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LATEST ENROLLMENT DATA STILL FAIL TO DISPEL CONCERNS ABOUT HEALTH SAVINGS ACCOUNTS

By Edwin Park and Robert Greenstein

In his upcoming State of the Union address and as part of the fiscal year 2007 budget, President Bush is expected to tout the success of Health Savings Accounts (HSAs) and to propose significant new HSA expansions.[1] Debate continues, however, over Health Savings Accounts as HSA enrollment rises. Many leading health care analysts and economists have warned in the past that HSAs pose a high risk of causing "adverse selection," under which healthy people and less-healthy people separate into different insurance arrangements, and the cost of insurance for the less-healthy consequently rises and places such individuals at greater risk of becoming uninsured or underinsured. Past studies by the Urban Institute, the American Academy of Actuaries, and RAND concluded that accounts like HSAs would likely have these effects if use of the accounts became widespread.[2] Health and tax policy analysts also have concluded that HSAs are likely to be used extensively as tax shelters by high-income individuals.

In 2004, HSA advocates and lobbyists tried to dismiss these warnings by arguing that initial data on enrollment in HSAs in the individual health insurance market showed that the conclusions of these past studies were unfounded.[3] Careful examination of these HSA enrollment data, however, demonstrated that such claims by HSA proponents rested on misuse of the enrollment data and did

[1] See, for example, Sarah Lueck, "Bush to Seek Bigger Health-Savings Tax Break," *Wall Street Journal*, January 21, 2006 and Peter G. Gosselin, "Health Plan to Revive Debate," *Los Angeles Times*, January 23, 2006. Such expansions may include: a deduction for the premium cost of a high-deductible health insurance plan attached to a HSA purchased in the individual health insurance market; an increase in the tax-deductible contributions that individuals can make to their HSAs; a refundable tax credit for low-income individuals to purchase health insurance, including high-deductible plans and HSAs, in the individual market; and a tax credit for small employers contributing to their workers' HSAs.

[2] See Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association,* June 5, 1996, p. 1666-71; Len M. Nichols, et. al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Urban Institute, April 1996; and American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.

[3] See, for example, Laura Trueman, "Health Savings Accounts: Myth vs. Fact," National Center for Policy Analysis, July 19, 2004; Grace Marie Turner, "Health Savings Accounts Gain Popularity," Galen Institute, July 26, 2004; Richard Nadler and Dan Perrin, "The Center on Budget and Policy Priorities' Study on HSA Premium Tax Deduction Misses the Point," The HSA Coalition, May 25, 2004; and Derek Hunter, "New Data on Health Insurance, the Working Poor, and the Benefits of Health Care Tax Changes," Heritage Foundation, April 28, 2004.

not stand up under scrutiny.[4] In the past year, HSA proponents have again claimed that the latest HSA enrollment data prove there is little risk of adverse selection and that HSAs are not disproportionately used by people with better health or high incomes.[5]

This analysis considers the latest enrollment data. As this analysis indicates, the new data do not support the claims of HSA proponents. The data that are available remain quite limited and continue to shed little light on the issues in this debate. Moreover, other recent data regarding HSAs are inconsistent with the claims of HSA supporters. While these data also are limited, they indicate that HSAs (as well as similar accounts attached to high-deductible health insurance plans) may be disproportionately used by healthy, affluent individuals.

Background on Health Savings Accounts

Health Savings Accounts were established as part of the 2003 Medicare drug legislation and made available as of January 1, 2004. In tax year 2006, any individual who enrolls in a high-deductible health insurance plan with a deductible of at least $1,050 for individual coverage and $2,100 for family coverage may establish a tax-favored savings account known as a Health Savings Account.[6] An individual with a HSA may take a tax deduction for contributions he or she makes to the account (up to the amount of the deductible in his or her high-deductible insurance policy), as long as the contributions do not exceed an annual limit, set at $2,700 for individuals and $5,450 for family coverage.[7] Both employers and employees may make deductible contributions to an employee's HSA in the same year; the combined contributions made on behalf of an individual may not exceed the plan deductible or the contribution limit whichever is lower.

Funds held in these accounts may be placed in various investment vehicles such as stocks and bonds, with the earnings accruing on a tax-free basis. Withdrawals from the account also are exempt from tax as long as they are used to pay for out-of-pocket medical costs such as deductibles, copayments, and other uncovered medical expenses. Withdrawals for non-medical purposes are subject to income tax and a financial penalty, but no penalty applies to withdrawals for non-medical purposes made after an individual reaches age 65.[8]

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[4] Edwin Park and Robert Greenstein, "Initial Data on Individual Market Enrollment Fail to Dispel Concerns About Health Savings Accounts," Center on Budget and Policy Priorities, September 13, 2004.

