry could see a shakeout in which inefficiency and poor quality, hallmarks of much of American health care to date, are banished.

The Menacing Side of HSAs

Where some see market empowerment of healthcare consumers, others see a threat to an established financing mechanism that has protected Americans for decades from the financial burden that capricious injury and illness can impose.[8] Critics of HSAs charge that this approach restricts insurance coverage to the point at which its value is severely compro-

mised. HSAs confer a tax-free windfall on those who are fortunate enough to remain healthy, but leave many who incur large medical expenses through no fault of their own without the means to obtain needed care.

HSAs pose a disadvantage for the sick, it is argued, because those with chronic diseases are ensured of incurring yearly medical costs that are not covered by their catastrophic insurance policy. If the condition is serious, these costs could exceed the amount accumulated in an HSA, forcing the patient to use additional funds of his or her own. This pattern is likely to repeat each year, so that there will be no buildup of HSA savings over time, and upon retirement, nothing to withdraw. In contrast, a healthy patient can hope to limit medical spending to a level below the annual HSA contribution, with funds rolling over from year to year. After a few years, enough money will have been saved to cover the catastrophic insurance deductible in future years, leaving an excess to save for retirement, even if a few major medical expenses arise before then.

HSAs also represent a disadvantage for those with lower incomes, it is contended, because these people are less likely to have savings that can supplement HSA funds, if needed to treat serious illness. In addition, lower incomes translate into lower marginal tax rates, so tax-free savings are worth less than those for higher incomes. In effect, the government is granting a larger tax subsidy to those who are better off financially and, therefore, need the help less.

In the most dire scenario that opponents describe, HSAs could jeopardize the entire insurance industry. As healthier patients leave traditional insurance plans, the percentage of sick patients in the remaining coverage pool increases. This demographic change forces insurers to raise premiums, which in turn drives even more healthy patients away. Eventually, this process of adverse selection leaves conventional insurance to cover only the very sick at premiums that no one can afford. Once this occurs, the traditional insurance function of spreading the risk of major medical costs across a large group of people no longer operates.

Critics also question how comparison shopping for medical services realistically would work in practice. It is easy to see how purely elective services, such as cosmetic surgery, could be bought and sold in a market system. Buyers have time to consider their options and weigh different sources of information. However, how would this approach work in an emergency? A patient in an ambulance with chest pain has no time or ability to compare quality ratings for cardiac care at competing hospitals or comparison shop for price. Con-

sumerism has little meaning in such a situation. Even with time to evaluate options, where will patients find reliable information that is understandable to a lay consumer in a field as technical and complex as medical care? Outcome reporting on healthcare providers is still in its infancy, and it is not yet clear whether it will ever mature to the extent needed to support an effective consumer-driven system.

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Weighing the Merits of HSAs

The contrasting visions of HSAs have sparked lively debate in many policy forums, including last winter's annual National Health Policy Conference, sponsored by AcademyHealth, the nation's largest health policy and health services research organization.[9] Ray Ramthun, Special Assistant to the President for Economic Policy, extolled the virtues of a new approach to healthcare finance that could pick up where managed care left off in controlling costs and enhancing access. While managed care uses the blunt force of an outside arbiter in deciding what services a patient may or may not obtain, HSAs put this control in the hands of the patients themselves, who decide how to use funds that they own. If they spend prudently, financial rewards lie ahead. If they overspend on unnecessary care, they will bear the financial consequences.

The most impassioned words of caution came from Princeton University economist Uwe Reinhardt, who complained of the illusion of an "ownership" system.[10] He echoed the concerns of HSA critics in warning that health care often responds in perverse ways to the market forces that guide the purchase and sale of routine consumer goods. HSA proponents predict that patients will be more prudent purchasers if, by using their own funds rather than those of an insurance company, they put some "skin in the game." Professor Reinhardt wondered how much "skin" a surgery patient could stand to lose, both figuratively and literally. Universal insurance coverage that treats all patients more or less equally, he argued, is a far preferable approach.

Possible Consequences for Medicare

With the decibel level rising on arguments about the near-term effects of HSAs on private health insurance, there has been little public debate about the possible longer-term effects on Medicare. If the HSA approach is successful, many of those entering the Medicare program over the coming years will have sizeable accounts that can supplement Medicare coverage. This change could have profound effects on patients and providers.

What will it mean for patients to gain Medicare coverage with a large supplemental spending fund available? As a start, they will likely demand more noncovered services, including elective procedures and lifestyle drugs. They may seek higher levels of quality in services that are covered, perhaps paying the additional costs for private hospital rooms, private-duty nurses, and extra follow-up care. They also may be more willing to incur the costs of physicians who opt out of Medicare participation and require direct patient payment. Overall, demand for high-end healthcare services is likely to grow.

If successful in the long term, HSAs may reinforce another innovation that Congress sought to promote through the MMA. That law encourages the growth of private managed care plans as an alternative to traditional fee-for-service Medicare coverage. Patients can opt to receive all of their coverage through Medicare Part C, which was renamed "Medicare Advantage." Plans operating under this program vary considerably in the generosity of their benefit structures and the cost of premiums. If Medicare Advantage matures alongside HSAs, a growing number of seniors will have the resources to join high-end managed care plans. Such a trend could add further fuel to the engine driving Medicare managed care growth.

More discretionary healthcare spending in the hands of beneficiaries may lead to an altered political dynamic for Medicare. Congress may find it easier to cut basic Medicare services if a sizable proportion of beneficiaries is able to supplement coverage on its own. As financial pressures on Medicare grow with the aging of the cohort born during the baby boom

years, reductions in coverage may be easier to sell to a public that can cushion the effects with tax-advantaged savings.

