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Health Savings Accounts: A Band-Aid for a Gapping Health Care Wound

Introduction

One of the new ideas coming from the current federal administration that seeks to curtail health care costs is the idea of Consumer –Driven – Health Care (CDHC). This idea is really not new, and it flows from a program enacted under the previous Clinton administration. The idea works on a simple business principle: if the individual has the ability to exert more control over personal health care spending, to choose their own provider, to choose their own insurance, insurance agencies would have to compete for their business. If the agencies compete, the outcome will be increased and improved health care services. In turn, the “new and improved” services would slow the skyrocketing costs of health care. As with any theory, there should be attempts to prove the outcomes before implementation. Despite the lack of evidence, CDHC is being implemented. Implementation ranges from the government Medical Savings Accounts (MSA), to Health Savings Accounts (HSA) used by both small businesses and large corporations as a cost savings measure. Little evidence exists that demonstrates that the plans will benefit low-income workers or improve care for the growing number of uninsured workers. The purpose of this paper is to explain the MSAs, HSAs and to

discuss the impact of the plans on the health care system and the consumer, particularly low –income workers and the uninsured.

Consumer Driven Health Care

Medical Savings Accounts (MSA), signed into law in 1997, were created as a demonstration project under the Balanced Budget Act. Demonstration projects are established to meet general goals and objectives of a new social program. These projects focus on new approaches to solving a problem and if successful, additional programs may be funded. MSAs are specialized savings accounts into which consumers place pre-tax dollars for use in paying medical expenses. Individuals can then purchase a less expensive catastrophic health insurance policy instead of a comprehensive health insurance or a managed care plan (Kongstvedt, 2001).

Under the demonstration project, the rationale for MSA plans were to eliminate the “first dollar” coverage by a third party and thereby make individuals more prudent purchasers of health care (Kongstvedt, 2001, p. 660). Under the demonstration, the government planned to enroll select Medicare beneficiaries in a MSA plan with a high deductible plan (M+C) (IRS publication 969). To be qualified under this program, a person would have been eligible for Medicare, must have a high deductible health plan with a high deductible approved by Medicare, the deductible cannot be less than \$1,500, and the deductible in the year 2000 cannot be more than \$6,300. The annual out-of-pocket expenses cannot exceed \$3,100 and the person must have a trustee or custodian account. Medicare would make a tax- free contribution to the individual’s MSA and pay a monthly premium for the health insurance policy. Interest earnings would be tax- free and any unused amount would be accumulated. However, withdrawal for reasons other

than medical expense would be subject to a 50% penalty (Hau, 2001). This author could find no evidence in the literature of any additional programs funded under the project.

Also under this project, if a person is employed by a small employer (50 workers or less in the past 2 years when the MSA starts) or is self-employed, an MSA could be put in place. The employee would have a High Deductible Health Plan (HDHP), otherwise known a catastrophic plan with minimum and maximum deductibles and maximum out-of-pocket restrictions of \$1,550 and \$2,350 for an individual and \$3,100 and \$4,650 for a family. The maximum annual out-of-pocket expenses would be \$3,100 for an individual and \$5,700 for a family. The account is set up as a trust or custodial account with a qualified financial institution. The employee could not have insurance plans other than an HDHP, except for dental, vision, long-term care, workers' compensation, and/or specific disease plans. Contributions could be made to a trustee, who could be a bank, an insurance company, or any other parties approved by the IRS. Contributions made by employers are tax-free and employee contribution is tax deductible (Kongstvedt, 2001).

One study which analyzed the health insurance cost data from Ohio public employees and 27 Ohio private firms that adopted MSAs under the demonstration project, showed that Ohio public employees could reduce their health insurance costs an average of 12 percent for single coverage and 34 percent for family coverage with MSAs compared to traditional plans. The study concluded that the MSA approach rests on the correct assumption that a more market-driven form of health insurance will provide incentives that have the potential to lower costs without imposing added controls on consumers and providers (Bond, M.T. , Heshizer, B.P. & Hrivak, M.W. , 1997).

According to Battistella (1999), after a comparison of regular employment-based insurance with MSAs, MSAs are practical and cost-effective for employers and workers. MSAs would allow consumers to put money they do not spend on health care directly into their retirement accounts. Battistella speculated that this plan would curtail rising health care costs. Other proponents of MSAs speculated that the MSA/high deductible product would sell so well that the cap (number of programs allowed under the demonstration) would be reached on participants in such plans. However, despite the availability of the product, response to the project was modest. Supporters of the plan blamed the demonstration design for lack of interest in the plans and continued to advocate that MSA products be available to all employees and individuals (Kongstvedt, 2001).