[5] See, for example, Derek Hunter, "Health Savings Accounts: The News Keeps Getting Better," Heritage Foundation, September 6, 2005; Grace Marie Turner, "Consumerism in Health Care: Early Evidence Is Positive," Galen Institute, August 11, 2005; Blue Cross and Blue Shield Association, "Blue Cross and Blue Shield Association Consumer Survey Shows High Rate of Satisfaction with HSAs, Cites Increased Reliance on Decision-Support Tools," September 28, 2005; Derek Gratzer, "Congress Got Something Right!", *Wall Street Journal*, December 7, 2005; and Sally C. Pipes, "Health accounts milestone," *Washington Times*, January 1, 2006.

[6] In 2006, the high-deductible health insurance plan must have an out-of-pocket limit of no more than $5,250 for individuals and $10,500 for family coverage. The out-of-pocket limit may be higher for out-of-network services. Certain preventive services such as annual physicals and routine screenings may be exempted from the deductible.

[7] Individuals age 55 or older may make additional contributions, in excess of the regular limit, of another $700 in tax year 2006, rising to $1,000 by tax year 2009. Individuals age 65 or older who are eligible for and participating in Medicare are not eligible to make deductible contributions to HSAs.

[8] The financial penalty for a non-medical withdrawal prior to retirement age of 65 is equal to 10 percent of the amount withdrawn. Unlike other retirement accounts, there are no mandatory withdrawals upon retirement.

Due to the structure of HSAs, they hold particular attractions for healthier and more affluent people. For healthy individuals who do not expect to incur significant health care costs, HSAs provide a way to build up a stream of tax-favored savings. To the extent that funds in HSAs are not needed for health care costs, account-holders can build up account balances that accumulate over time and enjoy tax advantages that regular savings accounts do not have. These tax advantages are worth the most to people at higher-income levels; the higher your tax bracket, the greater the benefit that the HSA tax breaks provide you.

HSAs do not provide the same benefits for less healthy individuals. For such people, who tend to consume more health care, the high-deductible insurance policies that must be used in conjunction with HSAs can mean significantly greater out-of-pocket costs, as compared to the out-of-pocket costs typically borne under comprehensive health insurance, which usually carries significantly lower deductibles. For example, a recent survey by the Employee Benefit Research Institute and the Commonwealth Fund found that in 2005, some 31 percent of individuals with high-deductible plans attached to HSAs or Health Reimbursement Accounts (HRAs)[9] incurred out-of-pocket medical costs — including health insurance premium costs — that exceeded five percent of their income, a percentage more than two-and-a-half times the average rate among people enrolled in comprehensive insurance. (The survey found that 12 percent of people with comprehensive insurance incurred out-of-pocket costs exceeding five percent of their income.)[10]

This is of particular concern for sicker individuals who obtain health insurance through their employer, since such coverage typically offers the low-deductible, comprehensive insurance that is better suited for such people. For example, the Urban Institute determined that among individuals in employer-based coverage between 2000 and 2002, those in the poorest health — individuals in the top quintile of health care costs — paid an average of nearly 10 percent of their income on out-of-pocket costs. By comparison, individuals in the poorest health who are covered by insurance purchased in the individual market — which typically requires high deductibles similar to those required under HSAs — spent nearly *20 percent* of their income on medical costs.[11]

While employers are permitted to contribute to employees' HSAs to help offset some of the higher out-of-pocket costs that can be associated with high-deductible insurance plans, early evidence indicates that more than one-third of all firms that offer high-deductible policies with

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[9] A Health Reimbursement Account (HRA) is a tax-favored savings account that, like an HSA, is generally attached to a high-deductible health insurance plan. It does not, however, have the same tax advantages as HSAs. For example, only employers can make tax-favored contributions to an HRA and individuals do not retain ownership of the HRA after leaving employment.

[10] The EBRI/Commonwealth Fund study also determined that nine percent of individuals with HSAs or HRAs spent more than *10 percent* of their income on out-of-pocket medical costs (including health insurance premium costs) as compared to only three percent of individuals with comprehensive insurance. See Paul Fronstin and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute and the Commonwealth Fund, December 2005.

