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HEALTH SAVINGS ACCOUNTS: THE FUTURE OF HEALTH CARE FOR KANSANS

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There is a crisis of rising health insurance premiums that are straining workers' budgets and forcing many to forego health coverage. Recent estimates by the Census Bureau claim that 45 million Americans lack health insurance — accounting for 15.6 percent of the population. In Kansas the picture is somewhat better than the national average with about 10.7 percent of the population uninsured.[1] Yet, this still means that more than 291,000 Kansans lack health coverage.[2]

Additionally, there is a consumer backlash against the rationing of care by third parties, such as managed care providers. Partially because of this, many economists and health care experts predict that consumer-driven health insurance plans will soon replace managed care as the next big health insurance initiative. Consumer-driven plans may account for as much as half of the market for employer-sponsored health insurance within the next few years.[3] This is a truly amazing development, considering that a couple years ago only about one percent of U.S. workers were enrolled in these plans.

The Problem With Health Care

People first began receiving health coverage as a "noncash" benefit during World War II because of wage controls in place at the time. A few years later Congress essentially codified the role of employers as sponsors of health plans when it confirmed that health insurance was exempt from taxable wages.[4] The result is that many workers receive tax relief worth up to 40 cents or more for every dollar they spend through employer plans, but no tax benefit for funds paid for individual insurance.[5] The same has been true of funds used to pay for incidental medical needs. As a result, coverage received in lieu of wages is more affordable than using after-tax wages to purchase health insurance.

This explains why approximately 88 percent of Americans with private health insurance are insured through their jobs.[6] Thus most Americans today are paying third parties to manage all their health care spending — including routine medical care.

Unfortunately, this has created a whole set of problems, including wasteful utilization, rising prices, fewer choices and, in many cases, rationing of care. From the standpoint of health economists, the essential problem in health care is too much third-party payment. Third parties — government, employers or insurance companies — pay for about 85 percent of all health care received today. The proportion of health care paid directly by consumers has been falling for years:[7]

- In 1960, consumers paid about 50 percent of health care directly.
- In 1980, the proportion of health care costs borne directly by consumers had fallen to about 24 percent.
- Today, consumers pay about 15 percent of health care costs.

Most of the funds consumers pay directly for health care purchase over-the-counter (OTC) drugs, vision care, dental care and cosmetic surgery such as Lasik. Unfortunately, because of third-party payments most medical services are free (or cost little) at the point of service. Consequently consumers and doctors have the incentive to use as many services as insurers are willing to pay for. In other words if consumers only pay 15 percent of medical costs directly, they have an incentive to consume care until the last dollar spent is only worth 15 cents to them. From an economic standpoint, this is very wasteful. Patients would consume fewer medical services, and pay less for health care in the long run if most incidental medical services were paid out-of-pocket.[8]

An additional problem with giving more control to third parties is that consumers have fewer choices.[9] Our current system of health coverage functions like an "all you can eat buffet" that isn't of our choosing. An employer contracts with a managed care organization to select the medical menu, pay the tab and tell us how much we're allowed to consume.

When third parties control our health care dollars, medical care will always be rationed. For instance, managed care was supposed to counter the tendency to over-utilize care by telling patients which medical services they needed and could have. This attempt to control the amount of medical services consumed resulted in a backlash from consumers.[10] Third parties also have higher overhead and administrative costs since many of their procedures are designed to ensure that only appropriate care is given and claims are not fraudulent.

Finally, too much payment by third parties reduces patients' ability to express preferences and make the tradeoffs that are common when purchasing other types of goods and services. Third-party payments also create moral hazards.[11] This is another way of saying that consumers do not bear the burden of their own poor lifestyle choices.

For instance, those that choose to smoke or engage in other types of unhealthy behaviors generally do not pay more. Consequently, they have few incentives to change their behavior. Likewise, people with first-dollar coverage for medical care and prescription drugs are not penalized for wasteful spending on unnecessary physician visits. Nor are there incentives to choose low-cost generic drugs over name-brand drugs.[12] Thus, we all have little reason to be prudent consumers of health care.

