

Virtual Mentor

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Op-Ed

HSAs: A Great Tax Shelter for Wealthy, Healthy People but Little Help to the Uninsured, Underinsured, And People with Medical Needs

by Mila Kofman, JD

In 2003 Congress passed legislation allowing people to pay their out-of-pocket medical expenses from a tax-exempt personal account. These accounts, called health savings accounts (HSAs), can only be opened if one is already enrolled in a qualifying high-deductible health plan (HDHP). The tax deduction for annual contributions to the HSA, interest on the deposited account balances, and other earnings (dividends, investments, interest, etc) are not taxed if the account is used for qualified medical expenses.

The new “above the line” tax deduction will benefit people in the upper income tax brackets more than it will other income earners by allowing the wealthiest to decrease their taxable income. The biggest benefit comes when the money in the HSA is not spent and grows, tax-free. Transaction and set-up fees charged by the financial institutions that manage the accounts are high [\[1\]](#) so people with HSAs have an incentive to limit the use of the account: minimizing fees that could diminish the tax advantage. If you are 1 of the 125 million Americans with a chronic condition, HSA tax savings are unlikely to exceed your out-of-pocket expenses. Moreover, your out-of-pocket expenses will probably be greater than they would have been under low-deductible health coverage.

But what does all this mean for the way we finance medical care? Can HSAs help uninsured people or will they create a greater underinsurance problem? Will requiring patients to make decisions about which medical procedures to pay for make them smarter consumers of health care? Can physicians rely on patients rather than health plans to pay huge bills, or will there be more uncompensated care? Stakeholders should be asking these and many other questions before encouraging the growth of HSAs. Although HSAs are projected to cost taxpayers only \$7 billion in lost revenue to the treasury over 5 years, their impact on how Americans finance medical care might carry a bigger price tag and affect people’s lives adversely, resulting in a decline in health, financial ruin, and limited or eventually no comprehensive coverage for millions of Americans with medical needs.

Uninsured

HSAs have been promoted as a way to address the problem of 45 million Americans without health insurance. It is unclear, however, how HSAs will help. Two-thirds of uninsured people are in families with incomes of less than 200 percent of the federal

poverty level (FPL) [2]—200 percent FPL for a family of four in 2005 is \$38 700. These low-income uninsured people are unlikely to have federal tax liability, so the tax advantage of an HSA for them would be 0. If a moderate-income family wanted to open an HSA and receive a tax benefit, they would need to deposit funds to open the account and have \$2000 available for services not covered until the annual deductible is met; \$8200 for co-insurance and other medical expenses not covered (\$10 200 is the maximum out-of-pocket limit, however not all expenses count toward the limit); plus money to pay premiums for health insurance. Consider expenses for food and shelter and other necessities like transportation to work, and, financially, HSAs are not an option for low- and moderate-income people.

Forty percent of the uninsured report that their health is not very good [3]. The law does not require insurers to sell health insurance to people with past or current medical conditions. In 46 states, people can be turned down for an individual policy even if they can afford it. So, even for the uninsured with incomes above 200 percent of the FPL, coverage options remain limited.

Cost Containment or Cost Shifting?

Proponents of HSAs believe that the accounts would help contain costs by creating a financial incentive for people to avoid over-utilizing medical services. That assumption, however, is not supported by data. According to a RAND study, for example, doubling co-payments for long-term prescription drug use caused patients to decrease the recommended dose, which resulted in more frequent and longer hospital stays, including more emergency room visits [4]. Other studies have shown that, instead of a decline in over-utilization of services, high out-of-pocket expenses lead to: delays in care, medical debt, and bankruptcy. One study found that half of those surveyed with an annual deductible of \$500 had problems with medical bills and medical debt (HSAs require an annual deductible of \$1000 for individuals and \$2000 for families) [5]. In fact, medical bills are the leading cause of personal bankruptcies in the US [6]. Instead of reducing unnecessary medical procedures, HSAs are likely to contribute to more medical debt, more personal bankruptcies, and delays in or lack of medical care for people who need it.

