Consumers Union
Nonprofit Publisher of Consumer Reports

Statement for the Record
Of

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To the Committee on Ways and Means
U.S. House of Representatives
June 28, 2006

Hearing on Health Savings Accounts

Mr. Chairman, Members of the Committee:

Consumers Union, the independent non-profit publisher of *Consumer Reports*, opposes more public expenditure of limited tax dollars on health savings accounts (HSAs).

We believe that HSAs are harmful from a societal point of view and to those who most need help with health care expenses. While some healthier and wealthier individuals may benefit from HSAs, when Federal debt is increasing roughly $1,000,000,000 a day, this is not where additional health care dollars should be spent.

The evidence is quickly mounting that HSAs are primarily attractive to upper income people and people who tend to be healthier.

The tax shelter nature of HSAs is revealed by a GAO report[1] that some people actually pay for medical expenses out-of-pocket rather than draw down their tax sheltered HSA accounts. This may or may not be good savings and tax policy for upper income people, but it has little to do with good health policy.

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Polling by the Employee Benefit Research Institute and the Commonwealth Fund[2] show that people with HSAs are

--less satisfied than those with traditional insurance coverage,

--often forgo needed care,

--may actually spend more on health care and have higher out-of-pocket costs, and

--generally have a difficult time shopping for health care (finding hospital and doctor quality and cost data).

In attachments #1 and #2, we discuss these issues in greater detail.

To throw more money at this scheme when we are facing serious cuts in successful programs like the State Children's Health Insurance Program (S-CHIP) makes no sense. We urge this Committee to resist further tax expenditures on HSAs and instead save the revenues for the kind of health care programs that Americans really want. (We note that in picking Medicare Prescription Drug Plans, a great deal has been made of the fact that seniors have preferred the plans with the lower deductibles. The Part D experience should be a lesson about how consumers clearly favor low-deductible coverage; high deductible health insurance policies are being imposed on consumers in many cases.)

So called "Consumer-Driven Health Care" is an Orwellian slogan designed to hide the fact that costs are being shifted onto the backs of consumers. And in the realm of health care, increased cost sharing means that the lower income in our society will go without—and their health and the health of their children will suffer. Instead of shifting costs to consumers when they are sick or as they age, Congress should help address the underlying causes of run-away health costs.

HSA advocates forget the core fact that governs the world of health insurance: 50% of the healthiest people use 3% of the health care dollar; 10% of the sickest people use 70% of the health care dollar. To take money out of the health care insurance system (i.e., spend less on high deductible catastrophic insurance policies) and give that cash to the healthy half of the population to put into savings accounts means that the money will not be there for the very sick who need intensive, expensive care.

For all these reasons, we urge the Committee to stop diverting money in an ill-advised experiement and return to the consideration of meaningful health care reforms and true cost containment strategies that the American public need and want.

Attachment 1, from Consumer Reports, May, 2006

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False promises: 'Consumer driven'health plans

A promotional pamphlet for a health savings account (HSA) boasts, "If you plan correctly, you may find that you spend far less for health care than ever before." True, if you could plan to avoid cancer, being hit by a car, or growing older. But you can't.

Three million Americans have signed up for high-deductible health plans, which are often paired with tax-advantaged HSAs designed to give them the funds they need to pay those deductibles. Proponents call this "consumer driven health care." They claim that patients who have to take on more of the costs themselves--annual deductibles range from $1,050 to a total deductible and costs of $10,500--will avoid unnecessary care and look for medical providers who deliver high-quality care at the lowest price, thus driving down costs. The plans are touted by some, including President Bush, as a solution for the U.S. health-care crisis, with its 46 million uninsured.

The reality is that these schemes shift increased financial risk to consumers and will surely weaken our already fragile health-insurance system. HSAs provide little assurance of affordable, quality health care to those with chronic illnesses, families with children, those of moderate incomes, or older Americans with more health-care needs. HSAs do nothing to address the factors that really drive up health costs: care for those with chronic diseases; overuse of technology; hospital care; prescription drugs; and end-of-life care.

WHO BENEFITS, WHO DOESN'T?

HSAs may benefit young, healthy workers without dependents, who don't spend much on medical care. They're especially advantageous for the wealthy of all ages, since the higher the tax bracket, the more valuable the tax break. Contributions to HSAs are tax-deductible, the account grows tax-free, and money pulled out for medical expenses is not taxed. After age 65, money saved in the account can be used for any purpose, without a tax penalty. But the income level of the vast majority of uninsured Americans prevents them from reaping those tax benefits.

