More than three years have passed since President Bush signed legislation making health savings accounts (HSAs) available to millions of Americans. Promoted as a new, affordable option in health care coverage, HSAs—a form of medical savings accounts attached to a high-deductible health plan (HDHP)—were touted as an answer to the country’s worsening health care crisis, with experts projecting massive growth of these plans over the next several years.

But despite a profusion of optimistic predictions, enrollment in HSAs has remained modestly low since their inception. According to a Kaiser Family Foundation survey from 2006, only one to three million people with employer coverage currently have these consumer-directed health plans (CDHPs). This is about 4% of covered workers, a rate that has remained virtually unchanged since 2005.

Employers, too, have shown themselves to be less than enthusiastic about CDHPs, remaining skeptical about their ability to control costs and improve quality. The same Kaiser study showed only about 7% of American employers offered an HSA-qualifying HDHP or an HDHP with a health reimbursement arrangement (HRA) in 2006.

One of the initial attractions of HSAs was that individuals were allowed to save money tax-free and to use those funds, also tax-free, to pay their out-of-pocket health care expenses up to the plan’s deductible. In 2006, the minimum annual deductibles for HSA-qualifying HDHPs were $1,050 for self-only coverage and $2,100 for family coverage.

Any unused funds from HSAs carry over to the next year; unlike third-party insurance, these unused funds are portable from job to job. Employees can contribute to their HSAs with pretax dollars, and employers can also make tax-deductible contributions or match employee contributions, up to annual limits.

At the heart of the debate over HSAs was the idea that making people more accountable for their health care would motivate them to become more informed consumers as they shop for the best value for their health dollar, thus leading to lower costs and greater efficiency in the health care system. Proponents say that HSAs help to make health care accessible to more Americans; however, critics claim that these types of plans attract only the healthy and wealthy, leaving a disproportionate number of sick people in traditional insurance, thereby driving up premiums and making policies unaffordable.

Indeed, a Government Accountability Office (GAO) study published in 2006 found that federal employees who were enrolled in HSAs tended to be younger and better paid than those who did not choose this option. About 43% of employees enrolled in HSA-affiliated plans earned more than $75,000 per year, compared with 23% of those in all federal employee plans.

Another concern about CDHP designs is that increased out-of-pocket costs might discourage some people, particularly lower-income individuals, from getting the health care they need. A December 2006 survey conducted by the Employee Benefit Research Institute found that people with CDHPs were less likely than those in traditional plans to seek health care because of cost, especially respondents with an income below $50,000 per year (i.e., 80% of the population). Of adults with health problems, 40% of those in CDHPs said they “delayed or avoided getting health care” because of the cost.

With an HSA, prescription drugs are subject to the high deductible before coverage begins, so there is an added worry about compliance with medication. Studies have found that increased cost sharing for prescription drugs results in reduced utilization.

One major study compared drug utilization by a company’s employees before and after the implementation of a “fullreplacement” CDHP. The use of prescription drugs from the top 20 drug classes decreased by about 23% from 2003 to 2004; the most significant reductions were in medications for coughs, colds, and allergies; penicillins; dermatological drugs; estrogens; antidepressants; cephalosporins; macrolides; anti-diabetic agents; analgesics; ulcer drugs; and antihistamines.

Costs associated with the underuse of medications among the chronically ill are also a concern. A Health Affairs article from 2006 by Jill Yegian, PhD, Director of the Health Insurance Program at the California Health Care Foundation, noted mixed evidence of how patients respond to higher cost sharing.

The Strategic Health Perspectives effort, led by Harris Interactive, found that many more chronically ill patients who were enrolled in HDHPs tended to forgo certain prescription drugs because of cost than did enrollees in traditional insurance plans. However, a June 2005 report by the research firm McKinsey & Company indicated that chronically ill respondents who were offered only CDHPs were more likely than those in other plans to be compliant with treatment regimens. Dr. Yegian concluded that the divergent study results might have been caused by the presence or absence of employer-funded accounts such as HSAs and HRAs.

Although it is still too early to predict whether HSAs will become a favored health coverage option for employers or employees and how effective HSAs will be as a long-term solution to rising health care costs, the numerous studies conducted so far indicate that CDHPs are far from being seen as a cure-all for everyone’s health care woes. According to the Kaiser survey, relatively few companies that offer other types of health insurance...
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ance are “very likely” to adopt HDHPs that are associated with an HSA in the next year. Employee surveys suggest that many remain skeptical or uninformed about HSAs, many are simply confused by all the choices they face, and still others have tried and are not satisfied with HSA-style plans.3

Were those early forecasts of HSAs thus overly optimistic? It all depends on whom you ask.

Even with such ambivalent responses, the Bush administration has high hopes for HSAs. The Treasury Department has projected that by 2010, 25 to 30 million people will be covered by the plans. In December 2006, President Bush signed into law several enhancements aimed at boosting the plans’ appeal and flexibility, such as allowing employees to roll money into an HSA from a flexible spending account or an HRA and increasing the amount of money that employers may contribute to the accounts. Whether these changes will be enough to increase participation in HSAs remains to be seen.

REFERENCES