Neither do HSAs address the reasons why health coverage is expensive. If utilization rates decrease because of forgone or delayed necessary care, then ultimately HSAs will lead to more spending on high cost care for illnesses that could have been prevented. HSAs do not remedy the fact that a minority of people—typically the elderly and individuals with chronic conditions—account for the vast majority of health care costs. Without any mechanism for meeting the specific needs of the elderly and the chronically ill, elevated medical expenditures will remain a substantial issue.

Patient Empowerment?

Proponents assume that individuals can make informed medical decisions about their medical care and will, if forced to spend their own money. However, this assumption may not be realistic given the low rate of medical literacy in the US. There are nearly 90 million adults who have difficulty understanding and acting on health information [7]. Those who *are* capable of making decisions soon discover a disconnect between

the information they need to make informed decisions and what is available (eg, it is difficult to compare the cost and benefits of various procedures because that information is not available from health plans or physicians). Even if better information were available, it would not necessarily be helpful for patients with serious illnesses. A cancer patient undergoing radiation or chemotherapy, for example, may have an hour of energy per day to take care of life's needs—cooking, cleaning, paying bills. It is unlikely there would be time to research the cheapest labs or physicians, nor would the patient always opt for the cheapest. A key premise underlining HSAs is that consumers will choose the “cheapest” options. But medical care is not like milk; if you need heart surgery, you do not shop for the “cheapest” heart surgeon but for the best one.

The HSA Threat to Comprehensive Health Insurance

When individuals are given a choice between low-cost, high-deductible coverage and more costly comprehensive health insurance, healthy people are more likely to choose the low-cost, high-deductible coverage. Thus, if HSAs become more widely available, healthy people may opt for them leaving fewer healthy people covered under traditional insurance; premiums for traditional insurance could rise as a result. Insurance works when a mix of healthy and sick are covered. Over time, comprehensive job-based coverage for older workers and those with medical needs would become more expensive and eventually disappear, absent legislative interventions to subsidize it.

Ironically, although proponents of HSAs claim to be supporters of the private market, this latest legislative intervention may help to disrupt comprehensive, job-based insurance and may ultimately lead millions of Americans to demand more real reform. The public is too smart to believe that HSAs empower the consumer. When America's consumers are asked to pay more for fewer benefits, they know that it's not empowerment but merely cost shifting and will say “we've had enough.” And America's physicians should do the same, because when insurers stop paying the bills and the patients can't afford to, physicians will find it impossible to care for their patients.

References

1. Henrickson K, Holmes BJ, Brown EG, McAulay SE. *Will Health Plans Profit From HSAs? Forecast of Health Savings Account Assets and Transactions*. Forester Research. Available at: www.forrester.com/research/document/excerpt/0,7211,36469,00.html. Accessed June 29, 2005. According to this source financial institutions will make an estimated \$1 billion in asset management and transaction fees by 2012.
2. The Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage in America 2003 Data Update*. Kaiser Family Foundation. November 2004; 8.
3. The Kaiser Commission on Medicaid and the Uninsured, Figure 10.
4. Goldman DP, Joyce GF, Escarce JJ, et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004;291:2344.
5. Half of insured adults with high-deductible health plans experience medical bill or debt problems [Press release]. Commonwealth Fund; January 27, 2005.
6. Himmelstein DU, Warren E, Thome D, Woolhandler S. *Market Watch: Illness and*

Injury as Contributors to Bankruptcy. February 2, 2005. Web Exclusive. Available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>. Accessed June 29, 2005.

7. Institute of Medicine. *Health Literacy: A Prescription to End Confusion. Report Brief*. Available at: <http://www.iom.edu/Object.File/Master/19/726/0.pdf>. Accessed June 21, 2005.

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