A recent national survey by the Employee Benefit Research Institute, a nonprofit organization, found those currently in HSA-type plans were significantly more likely to spend a large share of their income on out-of-pocket health-care expenses than those in comprehensive plans. They were also more likely to skip or delay health care because of costs. And though HSAs work on the premise that consumers have access to reliable cost estimates and comparative information about providers, that information all too often does not exist. No surprise that the survey found those enrolled in HSAs far less satisfied than those with traditional, comprehensive coverage.

So, who, besides the wealthy, benefits from HSAs? Employers do, since they are shifting health-care costs to their employees and are more able to predict health-care expenses. And financial institutions offering HSAs are poised to reap billions in profits from the fees they can charge in setting up those accounts.

A health-insurance system can function only if costs and risks are spread among healthy and sick participants. But healthy employees who don't expect to need much medical care are the ones most likely to abandon traditional plans in favor of low-premium, high-deductible ones. Those left in traditional plans will be sicker and more risky to insure. That means a greater likelihood of steep premium increases, pricing coverage out of the reach of more workers and adding to the ranks of the uninsured.

"Consumer driven" health plans, including HSAs, abandon the premise that the community has a responsibility to care for all members. The health-care system needs fixing, but HSAs are a sham substitute for comprehensive reform.

For more on health savings accounts, go to *www.consumersunion.org/HSA*.

Commentary——Defined Contribution Health Plans: Attracting the Healthy and Well-Off[3]

by Gail Shearer

Driven by a philosophy that favors unbridled faith in the free marketplace, the year 2003 may well go down in health care history as the year that the health care system officially abandoned the premise that the community has a responsibility to care for each member, replacing it with the philosophy that individuals should each look after themselves.

The most visible change that nudges the system toward self-insurance is the provision in the Medicare bill that expands and makes permanent ‘‘health savings accounts’’ (HSAs) (formerly known as ‘‘medical savings accounts’’ or MSAs). This provision allows most Americans to set up tax-advantaged savings accounts (no tax is paid when money is paid in or when paid out, an unprecedented new tax loophole), when they also have a high-deductible health insurance policy. These new accounts are likely to favor the healthy (who stand to benefit financially from a new tax shelter since their accounts need not be depleted on health care expenses) and the wealthy (the higher tax brackets mean higher tax benefits).1 In his State of the Union address, President George W. Bush’s proposal for a new tax deduction for premiums for high-deductible policies introduced the possibility that health savings accounts’ penetration of the marketplace——and the demise of the employer based health care system——will be accelerated.2

The second development is the encroachment of so-called consumer driven health care plans (CDHC) into the employer-based health insurance marketplace. This new approach is dressed up with a consumer-friendly name, but in reality, as noted in Christianson, Parente, and Feldman (2004, this issue), this new approach is characterized by higher deductibles for employees. A more apt label, and one that seems to have been overtaken by CDHC, is ‘‘defined contribution health care.’’ As a gentle reminder to health researchers and policymakers that a consumer-friendly name should not be used to mask a marketplace change that may be harmful to consumers, I will use the ‘‘defined contribution health plan’’ (DCHP) label to refer to these new plans. ‘‘Defined contribution’’ accurately connotes limited employer liability for health care costs. ‘‘Consumer-driven’’ implies that the consumer exerts considerable control——hardly an accurate portrayal of high-risk consumers’ likely experience with a high-deductible plan.

The two studies raise red flags about the potential for these new plans to appeal disproportionately to the healthy and those with high income. They contribute to the dangerous distraction of policymakers from the goal of working toward a health care system that provides affordable, quality health care to all by spreading costs broadly and fairly across the community.

COMMENTS ON STUDY 1 (UNIVERSITY OF MINNESOTA)

Study 1 (Christianson, Parente, and Feldman 2004, this issue) considers the experience at the University of Minnesota, when 16,000 employees were offered several health insurance choices,

including policies that combine relatively high-deductible health insurance coverage, a personal care/health care savings account check, and a gap between the amount contributed to the account and the deductible, assuring that employees would face some out-of-pocket costs before their health insurance policy provided coverage. This study does nothing to make DCHP appear to be consumer-friendly and confirms concerns about what a shift toward DCHP will mean for the health care system. This section summarizes and considers some of the key findings. DCHP Appeals Disproportionately to People with Relatively High Income The average income for employees who enrolled in DCHP (and responded to the survey) was 48 percent higher than the income for employees who did not enroll in DCHP ($71,406 versus $48,148) (Christianson, Parente, and Feldman 2004, Table 1, this issue). This wide disparity lends strong support to the notion that higher-income individuals are more likely to enroll in a high deductible health insurance plan in which they could be at risk of large out-of-pocket costs before meeting a deductible.