Why Health Costs Rise[13]

Prices for medical services have been rising faster than prices of other goods and services for as long as anyone can remember. A primary reason why health care costs are soaring is that most of the time when we enter the medical marketplace as patients, we are spending someone else's money. But not all health care prices are rising. Although health care inflation is robust for those services paid by third-party insurance, prices are rising only moderately for services patients buy directly. For example, the real (inflation-adjusted) price of cosmetic surgery fell over the past decade — despite a huge increase in demand and considerable innovation. Despite the quadrupling of the number of surgeries over the past decade or so, cosmetic surgeons' fees remained relatively stable. For instance, the average increase in prices for medical services from 1992 through 2001 was 47 percent. The increase in the price of all goods, as measured by the consumer price index (CPI), was 26 percent. Cosmetic surgery prices went up about 16 percent. Thus while the price of medical care generally rose almost twice as fast as the CPI, the price of cosmetic surgery went up less than two-thirds as much. Put another way, while the real price of general health care rose, the real price of cosmetic medicine fell.

What explains this price stability? One reason is patient behavior. When patients pay with their own money, they have an incentive to be savvy consumers. A second reason is supply. As more people demanded the procedures, more surgeons began to provide them. Since almost any licensed medical doctor may obtain training and perform cosmetic procedures, entry into the field is relatively easy. A third reason is efficiency. Many providers have operating facilities located in their offices, a less expensive alternative to outpatient surgery at a

hospital. Surgeons generally adjust their fees to stay competitive and usually quote patients a package price. Absent are the gatekeepers, prior authorization and large medical office billing staffs needed when third-party insurance pays the fees. A fourth reason is the emergence of substitute products.

Patient control fosters patient responsibility

If patients controlled a portion of the money used to pay for incidental medical services and benefited from any money saved, then the incentive to waste medical dollars would be sharply reduced. Research on this concept began several decades ago. The RAND Corporation performed a series of health insurance experiments in which they provided randomized samples of participants with different levels of health care deductibles and cost-sharing. Those with higher co-pays and levels of cost sharing consumed about 30 percent less health care annually with no ill effects on health.[14]

With experiments like these it became increasingly clear that the key to improving health care and holding down prices is getting consumers involved in decisions regarding their own care. This explains why in a recent poll, two-thirds of the members of the National Association of Business Economics (NABE) said that consumer-driven health insurance is either very important or extremely important.[15]

One of the ways employers are attempting to connect employees with decision-making is through defined contribution health insurance.[16] Employers "define" their contributions while employees choose among the types of policies they purchase. An employee wanting a richer benefit package might have to contribute additional money out-of-pocket to cover the cost. On the other hand, employees choosing less expensive (high-deductible) health plans might have funds left over to deposit into a personal health account, such as a flexible spending (FSA) or a health savings account (HSA). This works because high deductible policies are less expensive than policies offering first-dollar coverage. Funds placed in an FSA or HSA are used to pay for incidental health care needs up to the level of the health insurance policy deductible. Employees also may shore up these accounts by depositing additional funds into them tax free.

How HSAs Work

HSAs are the most flexible, consumer-friendly accounts yet devised.[17] They allow individuals and employers to make deposits each year equal to their health insurance deductible. The health insurance policy that must accompany an HSA is required to have an overall deductible of at least $1,000 for an individual or $2,000 for a family policy. A typical plan will work like this: When individuals enter the medical marketplace, they will spend first from their HSA. If they exhaust their HSA funds before reaching the deductible, they will then pay out-of-pocket. Once they reach their deductible, insurance pays all remaining costs. Unused funds roll over each year for use in subsequent periods. These balances remain the property of the account holder until they are used. Annual tax-free deposits to an HSA cannot exceed the amount of the health insurance deductible, and typically cannot exceed $2,600 for individuals and $5,150 for families.[18]

HRAs

Health reimbursement arrangements (HRAs) are another type of personal account from which employees can pay directly for their medical care.[19] A June 2002 Internal Revenue Service (IRS) revenue ruling clarified that HRA funds can roll over each year and grow tax free.[20] Like HSAs, the accounts are not a taxable employee benefit and employers' contributions are tax deductible. Employers have great flexibility in designing plans to meet their employees' needs. An employer can place a uniform amount into every employee's HRA, which the employees use to pay medical expenses.