The other side of a burst in high-end medical services, however, would be a reduction in access to health care for those who reach retirement age without an HSA surplus. People who have spent years treating chronic diseases or who have had to confront other major medical expenses for themselves or family members are likely to reach Medicare eligibility with their HSAs depleted. Most of them would have no resources with which to demand discretionary care. Of greater concern, they would similarly lack resources with which to cover any cutbacks in Medicare coverage. The most direct effect on providers would be an increase in uncompensated care and, possibly, the number of collection problems.

Tax Relief and Health Care Act of 2006 Impacts HSAs

The US Congress passed the *Tax Relief and Health Care Act of 2006* (H.R. 6111) on December 8, 2006, and President Bush is expected to sign the bill before the end of the year.[1] The Act provides several improvements to HSAs, including the following[2]:

- Rollover of money from other tax-favored accounts into an HSA. Eligible accounts include savings from a company Health Reimbursement Arrangement, an IRA, and the health dollars in a Flexible Spending Account (FSA).[2] The rollover is a one-time transfer.[1]
- Increased annual contribution limits for HSAs. Current law prohibits yearly deposits that are greater than the amount of a person's health insurance policy's deductible. Under this legislation, HSA insurance policy owners can contribute the maximum amount of $2700 (individual) or $5450 (family) in 2006.[2]
- Cost-of-living adjustments for HSA contribution and deductible amounts published by the Treasury Department in March (not April).[2]
- Full annual contribution to HSAs, even if the accounts are not yet set up.[2]
- Higher contributions to HSAs by employers for lesser-paid employees.[2]

The HSA enhancements are permanent, and most take effect for tax years beginning after 2006. These changes will have a major impact on employer-sponsored healthcare decisions.[1]

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The Next Steps for HSAs

The launch of HSAs is still very much an experiment. While the rate of uptake is growing rapidly, it still represents only a fraction of private health insurance policies. Experience over the next few years will be crucial in determining their fate. As with any health policy innovation, predictions must be taken with more than a grain of salt. Ten years ago, prognosticators saw a healthcare system dominated by HMOs based predominately on primary care. HSAs were proposed, in part, as a means to pick up the pieces that remained of that shattered vision.

Two factors will play key roles in determining the outcome of HSAs. The first is the maturation of information resources. Markets only work if consumers have sufficient information with which to make purchasing decisions. Pricing and objective quality data are still not available in a form that is widely accessible to lay healthcare consumers. The growth of HSAs may generate enough demand for this resource to stimulate its rapid development. However, it remains to be seen whether truly informed comparison shopping for life-and-death healthcare services is actually feasible.

The second factor is government regulation. Many aspects of HSAs were spawned into a regulatory void.[11] Federal legislation exempts HDHPs from much state oversight, but does not substitute rigorous federal standards in its place. The administration of many HSAs is likely to find its way to banks, which are subject to financial, but not healthcare, regulation. Under this structure, who will ensure that health considerations are addressed? Moreover, who will police the dissemination of consumer information against fraudulent and deceptive practices? The answers have yet to be devised.

America's disjointed system of healthcare finance reflects pieces of many innovations implemented over the years. Despite a meteoric rise in market share during the 1990s, HMOs never came to dominate, but the role of insurers as managers of care seems here to

Provider Action

Impact to You

HSAs will likely result in a large pool of consumers demanding noncovered Medicare services. These consumers will seek higher levels of quality in services, looking toward the Internet as a source of information. They may also be more willing to incur the cost of physicians who opt out of Medicare participation and require direct patient payment. Overall, demand for high-end healthcare services is likely to grow.

What You Need to Know

It is important to understand the workings of HSAs so that you can best advise patients, as well as consider this option for yourself. In addition, realizing how the growth of HSAs will affect the marketplace so that you can prepare for the likely changes is essential.

What You Need to Do

Already, consumer-driven health care is leading some patients to expect and demand more in terms of provider responsiveness. These patients are also increasingly evaluating quality outcomes data that are available on the Internet. Practices that prepare for this new patient pool will be best positioned to take advantage of this market change. Preparation includes better collection, analysis, and reporting of quality data and being well represented on the Internet.

stay. Fee-for-service reimbursement, which prevailed before the rise of managed care, sank as a result of its unmanageable price tag, but its central feature of patient choice of providers remains a key element of many insurance plans. HSAs may or may not survive and thrive in the form envisioned by the MMA. However, the concept of greater patient control over healthcare spending decisions and patient sensitivity to the consequences has been gaining considerable support for some time. It is likely to remain influential in financing mechanisms in some shape or another for the foreseeable future. MPM

Robert I. Field, JD, MPH, PhD, chairs the Department of Health Policy and Public Health at the University of the Sciences in Philadelphia, PA. He is also a senior fellow of the Leonard Davis Institute of Health Economics at the University of Pennsylvania, Philadelphia, PA.

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Adverse Event Reporting Promotes a Culture of Safety

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task, but it's a challenge that everyone, ourselves included, should accept. Join us in creating a culture of safety throughout the healthcare community. MPM

Both Alan B.K. Rabinowitz, MA, and Laurene Baker, MA, are employed by the Pennsylvania Patient Safety Authority in Harrisburg, PA. William M. Marella, MBA, is employed by the Pennsylvania Patient Safety Reporting System (PA-PSRS) in Harrisburg, PA, and by the Emergency Care Research Institute (ECRI) in Plymouth Meeting, PA.

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