[11] These out-of-pocket figures, unlike those cited in the previous paragraph, do not include health insurance premium costs. Factoring in premium costs, out-of-pocket medical spending for the sickest individuals (those in the top quintile of health care costs) rises to an average of 16.3 percent of income for individuals with employer-based coverage, and to 47.8 percent of income for individuals with coverage in the individual market. Linda J. Blumberg, Lisa Clemans-Cope, and Fredric Blavin, "Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs," Urban Institute, December 2005.

HSAs make *no* contributions to the HSAs, and that the average contribution among firms offering HSA plans appears to be significantly lower than the average deductible for the insurance attached to those plans.[12] These increased out-of-pocket costs are of greatest risk for less-healthy individuals who are not in the higher tax brackets, as they have fewer resources to draw upon and also would derive much less benefit from the HSA tax breaks.

Health Savings Accounts Raise Substantial Concerns

HSAs were a controversial element of the 2003 Medicare prescription drug legislation. They raise two principal concerns: that they are likely to weaken the comprehensive employer-based health insurance system through which the vast majority of Americans now obtain their health insurance; and that they will be used primarily as tax shelters by healthy, affluent individuals.

Effects on employer-based coverage. Under employer-based coverage, healthier and sicker employees are combined into a single insurance pool. This enables less healthy individuals to obtain insurance at an affordable price. If each individual had to purchase insurance individually based on his or her own health status, sicker workers would in many cases be priced out of the market.

A major concern about HSAs is that if employers begin offering HSAs and high-deductible insurance as an option alongside traditional comprehensive insurance, then healthy and less-healthy workers may separate into different insurance arrangements, with the healthier workers shifting to HSAs and high-deductible policies and workers in poorer health seeking to remain in comprehensive coverage. Numerous health policy experts believe this development is likely under HSAs.

Such a development would be highly problematic. The cost of insuring any group of workers — and hence the price of insurance coverage for those workers — depends on the health status of the people in the group. If the healthier, less-costly-to-insure employees opt out of comprehensive coverage to take advantage of the HSA tax breaks, the average cost of insuring the people remaining in comprehensive plans must go up, since those left in comprehensive plans will be a less-healthy group that tends to use more health care services.[13]

The withdrawal of healthier workers from comprehensive employer-based coverage to take advantage of HSAs also could occur even if an employer does *not* offer HSAs and high-deductible

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[12] In their 2005 survey of employers, the Kaiser Family Foundation and Health Research Educational Trust found that the average employer contribution to a HSA was $553 for individuals and $1,185 for family coverage while the average high deductible was $1,901 for individuals and $4,070 for family coverage. The actual gap between the employer contribution and the high deductible is likely to be somewhat smaller in firms that make such contributions; the calculation of the average employer contribution cited here included all firms that offer HSAs, including those that made no contribution to their employees' accounts. Gary Claxton, Jon Gabel *et al.*, "What High-Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," Web Exclusive, *Health Affairs*, September 14, 2005.

[13] See Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association,* June 5, 1996, p. 1666-71; Len M. Nichols, et. al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Urban Institute, April 1996; American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995; Daniel Zabinski et. al., "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection," *Journal of Health Economics*, April 1999, p.195-218; and Gail Shearer, "The Health Care Divide: Unfair Financial Burdens," Consumers Union, August 10, 2000 (relying on Lewin Group estimates).

insurance as an option. Some affluent, healthier workers may conclude they would do better purchasing a high-deductible policy in the individual insurance market and setting up a HSA than remaining in employer-based coverage (especially if the employer-based coverage requires employees to bear a significant share of the premiums).

If HSAs lead significant numbers of healthier workers to opt out of comprehensive employer-based coverage, thereby making those who remain in such coverage more expensive, on average, to insure, the comprehensive coverage that employers typically offer will become less affordable over time and a growing number of employers may ultimately cease to provide it. That would pose a particular problem for vulnerable workers in poorer health who need such coverage and seek to remain in it.

Creation of a lucrative new tax shelter. The second concern stems from the fact that under HSAs, not only are contributions to the accounts tax-deductible, but withdrawals from the accounts to pay for out-of-pocket medical costs are tax-free. This tax treatment — under which *both* contributions to a savings account *and* withdrawals from that account are tax advantaged — is without precedent in the tax code. Retirement accounts such as traditional Individual Retirement Accounts (IRAs) and 401(k) plans permit deductible contributions, but withdrawals upon retirement are treated as taxable income. Other plans, such as Roth IRAs, permit tax-free withdrawals but the contributions are not tax-deductible.