Indeed, employers can tailor benefits to suit different types of employees' medical needs. For instance, to encourage employees to seek preventive care, employers can stipulate that a portion of the HRA is forfeited if not used within the year. However, HRAs only allow employer contributions. Employees may not contribute to HRAs either directly or in lieu of wages.

If an employer's HRA plan is set up to allow it, employees have post-employment access to accumulated funds to use for retirement health benefits. However, many plans do not allow employees to access accumulated funds once they leave the employer. An HRA can also never be "cashed out," with accumulated balances used to purchase non-medical goods.[21] These restrictions most likely reduce employees' willingness to economize since unused funds are not seen as valuable as cash and may benefit the employer rather than the thrifty employee.

Ownership Society: HSAs for Families

It is better to own than rent. Yet traditional health insurance is like renting health coverage: A person pays monthly premiums to a health plan in return for access to medical services throughout the annual policy period but accrues no equity. Funds not used in a given year cannot be rolled over for use in future periods when health needs may be greater. Consequently, patients often do not benefit financially for prudent use of medical services. Leaving a job often means workers must buy insurance in the individual market where rates are based on expected costs. If workers retire early or leave to start your their business after reaching middle age they will find costs are high. The fact that a worker — while young and healthy — may have paid contributions for 20 or 30 years and used few services does not translate into affordable coverage once that person leaves their employer's risk pool.

Contrast this bleak scenario to HSAs, which are like owning one's own health plan. HSA balances belong to the individual account holders and remain theirs if they switch jobs, become unemployed or retire. The funds can be used to pay expenses not covered by insurance, insurance premiums during unemployment and health expenses during retirement. In the event of death, HSAs may be bequeathed to a spouse — like an IRA — or to other heirs.

Balances remaining in an HSA at the end of the year are rolled over tax free for use in subsequent years. The account balances can earn interest or be invested in stocks or mutual funds where they will grow tax free. Thus, a young person could possibly accumulate hundreds of thousands of dollars by the time he or she retires.

Consider an example of a male worker with employment-based health insurance for about 15 of the past 19 years. Employer and employee contributions totaled about $30,000 during the coverage periods. Total medical expenses covered by health insurance have been no more than $1,000. Non-covered, incidental medical costs of about $2,000 were paid out-of-pocket.

What this means is that 15 years worth of health coverage cost $30,000 and only returned $1,000 in covered medical benefits. It can also be argued that health coverage also allowed the worker a measure of "health security" that is difficult to quantify. How much is this fuzzy concept of health security really worth? A way to estimate it is to calculate how much it would cost to purchase inexpensive, high-deductible health insurance and put the balance of funds into a personal health account such as an MSA or HSA.[22]

To analyze this scenario one must understand that some portion of insurance premiums go toward underwriting actual risk. A second portion of insurance premiums are essentially pre-payment for medical services that workers expect to use. The remaining portion is a cross-subsidy to others. This is due to the fact that people expecting to use more medical care than they pay in premiums experience a net gain. On the other hand, to the extent that our hypothetical worker's expected medical costs are lower than the premiums paid, our worker creates a cross-subsidy that benefits other patients in his health plan.

A good rule of thumb is that insurance policies with high deductibles of $1,500 to $2,500 generally cost about half as much as policies that range from first-dollar coverage to nominal deductibles of $500 per year. This would suggest that insuring against catastrophic events that were

unlikely to occur (e.g. pure insurance) has cost our worker no more than $15,000 over the past 19 years. The true total is likely much lower given that the $30,000 paid only resulted in $1,000 in covered medical expenses. The balance between what our worker received in care (~$1,000), and what represents underwriting actual risk (<$15,000) is the portion of his premiums that were lost to inefficiency, bureaucracy, over-utilization by co-workers and cross-subsidies to those who were benefiting from his largess. Rough estimates suggest that our worker could have accumulated $14,000 dollars over the course of 19 years. To calculate what our worker really lost, take the net present value of yearly contributions (minus medical expenses) over the past 19 years. Multiply these by annual values representing a middle-of-the-road investment fund consisting of 50 percent stocks and 50 percent bonds. The average annual rate of return on this hypothetical HSA was about 5.4 percent. The bottom line is that had our worker started out with a HSA in his first job, and kept it during his entire career, he would now have nearly $30,000 in an account that he owns and controls. When the worker projects and deducts an increasing yearly amount for medical needs as he ages, the worker could have had a balance nearing $100,000 by the time he reached 55.