In 2003, supporters of such plans got their wish. New health savings account legislation was signed into law by President Bush on December 8, 2003 (HR 2351). The new Health Savings Accounts (HSA) have some aspects of the old MSAs but now almost everyone qualifies for the new plan. HSAs are a tax-sheltered savings account similar to the IRA (Individual Retirement Accounts) with the savings earmarked for medical expenses. Deposits are 2005 tax deductible for the self-employed and many others under the new legislation. The money can be used to pay routine medical bills with tax-free dollars. Larger medical bills would be covered by a low-cost high deductible health insurance policy. Monies not used stay in the account and continue to grow. With this plan, HSAs when combined with the required low-cost high deductible health insurance policy are designed to replace high cost traditional health insurance policies. The idea is

to restore a higher degree of freedom of choice without the restrictions of many HMO (Health Maintenance Organization) type plans.

One major flaw of the plan is that fewer than 0.5% of the 125 million Americans covered by health insurance at work can participate. A national benefits consulting firm predicts that only a million more employees will join the HSA eligible ranks in 2005. Unless employers who are trying to reduce spiraling health care costs are willing to give generously to the employees' HSAs, movement to HSAs is likely to result in a way to decrease front end coverage. Workers who were accustomed to small co-payments are unlikely to embrace a plan with a \$2,000.00 deductible. Healthy employees may see the plan as another way to save pretax money for future expenses. However, health care costs have been growing far faster than investment returns. Consequently, money set aside for future health care costs cannot keep up with the real cost of health care (Cropper, 2004)

Another drawback of the plan is that if one is not a big spender in health care, an HSA may lower insurance premiums, but, if one has higher or more medical bills, you would be better off staying with traditional plans. According to Herzlinger in Feldman & Carbonara (2004), the government has at least three roles to play in CDHC. First, the government should act as a type of Securities and Exchange Commission for the health care industry, requiring transparent pricing and keeping public lists of the best and worst physicians, hospitals and treatments. Second, Herzlinger believes the government should require all citizens to have a high-deductible, low-cost catastrophic health care policies and should subsidize individuals and families who cannot afford the insurance. And

finally, the government should protect the sickest people. Since these three governmental roles are not part of the current plan, HSAs may just be a Band-Aid on the continued gapping wound in the current health care system.

Discussion

The purported cost saving areas of the current HSAs are unclear. Traditionally, in US health care, costs are simply shifted to someone else. CDHC may be another method to shift the costs where companies can pass the burden of rising expenses to the employees (Feldman & Carbonara, 2004).

Before the plan was enacted in 2003, a study was conducted by Zabinski et. Al., (1999), who found that despite a small positive gain in benefit from MSAs, there was a substantial variation across families in the gains and losses associated with the reforms. The data suggested that families losing the most from reform tended to be poorer. Families with a high risk for medical expenses had to chose between higher premiums or taking a higher financial risk. In both cases they were worse off compared to pre-reform plans.

The federal and state governments are already looking for ways to shift the costs of Medicare and Medicaid programs. The shift leaves open the major question of what will happen to the 80 million individuals currently covered by Medicare and Medicaid. The additional 45 million uninsured citizens also adds potential flaws in the CDHC plan. The government would have to balance the load for insurers by shifting money from

insurers with the healthiest patients to those with the highest risk. Finding support for such measures in the current political arena, which does not favor any government –based health care reform, is not likely (Feldman & Carbonara, 2004).

In the 1980s, employers embraced health maintenance organizations (HMOs) and other managed care plans as a solution to rising health care costs. But the backlash from the public forced companies in the 1990s to ease managed care restrictions and replace the HMOs with plans that were less restrictive. As a result, the inflation of medical costs returned to unbearable levels for the employers who began to search for other alternatives (Kongstvedt, 2001). HSAs appeal to healthy and more affluent families who opt for lower monthly premiums. The gamble is whether they can pay for out-of- pocket expenses if they are ill. The less healthy families would remain in traditional plans, causing the costs of such plans increase dramatically (Gleckman& Woellert, 2004).

The families who stay in the high deductible plans will be able to shop around for higher quality care that they can afford rather than staying in a managed care system. This presents the problem of how the consumers will handle their new medical spending power. Will the consumer stop wasting money on unnecessary care or spend more money as they use new buying power in the health care arena. Of greater concern is the risk that the public will scale back on care that is essential to the foundation of good health. This could leave Americans sicker and their eventual treatment more costly. In West Virginia, the top chronic conditions are heart disease, respiratory disease, diabetes, and cancer (WV 2010, 2001). Each of these disease processes is costly to treat.

Health care savings generally come from health promotion and prevention practices. For example: In order to keep an individual's cholesterol and blood pressure under control, and to reduce the progress of heart disease, developing healthy habits and taking appropriate medications is less expensive than a cardiac catheterization, and cardiac catheterization is less expensive than cardiac by-pass surgery. If the costs of medications are high and the individual is paying out-of-pocket for the expense, the likelihood of adherence to health promotion and prevention diminishes. Individuals with a high deductible may choose to wait until they can afford to have a cardiac catheterization, but they may end up instead in the emergency department requiring surgery for a cardiac by-pass. The insurance company then has to pay the much higher costs and the provider and hospital will most likely not be able to recover the deductible.

