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PNHP Fact Sheet: Health Savings Accounts – No Savings

What is a Health Savings Account?

Health savings accounts (HSAs) are promoted by insurers as the "consumer-directed" solution to the health care crisis, and by some conservatives as a way to make individuals more "responsible for their health care choices." HSAs, which were created by the 2003 Medicare drug law, are tax-free savings accounts. Individuals and families with high-deductible health insurance plans (HDHP) (a minimum of $1,000 for an individual or $2,000 for a family) are eligible to open/purchase an HSA.

Individuals and employers can contribute funds tax-free to the HSA (maximum deposit depends on insurance plan deductible), which can only be spent on *approved* medical expenses. Unused funds (less the significant set-up, transaction, and management fees) roll over from year to year. At retirement, an individual can cash out an HSA by paying taxes on it. A wide variety of corporations – from insurers to banks – have started selling HSAs to profit off the hefty management fees and, like pharmacies, the detailed data sets on health care utilization that will result.

The Theory Behind Consumer-Directed Health Care (CDHC)

Advocates of HSAs contend that health insurance "disguises" the true cost of health care. Patients with health insurance, advocates say, see the health services they receive as being "free," and therefore overuse them, causing health care costs to rise. This is known as the theory of "moral hazard."

Health savings accounts purportedly solve this problem by forcing consumers to purchase health services "with their own money." When patients pay for care out of private accounts, the theory goes, they will cut back on "frivolous" health services and demand price competition from doctors, hospitals, and other providers, thereby lowering costs. Both parts of the theory behind HSAs have proven false (1, 2).

What Does An HSA Plan Look Like?

HSA-compatible high-deductible insurance plans trade a small reduction in premiums for a significant increase in the plan's deductible and other cost-sharing (e.g. co-pays and co-insurance). Funds deposited tax-free in the HSA can be used to pay out-of-pocket costs. Once HSA funds are depleted, the individual is responsible for paying all costs until the deductible is reached. After that, the insurance coverage kicks in, but often still requires significant patient outlays for cost-sharing and uncovered services. The rules about what HSAs can cover and what expenses apply to the deductible are so complicated that Bruce Bodaken, CEO of Blue Cross of California, stated that he can't understand his own plan.

For patients who have low or no health spending in a given year, HSAs allow the benefit of a slightly lower premium. Additionally, the funds in the HSA are sheltered from taxes (benefiting those in higher brackets most) and unspent funds (less management fees) roll over each year, becoming a small additional retirement account.

Patients with a serious injury, illness or chronic disease, however, will rapidly deplete their HSA savings. They will face the full brunt of the skimpy benefits of their HDHP (both in deductible and co-insurance, which at a typical level of 20% of hospital and physician costs, could quickly bankrupt a middle-class family). Thus, "consumer-directed" health care intentionally shifts costs (and risk) from insurers to

patients. Already, 40 percent of Americans aged 18-65 (77 million) report problems with medical debt and reduced access to health care due to debt and costs. Half of all personal bankruptcies are related to medical bills and injury.

Why HSAs won't work:

* **Health care doesn't work as a "market."** Economists have concluded that medical care does not and cannot work like a market; it works like a public good. Patients don't decide what to "buy," they rely on doctors and nurses to guide treatment decisions, and hospitals to have all necessary personnel, equipment, and supplies at the ready. The information to compare prices and quality (such as when car shopping) does not exist and would be extremely unreliable anyway, since the easiest way for a provider to improve quality and lower price would be to shun the sickest patients. Finally, patients are poorly equipped to "shop around" for health care at the time in their life they are most vulnerable and in need of guidance and compassionate care (3).

* **Health savings accounts will not control costs.** Each year, ten percent of the population accounts for 69 percent of health spending. HSAs do nothing to control costs for these patients, they merely shift costs from the insurers to the patient (4,5).

* **Financial disincentives lead to rationing, discourage prevention, and result in worsened health outcomes.** Exposing patients to high out-of-pocket costs leads to rationing based on ability to pay. Studies have shown that increasing out-of-pocket expenses causes patients to forego needed primary and preventive care. It worsens health outcomes, particularly for low income patients and those with chronic illnesses such as high blood pressure (6,7,8).

* **HSAs will do nothing to reduce the number of uninsured.** Since the primary difference between an HSA and a regular savings account is that the HSA income isn't taxed, the only attraction of an HSA is its tax-deductibility. More than half of the uninsured have no income tax liability. In addition, skimpy HSA-compatible plans still have high premiums. A recent study estimates that widespread implementation of HSAs will reduce the number of uninsured Americans by less than 100,000 (9).

* **HSA plans increase administrative costs.** Administrative bloat and bureaucracy already consumes 31 percent of our health spending, hundreds of billions of dollars in waste each year. HSA plans, which require the tracking of all out-of-pocket spending by each patient, their HSA corporate manager, and their insurer will only increase these costs (10).

* **Patients are left exposed to massive debt.** Those experiencing an illness or injury find will themselves exposed to high out-of-pocket costs through the required deductible, co-payments co-insurance and uncovered costs. Many patients have been bankrupted well below the "catastrophic" thresholds outlined in some plans (11).

* **HSAs deplete funds from the insurance risk pool.** While the poor and sick quickly deplete their HSA funds each year, the rich and healthy retain their unspent money which would have previously gone to subsidize care for the sick. These health dollars are effectively removed from the system and will need to be replaced by cutting costs or raising premiums. Furthermore, as the subsidy of healthier patients disappears, the stability of insurance plans as a whole are threatened (the "death spiral")(12).

* **Patients with experience with HSA plans are dissatisfied with them.** A June, 2005 study by the pro-HSA consulting firm McKinsey & Company found that most (56 percent) of patients with HSAs are less satisfied with them than with their previous health plans. In some companies, as many as 75 percent said they were dissatisfied with their HSA-compatible plan (13).

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