Despite the fact that the worker was a very profitable customer of his health insurers for the past two decades, he can expect no sympathy as he ages and his medical costs rise. When the worker began his career nearly 20 years ago, HSAs were not in existence. The law allowing funds to accumulate tax free in an HSA only became effective on January 1, 2004. As it now stands, the worker has nothing to show for all the 15 years he made contributions into his respective employers' health plans.

HSAs For State And Local Employees

State and local government workers enjoy generous health plans when compared to private industry workers. According to the Bureau of Labor Statistics, the proportion of compensation spent on health benefits was 50 percent greater among state and local government workers compared to those in private sector. In fact, the average cost of health benefits per hour is more than double that of workers in the private industry.

For example:[23]

- The average cost of health benefits per hour of compensation for all state and local government workers was $3.38 in 2004.
- This accounts for 9.9 percent of their total compensation.
- By comparison, the average hourly cost of health benefits for private industry workers was only $1.54.
- This is only 6.6 percent of total compensation.

Experts claim the high cost of health benefits strains the budgets of many state and local governments.[24] In reality, it is the workers who suffer in the long run. This occurs because workers themselves are paying the high cost of their health benefits both directly and indirectly through reduced wages. Excessive health benefits are inefficient in other ways. Some workers may prefer fewer health benefits in return for increased cash wages. For these employees, excess funds spent on health benefits are not an efficient form of compensation since they would prefer more cash instead of more health insurance.

The solution is to let these workers express their preference while giving them an incentive to be wise consumers of health care and allowing them more control over how they spend their own money. Workers with greater health needs or those merely wanting more health services could use funds set aside in their HSA. Those wishing to do so could add to the HSA funds tax free for use during the year or later in life. Employees wishing to cash out some of their benefits and take funds as compensation could do so after paying a penalty equal to the taxes they would pay on cash wages. Most employees would roll over a portion of the funds each year for future use.

HSAs For Medicaid Beneficiaries

Medicaid, to put it simply, is an unsustainable program. Kansas and most other states are struggling to counter low-quality service and rising costs. Indeed, Medicaid costs are expected to overcome all other areas in the budget if left unreformed.[25] On top of this, federal officials are moving to become more stringent with how their portion of Medicaid funding – roughly 60 percent – is delivered and President Bush is expected to announce across-the-board cuts. Kansas has to begin thinking differently about how Medicaid operates if it is to remain viable going forward.

Fortunately, some states have already begun this process and Kansas policymakers can utilize their experience in crafting reform here. A few years ago, for example, Arkansas, Florida and New Jersey began experimenting with what is referred to as Cash and Counseling.[26] In this program, certain Medicaid recipients were offered the chance to control a portion of the dollars spent on their non-health care needs. These recipients were mainly allowed to choose their home care providers and control the funds that paid them. These experiments worked well since patients had greater choice over their providers and the providers looked to the patients as customers, rather than to the state.[27] Now, about half of the states have received waivers from the Department of Health and Human Services for similar demonstration projects.

According to The Heritage Foundation's James Frogue, "The initial successes of the Cash and Counseling experiments explode the myth that Medicaid beneficiaries are not capable of making their own decisions. In fact, it shows just the opposite: They can, they want to, and — once given that chance — do a very good job of it. This is amply demonstrated by satisfaction rates with the program that approach 100 percent."[28]

It is time to expand experiments like these and create similar programs that allow certain Medicaid patients to control a portion of their health care dollars. A type of unqualified HSA (or HRA) might accomplish similar results if applied to those Medicaid recipients with certain chronic conditions. These are precisely the patients whose medical conditions generate the highest costs and who would benefit from enhanced disease management. Conditions such as diabetes and asthma often lead to higher medical costs if patients do not adhere to treatment protocols. These plans would not need to meet IRS requirements to qualify for tax deductions, since most Medicaid enrollees have little, if any, tax burden.