Low-income workers with these chronic diseases are put at higher risk and may not opt to seek preventative or maintenance care due to the high deductibles. Individuals have a tendency to forgo treatment if they have to pay for it out of their pockets, especially low-income workers who have limited amounts (if any) of monies in their HSAs.

One of the biggest concerns is that HSAs will separate the healthy from the chronically ill and undermine the already faltering risk-pool of traditional insurance. States are already discussing the removal of safety nets in the Medicaid plans to save costs. If there is no subsidy from non-users in the traditional plans, the policies become more expensive and the more vulnerable population will have to pay the highest premiums. Middle class families making \$45,000 annually, most likely cannot afford to put aside thousands of dollars to cover high deductibles. Many may have to choose

between their retirement plans and HSAs. Low-income families and the working poor already have financial problems due to the high cost of housing; unless the government puts money in HSAs for them, they will continue to be underinsured or uninsured.

Rackner (2005) sums it up best when she states, “ Asking consumers to drive their health plans” is like asking blind people to become NASCAR drivers (p. 30). It is almost impossible for consumers to compare health care costs and maneuver through the health care system. Nevertheless, she asserts that consumers can collect information about costs and quality that will lead to informed choices on best health care value.

This author, a health care professional, recalls how difficult it was to navigate through a family member’s illness in managed care. Add to that difficulty, trying to figure out the cost, how far can one travel for lower cost, and what is the quality of the care, would lead anyone to have difficulty making health care decisions. Imagine trying to make those decisions when you are seriously ill. Some people especially in the poor and low-income groups have low literacy and poor social skills. It is difficult if not impossible for these families, who may not have a telephone much less a computer, to compare, contrast, and perhaps negotiate costs.

When any family, regardless of their financial status, faces a crisis such as a traffic accident that requires extended hospitalization and rehabilitation, HSAs are less attractive. In this case, a significant cash flow problem occurs. The lower the family income, the less likely the family will be able to handle the risk. In addition, now that the family is no longer “healthy” they may not be able to transfer back into a traditional health policy with low deductibles. The transfer decision is up to the employers who may

no longer offer the traditional plans to employees due to the increase in the costs of providing the programs.

Another potential problem, not mentioned in the literature, is the effect of tax savings plans on charitable donations. Families only have so much money no matter what their income level. If a family tries to fund a retirement account and HSAs, the tax savings may supercede that of charitable donations. “Paying oneself first” leaves open the question about the eventual affect on donations to charitable organizations. Charitable organizations are often the sources of funding for free clinics, community outreach services, and other programs that serve the underinsured and uninsured. Under the HSA plan the Kaiser Foundation predicts another 1.8 million citizens will be added to the roles of the uninsured. With the potential for less services, the question will be , “who will provide health care for this population?” The gap in the health care wound will continue to become larger.

In the President’s agenda for the 109th Congress, creation of HSAs is accompanied by the creation of some tax credits for the purchase of long term insurance for lower income families, entrepreneurs, and small business owners. Also included would be incentives for enrolling children in public heath care systems (Towers, 2005). This may be a problem in the 1990s since most states have stripped the public health system to the minimum or closed the sites. There also are some unclear provisions regarding safety net legislation for increased access to rural and underserved population which would include making prescription drugs more affordable. The president proposes to open community or rural health centers in every poor County in America (Towers,

2005). However, most of the items leave concern regarding funding of the projects since most of the agenda is now focused on the war on terror, spreading democracy, and changes in Social Security. No real plan exists for the reform so badly needed in the health care system of the United States. The longer reform is delayed, the larger the wound.

Conclusion

CDHC may provide tax relief for some families. Companies may benefit from the plans through lower costs for higher deductible plans. Families and individuals may gain more control over their health care decisions. Yet, the long-term consequences of such plans are yet to be seen. As higher risk people move into the high deductible plans, premiums and deductibles will have to rise. The costs will have to be shifted somewhere. The CDHC could become a cover for businesses to shift a greater share of the healthcare cost to the employees. The insurance companies will have to shift the costs of care for the sicker and chronically ill clients somewhere, resulting in higher costs for both traditional and catastrophic plans with higher deductibles. The impact on providers when people start to shop around for services(if they do) is yet to be determined. The shift will open a plethora of problems related to the delineation of costs in the current system. That alone will add to the cost of health care.

A future of decreased services to lower income populations, the poor, and uninsured could lead to serious consequences in the health of the society as a whole. In the future the healthy and wealthy may be courted by hospitals, providers, and insurers

while the poor and the sick get nothing. If you have HSAs, perhaps you may not worry if you are healthy, but you have only a Band-Aid to cover the gapping health care wound.

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