Furthermore, unlike under traditional IRAs, there are no income limits on participation in HSAs. As a result, affluent healthy individuals who have reached the maximum annual contribution limits on their IRA or 401(k) plans — or who are ineligible to make tax-deductible contributions to IRAs because their incomes exceed the IRA income limits — can use HSAs to shelter a greater share of their income for retirement. HSAs consequently are likely to become a major tax shelter for affluent individuals, causing significant revenue losses to the Treasury and adding to budget deficits.[14]

Of added concern, the exceptionally generous tax treatment that HSAs enjoy creates a dangerous precedent. If this type of tax treatment, under which contributions to an account are deductible *and* withdrawals are tax free, is extended in whole or in part to other savings accounts — such as retirement accounts, as some Congressional leaders have proposed — the adverse long-term fiscal consequences for the nation could be severe.[15] For example, a proposal to convert a portion of 401(k) and IRA accounts into HSA-like accounts, which was designed by Fidelity Investments and which Senate Majority Leader Bill Frist has spoken favorably about, would be likely to cost the Treasury hundreds of billions of dollars over coming decades.

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[14] A recent analysis of Internal Revenue Service data by a Treasury Department financial economist concluded that self-employed individuals who purchased high-deductible health insurance plans in conjunction with Medical Savings Accounts — the more limited predecessor to Health Savings Accounts established as a demonstration project in 1996 — were disproportionately higher income (defined as having incomes above the median famiily income). Alexandra Minicozzi, "Medical Savings Accounts: What Story Do the Data Tell?", *Health Affairs*, January/February 2006.

[15] See, for example, Edwin Park and Robert Greenstein, "New Retirement Medical Account Proposal Would Create Lucrative Tax Shelter and Swell Deficits but Do Little to Help Low- and Moderate-Income Seniors," Center on Budget and Policy Priorities, revised July 22, 2004.

Analysis of the Latest Enrollment Data Cited by HSA Proponents

HSA proponents have claimed these concerns and criticisms are incorrect or overblown. HSA supporters contend the latest data demonstrate that concerns about adverse selection are unfounded. They have cited data released last year by eHealthInsurance, Assurant Health, America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association as refuting concerns that HSAs will be used primarily by healthier or more affluent individuals. They also contend that these data show HSAs are an effective means of covering the uninsured.[16]

The eHealthInsurance and Assurant data are limited to HSAs purchased in the individual market. The AHIP and Blue Cross and Blue Shield data include enrollment data for both the individual market and employer-based coverage. Examination of these data shows they do not support the claims being made about them. In addition, some other recent data, such as data from a survey conducted by the Employee Benefit Research Institute and the Commonwealth Fund, indicate that HSAs may be most attractive to healthier and higher-income individuals.

Unsupported Conclusions by HSA Advocates

HSA proponents have drawn three questionable conclusions from these data.

1. HSA proponents have claimed the data show that HSAs are *not* primarily attracting healthy individuals and thus do not risk adverse selection. The eHealthInsurance, Assurant Health and AHIP data on HSA purchasers include *no* information about the health status of HSA purchasers. These data thus cannot be used to support this conclusion.

Only the Blue Cross and Blue Shield enrollment data include some information on health status. In August 2005, the Blue Cross and Blue Shield Association conducted a limited survey of 3,123 consumers enrolled in health insurance plans in both the individual market and the employer-based system. These data have been presented as showing that participants in high-deductible plans who are eligible for HSAs (including people not actually enrolled in a HSA) have nearly the same self-reported health status as people who are in other health insurance arrangements.[17]

Despite the Blue Cross and Blue Shield Association's claim that "this survey dispels the myth that HSAs are only for the young and healthy," however, these data simply do not allow a conclusion

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[16] eHealthInsurance, "Health Savings Accounts: The First Six Months of 2005," July 25, 2005; Assurant Health, "Quick Facts: Health Savings Accounts," September 16, 2005; America's Health Insurance Plans, "Number of HSA Plans Exceeded One Million in March 2005," May 4, 2005; Blue Cross and Blue Shield Association, "Blue Cross and Blue Shield Association Consumer Survey Shows High Rate of Satisfaction with HSAs, Cites Increased Reliance on Decision-Support Tools," September 28, 2005; and Maureen Sullivan, Blue Cross and Blue Shield Association, Presentation on "Health Savings Accounts: The Consumer Perspective," September 28, 2005, available at http://bcbshealthissues.com/events/consumer/sullivan_presentation.ppt.