DCHP Appeals Disproportionately to a Relatively Sophisticated Population of Faculty Members and Does Not Appeal to Union Members

Thirty-six percent of DCHP enrollees were faculty members; only 14 percent of non-DCHP enrollees were faculty members. Participants in the civil service/bargaining unit were more likely to favor non-DCHPs: 50 percent of enrollees in non-DCHPs were civil service/bargaining unit members, while only 23 percent of DCHP participants were. The DCHPs appeal disproportionately to relatively sophisticated participants (Table 1).

An Overwhelming Majority (96 percent) of Employees Favor Low-Deductible Coverage to DCHP, Based on Their Choices in the Marketplace

The low participation rate in DCHPs indicates that there is no groundswell of consumer demand favoring a health care system centered on high-deductible health insurance: 4.3 percent of the eligible population participated in the DCHP program. (This assumes that families do not have more than one employee eligible for this coverage. A total of 695 employees——349 individuals and 346 families——enrolled, out of a total population of 16,000 employees.)

The Study Design Is Inadequate to Allow Conclusions about Risk Segmentation by DCHPs

The study uses a self-reported measure of chronic illness to study the potential for risk fragmentation, and finds no significant difference among DCHP and non-DCHP enrollees. This measure is insufficient to draw a conclusion on risk fragmentation. A more in-depth measure of health care costs, possibly a time series, for all covered individuals in each family is needed. The measure used does not take into account whether employees might anticipate certain health care costs in the future (e.g., a planned pregnancy, elective surgery), which would discourage enrollment in a DCHP for fear of high out-of-pocket costs. Some health conditions might have regular costs associated with them, but respondents might not consider them to be a chronic illness (e.g., back pain) but more of a chronic condition. This is an area where further expansion of the underlying health status of respondents is critical.

The Satisfaction Level with DCHPs Is Not Impressive

While respondents in DCHPs were somewhat less satisfied than respondents in other plans (7.46 versus 7.55, on a scale of 0 to 10, 10 is best), the difference can be considered trivial even if technically statistically significant.

Internet Support Tools, a Key Selling Point of DCHPs, Were Used Only Moderately

While 30 percent of respondents in DCHPs used provider directories, only 8 percent used disease management information, and only 12 percent used pharmacy-pricing tools. These numbers do not support the premise that DCHPs mobilize employees to comparison shop and access Internet resources to manage their care and control costs.

Overall, the first study paints a picture of highly educated and high income faculty members gaming the health care system by selecting into the high-deductible plan if they believe that they will come out ahead financially. he limited measure of health status precludes drawing conclusions about the segmentation of the health risk pool, but overall there is nothing in this study to dispel the concern about risk fragmentation. Perhaps the strongest conclusion from this study is that DCHPs appeal disproportionately to highly educated, high-income members of an employee group. They appeal to a tiny portion of employees. The small fraction of employees who enroll do not make full use of the tools that they offer, and are not particularly satisfied with the plans' performance.

COMMENTS ON STUDY 2: HUMANA EMPLOYEES

Study 2 (Fowles et al. 2004, this issue) reports the results of a survey of 4,680 employees of Humana Inc., 7 percent of whom selected a new ''consumer defined health plan option'' (referred to as DCHC below). This is the epitome of a ''defined contribution health plan'': the employer would pay a fixed amount, 79 percent of the reference plan, for each employee. This study provides troubling confirmation of the potential of DCHPs to fragment the health risk pool to the detriment of the less healthy.

Those Selecting DCHP Are More Likely to Be Healthy

The study found that enrollees in DCHP were ''significantly healthier on every dimension measured.'' This study used a more comprehensive measure of health status, including measures such as reported health status, likelihood of a covered member receiving regular medical treatment, likelihood of having a personal physician, and existence of a chronic health problem. Those who selected the DCHP were less likely to have a chronic health problem (54 percent) and more likely to have had no recent doctor visits (3.07). Enrollees in DCHPs were more likely to be in excellent health (31 percent versus 18 percent) (Table 1). The study found that employees reporting that a family member had a chronic health problem were half as likely as others to select the DCHP.

Enrollment in the New Plans Was Modest

Like the University of Minnesota employees, the Humana employees did not flock to the high-deductible coverage (despite the annual premium savings of $400 per year for an individual and $1,200 per year for a family): only 7 percent enrolled in the new plan. Individuals were more likely to enroll in a DCHP than families.

Sociodemographic Findings

Those enrolling in DCHPs were more likely to be college-educated, white, male, and in positions exempt (from a union) than those who enrolled in other plans. The finding that blacks are about half as likely to enroll in DCHPs is troubling, and suggests that just as policymakers are waking up to the magnitude of disparities in our health care system, yet another policy that separates blacks (and presumably other minorities) from whites is created. Income is not listed as an independent variable, ruling out the ability to estimate the relative importance of race and income.