Florida, New Hampshire and South Carolina are already in the early stages of implementing such an approach. Under Florida's plan, counselors assist Medicaid recipients in choosing benefit packages that best meet their needs from among a host of providers. In fact, the program essentially allows participants to "opt out" of Medicaid by purchasing private coverage with their state-paid premium. Health care providers will create benefit packages falling into a combination of three components: basic care, catastrophic care and flexible spending. Participants — with the help of choice counselors — will choose the plan that best meets their needs.[29]

A principle of economics suggests that people are capable of innovative solutions when it is in their best interest to do so.[30] This also means that people will do little without the appropriate incentives. This explains why past attempts to get insured patients to minimize costs have failed miserably. The reasons are obvious. The benefits of thrifty behavior accrued to a third party. To induce people to economize and lower costs for the program, they must be given a stake in the outcome. Depending on how the plan is structured, patients holding down costs by avoiding unnecessary emergency room visits (or achieving other measurable goals) would enjoy a financial reward. Failure to allow enrollees to benefit financially from their efforts to save money would give them little incentive to participate.

How Well Have Consumer-Driven Health Plans Worked?

Data are emerging on how well consumer-driven health plans have performed. Early analysis of medical savings accounts (MSAs), the forerunner of HSAs, provides evidence of how the right incentives lower discretionary spending.

For instance, a recent study published by the National Center for Policy Analysis on MSAs in South Africa found that for those enrolled in the plans, discretionary spending (primarily outpatient spending) was 47 percent lower.[31] Individuals with an MSA were also much more likely to purchase a generic equivalent rather than a name-brand drug. By contrast, prescription drug spending by members increased 7.1 percent and the number of prescriptions filled per month grew 19.1 percent after the patient reached the policy deductible and were essentially spending insurance company funds. Once patients were spending insurance company funds use of brand-name drugs jumped 45 percent.[32]

Closer to home, a survey by Aetna of almost 13,500 members with HRAs found that members in their plan (called HealthFund) performed very well compared to a match set of non-HRA enrollees.[33] Employers offering HealthFund as an option experienced very modest increases of 3.7 percent in medical costs, compared to almost 16 percent in populations with similar demographics and more than 14 percent for Aetna's PPO plans. One HealthFund plan sponsor with "full replacement" actually saw costs fall 11 percent. HealthFund members decreased the number of overall prescriptions 6.5 percent and increased the proportion of generic medications they used almost 13 percent, which drove down pharmacy costs 11 percent. Half of the members had funds left over at the end of the year to roll over into the next calendar year — averaging 31 percent of their funds.

An additional benefit is that those enrolled in HSAs and HRAs tend to participate in more preventive care than a control group. This is probably because any savings accrued from prevention are captured by the enrollee. Traditional health insurers are reluctant to invest in preventive care since benefits might not be realized for years — often by another insurance company. Case in point:

- Adult Aetna HealthFund enrollees increased their preventive exams 23 percent.
- Outpatient cases fell 14 percent, primary care visits decreased 11 percent.
- Yet inpatient admissions only fell 5 percent, specialty visits only fell 3 percent and emergency room visits only fell by one percent — numbers that suggest people still obtained necessary care.

Answering the Critics

Some critics of personal health accounts argue that they will experience favorable selection by appealing only to the young, healthy and wealthy — leaving the poor and sick in traditional risk pools whose cost will rise.[34] However, preliminary data from Aetna has shown that the age distribution of those enrolling in their plans resembles a bell-shaped curve. In fact, the average age of HealthFund enrollees was slightly older than for other plans, not lower as critics might suggest. Overall, about two-thirds of HealthFund enrollees were between the ages of 35 and 55.[35]

These plans also enjoyed a high degree of customer satisfaction. Ninety percent of those enrolled in the plans reportedly were satisfied with their choice and were likely to renew for the following year.[36]

In conclusion, giving employees more choice and control over their health care makes good sense. It leads to lower costs and more control over the kinds of care they prefer.

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Notes

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