[17] The survey found, for example, that 12 percent of individuals participating in a high-deductible plan eligible for a HSA were in excellent health as compared to 10 percent of participants in non-HSA plans. One percent of individuals participating in a high deductible plan eligible for a HSA were in poor health, as compared to one percent in non-HSA plans. It is unclear to what the effect is of grouping individuals who are not actually participating in a HSA, but are in a high deductible plan that is eligible for a HSA, with actual HSA participants.

that HSAs are not more attractive to healthier individuals.[18] This is because the survey fails to distinguish between the health status of people in the individual market and people in employer-based coverage. It also fails to distinguish between the health status of people with employer-based coverage who are eligible for or enrolled in HSAs and the health status of people with other types of employer-based insurance. These data merely compare the self-reported health status of people eligible for or enrolled in HSAs *in the aggregate*, regardless of whether they are in the individual market or employer-based coverage, with people with other types of insurance arrangements, in the aggregate.

Aggregating participants in the individual market with participants in employer-based coverage, as these data do, is likely to skew the overall health status of participants.[19] The individual market is accessible primarily to healthier individuals, due to the widespread use in that market of medical underwriting, under which insurers can decline to offer coverage, offer more limited coverage, or charge much higher premiums to less healthy people. Moreover, the individual market typically offers high-deductible policies similar to those required for use of a HSA. As a consequence, it is likely that most people who have actually purchased a high-deductible policy in the individual market in conjunction with a HSA are people who are in similarly good health to people in the individual market who have purchased other types of plans, especially since less healthy individuals would be unlikely to be able to obtain or afford a more comprehensive policy in the individual market.

In addition, the Blue Cross and Blue Shield survey data do not distinguish between individuals in employer-based coverage who have a choice of health insurance plans and individuals who are in a firm with only one health insurance plan. Take the example of two firms with the same mix of healthy and sicker employees. Both firms provide only one health plan. One firm switches to a HSA; the other continues to offer a more traditional comprehensive health insurance plan. Assuming equal participation in the two plans by employees, the self-reported health status of HSA participants and of enrollees in comprehensive coverage would be identical. That would show nothing about whether HSAs are equally attractive to healthy and sicker workers if employees are given a choice.

To assess appropriately the degree to which HSAs may result in adverse selection, it is necessary to have data on the health status of workers with employer-based coverage who have chosen a HSA and how their health status compares to that of workers in the *same firm*s who have chosen more comprehensive health insurance plan. No such data are provided by the limited survey that the Blue Cross and Blue Shield Association conducted.

Moreover, some other new data show that HSAs may be attracting healthier individuals, thereby confirming the risk of adverse selection. For example, the Employee Benefit Research Institute and Commonwealth Fund survey, discussed above, found that 57 percent of individuals enrolled in a high-deductible plan attached to a HSA (or HRA) reported they were in excellent or very good health, as compared to 45 percent of those enrolled in comprehensive insurance.[20] An analysis by

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[18] Blue Cross and Blue Shield Association, *op cit.*

[19] The survey does not indicate what percentage of the 3,123 surveyed consumers were in the individual market or in employer-based coverage.

[20] Fronstin and Collins, *op cit.* Comprehensive insurance is defined broadly as health insurance with deductibles below the minimum levels required for HSAs.

Blue Cross and Blue Shield of Minnesota indicates that individuals enrolled in that firm's HSA or HRA plans were healthier than those enrolled in their traditional Blue Cross/Blue Shield major medical policies.[21] Finally, the General Accountability Office (GAO) examined enrollment in a high-deductible plan offered to postal workers (in conjunction with an HRA) and determined that enrollees in the high-deductible plan were more likely to report they were in excellent or very good health (73 percent) than those enrolled in other plans (58 percent).[22] (It is important to note, however, that like the data cited by HSA proponents, these studies are not conclusive because of the preliminary nature of their data and other limitations.[23])

2. HSA supporters have claimed that enrollment data show that HSA participants are *not* primarily higher-income individuals taking advantage of the tax shelter benefits of HSAs. Here, as well, the current data on HSA enrollees do not back up the claim. The Assurant Health data indicate that 29 percent of individuals who purchased individual market coverage from Assurant in conjunction with a HSA from January 2004 through September 16, 2005 had incomes