This study clearly demonstrates that widespread expansion of DCHPs within the employer marketplace will fragment the risk pools in the employer based health insurance marketplace, one by one. Employer-based health insurance coverage has been held up as the one place in which risk pools tended to be unified, with costs spread among employees (albeit paid directly in large part by employers). DCHP's have the potential to unravel this important risk-spreading role. This study clearly demonstrates that risk segmentation, to the advantage of the healthy and the disadvantage of the less healthy, will be a reality should the role of DCHPs expand in the health insurance marketplace.

IMPLICATIONS OF THE STUDIES FOR PUBLIC POLICY

Members of the public and policymakers should view these two studies as the proverbial canary in a coal mine. They raise red flags about the potential that DCHPs (like their cousins Medical Savings Accounts) appeal disproportionately to the wealthy and healthy. The first study shows that the income level of employees selecting DCHPs is 48 percent higher than those not selecting them. The second study finds that those selecting DCHPs are healthier ''on every dimension'' than those not selecting them. The concern that this new model of health care will appeal more to the sophisticated who can ''game the system'' and shift costs to the sick becomes greater after reviewing these studies. They should set off alarm bells about the potential long-term threat to our health care system.

The scope and design of these studies did not allow consideration of some of the most important issues that will affect the long-term impact of this new type of plan. Some important areas for future research include:

> To what extent will DCHPs merely shift cost to sicker employees, instead of truly lowering health care spending?

Over time, will sophisticated employees ‘‘game the system,’’ opting out of DCHPs when they anticipate high health care expenses related, for example, to pregnancy or elective surgery?

To what extent will employer’s health care premium dollars be diverted from paying for health care expenses to paying to build health reimbursement accounts?

To what extent do these new health plans create new financial barriers to health care for low-wage workers?

Do consumers have the necessary information about quality of providers on which to make informed decisions?

What are true consumer/employee preferences regarding deductible levels?

To what extent will the gap between the health reimbursement account and the deductible pose a financial barrier to getting needed health care?

Will anticipated cost savings occur, or will they fail to materialize since so much health spending is concentrated among those with catastrophic expenditures?

Will the new high deductibles and sense of spending one’s own money deter preventive care and early treatment for illness, ultimately leading to worse health outcomes and higher costs?

The findings from these two studies are troubling for another reason: because of the nature of adverse selection, over time, DCHPs may drive lower-deductible health insurance options out of the marketplace (Zabinski et al. 1999). Bolstered in the health care market with the enactment of the health savings account provision in the Medicare bill, in a few short years, it is very possible that unpopular high-deductible health insurance coverage will be the only choice that many employees may face for their coverage in the employer-based market. Those with high health care expenses will face higher out-of-pocket costs than they would in the absence of DCHPs. It is troubling that this type of change in the health care marketplace will take place in the absence of a public debate. Advocates of medical savings accounts, for example, maintain that there should be a choice of plans. The reality is that over time, as adverse selection pushes the next ‘‘relatively healthy’’ group toward high-deductible plans, an insurance marketplace death spiral will result and ultimately will remove the very choice (a low-deductible plan) that employees want.

Both studies contribute to the body of knowledge about DCHPs, ‘‘as a first, limited attempt to shed light on the important issues’’ (Christianson, Parente, and Feldman 2004, this issue). In considering the health policy expertise and money devoted to these studies, it is important for health researchers and policymakers to ask fundamental questions about priorities for future health research. The buzz about DCHPs in health policy circles creates a sense that valuable dollars are being spent in an effort to rearrange the deck chairs on the Titanic. More resources

should be devoted to charting the course to guarantee all U.S. consumers have guaranteed, quality, affordable health care. We should be moving full-steam toward this vision, not spending countless hours and resources analyzing new models that promise to split the healthy from the sick, shift costs to the sick, favor the highly educated and high-incomed, and grow the inequities on our system. The two studies confirm that DCHPs are a dangerous distraction from this mission; they undermine the important value of a communitywide approach to looking after one's neighbor in a health care system that would spread costs broadly in an effort to achieve affordable, quality health care for all.

NOTES

1. In addition to benefiting from a higher tax bracket (and higher tax benefit from HSAs), the wealthy are more likely than the non-wealthy to be able to risk the out-of-pocket costs of a high-deductible policy.
2. Because healthy individuals may be able to get a lower premium for a catastrophic policy in the individual market, the new tax deduction available to individuals, when combined with the possibility that employers will increasingly ''cash-out'' health benefits when the healthy opt-out of coverage, could lead to rapid erosion of the employer-based health insurance market.

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[1] GAO, "Consumer-Directed Health Plans," April, 2006. GAO-06-514.
[2] EBRI Issue Brief No. 288, December, 2005.
[3] "Consumer-Driven Health Care: Beyond Rhetoric with Research and Experience," Health Services Research (vol 39, no. 4) August 2004, Part II, pp. 1159-1166.