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[21] The study compared the health status of individuals enrolled in their HSA and HRA plans with those in their major medical policies. Individuals were given a health status "score" based on a classification system developed by John Hopkins University, with a higher score meaning an individual is in poorer health. The health status scores for their HSA and HRA enrollees were lower than those in their major medical policies. Blue Cross and Blue Shield of Minnesota concluded that based on these scores, overall, their HSA or HRA enrollees were eight percent healthier than their medical policy enrollees. Ironically, the Blue Cross and Blue Shield of Minnesota study was apparently intended to promote Health Savings Accounts. David Plocher, Cathy Lai and Nancy Garrett, "Options Blue: Population Profile Analysis Working Paper," Blue Cross and Blue Shield of Minnesota, November 30, 2005.

[22] General Accountability Office, "Federal Employees Health Benefit Program: Early Experience with a Consumer-Directed Health Plan," GAO-06-143, November 2005.

[23] The EBRI/Commonwealth Fund survey, for example, does not separately report the health status of individuals with HSAs and of individuals with HRAs. The data from this survey also do not differentiate between individuals in employer-based coverage and those in the individual market. As discussed above, there may be smaller differences in health status in the individual market than within employer-sponsored insurance. A comparison of the health status of HSA enrollees and individuals with comprehensive insurance *in the employer-based system* would be more useful in assessing whether adverse selection is occurring as a result of HSAs. In addition, the EBRI/Commonwealth survey relies on data collected through an online survey, which the study acknowledges can skew the results toward high-income individuals and can underrepresent minorities.

Similarly, the Blue Cross and Blue Shield of Minnesota analysis does not distinguish the health status of individuals in employer-based coverage from that of individuals in the individual market. Nor does it report separately the health status difference between HSA enrollees and people with major medical policies. That analysis also does not report separately the health status of individuals enrolled in the various major medical plans known collectively as Open Access. According to the Blue Cross and Blue Shield of Minnesota website, Open Access major medical policies in the individual, small group, and large group markets have a wide range of deductibles, including deductibles high enough to qualify for a HSA. A more useful analysis would examine health status differences between individuals in HSA plans offered by Blue Cross and Blue Shield of Minnesota and individuals in those Open Access major medical policy plans that have relatively low deductibles similar to the deductibles typically required under comprehensive employer-based coverage. Excluding those major medical plans that have higher deductibles may show a larger difference in health status between people in HSAs and people in more comprehensive insurance plans.

Finally, the GAO report looked only at a high-deductible plan offered to postal workers in conjunction with a HRA because data for other recently offered HSA plan options were not yet available. While the deductibles required under the HRA plan are high enough to meet HSA requirements (an individual deductible of $1,800 and a family deductible of $3,600), HRAs differ from HSAs on some other fronts, including their lesser tax benefits. As a result, while the GAO study indicates a risk of adverse selection, a study examining only HRAs may not generally be applicable to HSAs. A more useful study would examine the HSA options offered to postal workers, once such data become available.

below $50,000 per year.[24] This means, however, that 71 percent of HSA individual market purchasers had incomes of more than $50,000. The Assurant data do not provide a more detailed income breakdown of the purchasers with incomes above $50,000 so one cannot determine the extent to which high-income individuals purchased high-deductible plans and HSAs through Assurant.

The eHealthInsurance data similarly found that in the first six months of 2005, nearly 58 percent of all HSA individual market purchasers using eHealthInsurance had incomes of more than $50,000. The eHealthInsurance data do include a somewhat more detailed income breakdown. These data indicate that 22 percent of purchasers had incomes in excess of $100,000 annually.[25] (Neither the AHIP data or the Blue Cross and Blue Shield survey include information related to the income of individuals enrolling in HSAs.[26])

It is important to recognize that even these limited income data about HSAs are likely to be skewed downward because the Assurant and eHealthInsurance data come solely from the individual health insurance market. Lower-income workers tend to use the individual market in greater proportions than higher-income workers due to their greater lack of access to employer-based coverage. Lower-income workers often work for smaller businesses; such firms, particularly those with large numbers of low-wage employees, are among the least likely to offer health insurance coverage to their workers. As a result, in 2003 — *before* HSAs came into existence — insured households with incomes below $25,000 were nearly 80 percent more likely to obtain their coverage through the individual market than households with incomes of $75,000 or more.[27] Since it makes sense for people who already were purchasing high-deductible coverage in the individual market to set up HSAs, a sample of HSA purchasers in the individual market would likely be biased downward in terms of income. Such data cannot be used to make inferences about what the income of HSA will be if HSAs begin to be offered widely by employers.

A far more useful examination would look at individuals who participate in HSAs in the *employer-based* health insurance system and compare their incomes to the incomes of individuals enrolled in comprehensive health insurance plans offered by the *same* employers. Data on the income of employees who choose a HSA plan as compared to workers within the same firm who opt for a comprehensive plan would be particularly relevant. Such data are not currently available since the large majority of employers do not yet offer HSAs; according to the Kaiser Family Foundation and the Health Research Educational Trust, about two percent of firms providing health benefits offered a HSA in 2005, and about 15 percent of workers in those firms participated in HSAs.[28]

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[24] Assurant Health, *op cit.*

[25] eHealthInsurance, *op cit.*

[26] During the public presentation of the Blue Cross and Blue Shield survey data by Maureen Sullivan, Senior Vice President for Strategic Services, Ms. Sullivan stated that the HSA enrollment survey found that there was a "higher" percentage of HSA participants who had annual incomes in excess of $100,000 than those in traditional comprehensive plans and that about two-thirds of HSA enrollees had incomes in excess of $50,000. Maureen Sullivan, Blue Cross and Blue Shield Association, Webcast of Presentation, September 28, 2005, available at http://www.connectlive.com/events/bcbs092805/.

[27] CBPP analysis of 2003 CPS data.

[28] Claxton and Gabel, *op cit.*

Finally, while it does not differentiate the income of individuals with HSAs in the employer-based system from the income of individuals with HSAs in the individual market (or compare the income of individuals with employer-based average who elect HSAs to the income of individuals in the same firm who select other coverage), the recent EBRI/Commonwealth study provides some evidence that HSAs are disproportionately attractive to more affluent individuals. The survey found that nine percent of individuals with HSAs or HRAs had household incomes of $150,000 or higher, as compared to four percent of people with comprehensive coverage.[29]

3. HSA proponents also have claimed that the data show a large share of HSA users are people who previously were uninsured, and thus that HSAs can be an important tool for expanding coverage. According to the Assurant data, 44 percent of HSA applicants did not have health coverage in the months before purchasing a high-deductible policy in conjunction with a HSA in the individual market. The eHealthInsurance data found that 31 percent of HSA individual market purchasers were without insurance for at least six months prior to purchasing an HSA. Similarly, the AHIP survey determined that 37 percent of HSA purchasers in the individual market were previously uninsured. These statistics are cited to show that HSAs can play an important role in making coverage more affordable for the uninsured.

The Assurant, eHealthInsurance, and AHIP data for the individual market, however, require considerable qualification. The individual market is often a market of last resort, particularly for adults who have lost their jobs and health insurance, cannot afford COBRA coverage, and do not qualify for Medicaid. Even before the advent of HSAs, many individuals purchasing insurance in the individual market are likely to have been uninsured for a period immediately preceding the purchase. The fact that a certain percentage of people who purchased individual-market coverage in conjunction with a HSA were uninsured for the months before the purchase is not especially meaningful in assessing the contribution of HSAs. (Moreover, Assurant does not provide data on the percentage of actual HSA *purchasers* — as distinguished from HSA *applicants* — who previously were uninsured. Some uninsured applicants may have declined to purchase coverage once they were provided an offer of coverage if the offer carried a premium cost they considered unaffordable. It is curious that the Assurant data on the extent to which *purchasers* previously were uninsured have not been made available along with the data on applicants.)

Most important, these data are for the individual market only. HSA use will become widespread only if HSAs are adopted by large numbers of employers, which many analysts now expect to occur. Since the vast majority of employers who adopt HSAs are likely to be employers that already offer coverage to their workers, most employer-based HSA enrollment will involve workers who already are insured and are shifting their health insurance arrangements (or having the arrangements shifted by their employers) from comprehensive coverage to high-deductible plans attached to HSAs. Over time, the large majority of HSA participants thus is likely to consist of people who previously were insured.

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[29] Fronstin and Collins, *op cit.* As noted in footnote 23, these data do not separately report the characteristics of individuals in HSAs and individuals in HRAs. As a result, it is not known whether there are any differences between the income of individuals enrolled in HSAs and individuals enrolled in HRAs, which have fewer tax benefits and do not risk being used as a tax shelter. It is likely, however, that due to the attractiveness of HSAs as tax shelters to affluent taxpayers, the percentage of individuals enrolled in HSAs who have household incomes of $150,000 would be found to be higher than nine percent if one looked only at HSA enrollees rather than at individuals enrolled in either HSAs *or* HRAs.

Unlike the Assurant and eHealthInsurance data, the AHIP and Blue Cross and Blue Shield data include some information about employers offering coverage for the first time. AHIP determined that about 27 percent of small employers now offering HSAs had not previously offered insurance.

These data, too, need qualification, however. First, the AHIP data do not specify whether these data count *new* small businesses among the employers that did not previously offer insurance but are now offering plans that include HSAs (rather than counting only existing firms that previously did not offer insurance). Many new small businesses are created every year, and a number of them offer insurance. If such firms are counted by AHIP as employers that did not previously offer coverage but are offering it now, then the 27 percent figure tells little about the impact of HSAs on employers' willingness to provide coverage.

Second, the survey data that AHIP released cover a relatively small number of HSA participants who are employed by small firms. These data included 147,000 such people, of whom 37,868 were newly insured. AHIP notably did *not* release comparable data from the part of its survey that covered larger employers (firms with more than 50 people), even though the number of HSA participants in its survey who work for such firms is greater than the number who work for small businesses. Since the vast majority of large firms already offer health insurance, only a small percentage, if any, of the HSA plans offered by such firms would involve new coverage rather than the replacement of an existing insurance arrangement or the offer of a HSA plan as a new health insurance plan choice for workers.[30]

The Blue Cross and Blue Shield Association survey data also include some information on HSA enrollment in employer-based health insurance. Unfortunately, the BC/BS data that have been released do not separately show the percentage of HSA enrollees in the individual market who previously were uninsured and the percentage of HSA enrollees in employer-based coverage who previously were uninsured. The Blue Cross and Blue Shield Association data show that overall, *only 12 percent* of individuals with high-deductible policies eligible for HSAs were previously uninsured. This means that 88 percent of the individuals with such policies already had coverage. Considering that other data for HSA enrollment in the individual market show a significantly higher percentage than this of previously uninsured individuals, this suggests that the overwhelming majority of HSA participants who are obtaining HSAs through employers were already insured.

Conclusion

Some HSA proponents have claimed that the latest data on HSA use refute concerns that HSAs may weaken employer-based coverage through adverse selection and that HSAs may be used extensively as tax shelters by higher-income individuals. These proponents also contend that these data show HSAs are effective in covering the uninsured. In reality, the data do not support such conclusions. In addition, other recent data (which HSA supporters do *not* cite) indicate that the concerns raised by those who have questioned the wisdom of promoting HSAs as government policy may be well founded.

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[30] For example, in 2005, some 93 percent of firms with 50-199 workers offer health insurance to their employees and 98 percent of firms with 200 or more workers offer health coverage to their workforce. Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005 Annual Survey," September 2005.

HSAs are likely to become increasingly common in the employer-based health insurance system. The Kaiser Family Foundation and the Health Research and Educational Trust recently found that 27 percent of employers not currently offering an HSA are somewhat likely or very likely to offer a high-deductible health insurance plan attached to a HSA next year.[31] The figure is even higher for very large employers. Forty percent of firms with 1,000 to 4,999 workers and 35 percent of firms with more than 5,000 workers were found to be somewhat likely or very likely to offer such plans next year.[32] As more employers adopt HSAs over time, more data will become available to evaluate the risks that HSAs pose. These data will provide much better evidence than the preliminary, fragmentary, conflicting, and incomplete data now available.

It remains likely that when better data are available, they will confirm the risks that health and tax policy experts believe HSAs pose. A Mercer survey of employers released in 2004 heightens these concerns. The survey found that employers believe HSAs will be most attractive to healthy, higher-income workers. A plurality of employers surveyed (44 percent) reported they believed their healthiest employees would be most likely to participate in HSAs. A substantial majority of employers (61 percent) said they believed their higher-paid employees would be most likely to use HSAs.[33]

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[31] Claxton and Gabel, *op cit.*

[32] Kaiser Family Foundation and Health Research and Educational Trust, *op cit.*.

[33] Mercer Human Resource Consulting, "US Employers See a Role for New Health Savings Accounts in their Benefit Programs," April 26, 2004.