Bad Ideas

A series examining proposals that could move health care coverage in the wrong direction

How HSAs Can Drain Your Wallet and Harm Your Health

For the past two years, insurance companies and banks have marketed high-deductible health plans that can be used with Health Savings Accounts (HSAs). Marketers promise employers and individuals that high-deductible plans will save money on health insurance costs and that HSAs can accumulate tax-free savings with interest to use for future health care needs. While these features may be attractive at first glance, a closer look shows that high-deductible health plans represent a tremendous gamble and may impose significant financial burdens on people who get sick. Three examples illustrate what can happen to employees working for a hypothetical company, American Widgets, that purchases a high-deductible health plan.

American Widgets Chooses a New Health Plan

American Widgets had always paid the full cost of its employees' health insurance. This year, concerned about rising premiums, the company made a change: Instead of offering a comprehensive, low-deductible plan, American Widgets would offer a high-deductible plan that could be used with Health Savings Accounts (HSAs). The employer put part of the amount saved on premiums into Health Savings Accounts (HSAs) for each worker. The employer also encouraged employees to save some of their own money in the accounts, explaining that the amounts set aside in HSAs would be tax-free, as would any interest earned. The employer emphasized that employees could use any money saved in their accounts for medical expenses in future years, and they could take the accounts with them if they changed jobs.

American Widgets set up a Health Savings Account for each worker and purchased a fairly typical high-deductible health plan with the following features:[1]

Plan Feature	Single Employee Coverage	Family Coverage
Annual Deductible (No deductible for preventive care)	$1,900	$4,100
Out-of-Pocket Maximum	$2,550	$4,675
Employer's Annual Contribution to the HSA	$600 ($50 monthly)	$1,200 ($100 monthly)

American Widgets contributes $100 per month to the Health Savings Accounts of employees with family coverage. Employees can contribute additional amounts to these accounts themselves. Money in the accounts can be used to pay for medical care until they meet their deductible, for copayments (once the deductible is met and coverage begins), and for other medical expenses not covered by the plan. Together, an employer and employee can contribute to an HSA an amount up to the employee's deductible each year.[2] In this case, if the employer contributes $1,200 a year for family coverage, an employee can contribute up to $2,900 a year, which is about $242 a month ($4,100 deductible - $1,200 employer contribution = $2,900).

Under the high-deductible plan purchased by American Widgets:

- Families must pay the first $4,100 of medical expenses out of their own pockets (their annual deductible) before the plan will begin paying for most medical care. This particular plan will pay for some preventive care, such as annual physicals, before employees have met their deductible.
- After families pay $4,675 for medical care themselves (the "out-of-pocket maximum"), the plan will pay 100 percent of *covered* medical services. However, this coverage comes with some caveats: The only expenses that count toward the $4,675 threshold are those that the family pays toward covered services. For example, if a family pays for a service that their plan never *covered*, such as a prescription drug that is not on the plan's formulary, or a type of therapy that the plan does not cover, that expense does not count toward the out-of-pocket maximum. Further, for services that the plan does cover, only amounts up to the plan's approved prices will count toward the out-of-pocket maximum.

While American Widgets' new plan may sound reasonable, many of its employees will find that their health and their pocketbooks both suffer when they join the plan, as shown by the following three examples.

EXAMPLE 1:
Some people will put off care because of its cost and later find that they have damaged their health

Scenario:

Sam was feeling somewhat short of breath and had tightness in his chest. However, since he hadn't met his plan's $4,100 family deductible, he knew that if he sought care, he would have to pay the full cost of a doctor's visit and any lab work. Because he was already sick, this would not fall under his plan's coverage for preventive care. Besides, he wasn't sure that his symptoms were serious; he might just be experiencing symptoms left over from last month's cold. A friend of Sam's had recently gone to the doctor for heart tests. The friend's bill for an EKG, chemistry, hematology, a chest x-ray, and an emergency room visit totaled $2,200. And, after all those expensive tests, his friend found out that his heart was fine.[3] Sam decided that he would spare his family this expense.

Unfortunately, Sam was wrong—it turned out that he was having a heart attack.

Comment:

People in high-deductible health plans are much more likely to forgo care due to cost than people in more traditional health plans. In a recent survey, 44 percent of adults with deductibles of $1,000 or more reported that they had a medical problem but did not see a doctor; did not fill a prescription; did not see a specialist when needed; or skipped a recommended test, treatment, or follow-up visit. This percent was much higher than the proportion that went without care in lower-deductible plans—25 percent of adults with deductibles under $500 cited similar problems.[4]

Increasing Disparities:

High-deductible health plans exacerbate a problem that already exists in the minority community. African Americans and Latinos are more likely to forgo care due to cost.[5] This is part of an overall trend in which more people are reporting that they are unable to obtain medical care due to cost. For example, between 1998 and 2004, there was a 31 percent increase in the percentage of people who went without medical care at some point during the year.[6]

Cost barriers occur most frequently among individuals who report being in poor health, a population that disproportionately includes people from communities of color. In 2003, individuals who perceived their health as poor or fair were several times more likely to forgo needed medical care due to cost than people who reported being in good to excellent health.[7] This is a disturbing trend that suggests that the use of HSAs could actually *increase* racial and ethnic health disparities by imposing substantial financial barriers for groups that already suffer from worse health and are less able to afford the care they need.

EXAMPLE 2:

Some people will be unable to pay for their care when illness strikes

Scenario:

John, father of two, decided to save enough money in his HSA over the course of the year to meet his family's deductible in case any of his family members became ill. It was a struggle, but each month, in addition to the $100 that his employer contributed, John contributed $242 to his HSA. He reasoned that this would be enough to protect his family if they got sick, and that if they did not, he would have some tax-free savings to apply to future health care needs (such as glasses, braces, etc.).

Unfortunately, a month after enrolling in the new plan, John was diagnosed with prostate cancer. At that point, he had saved only $342 in his HSA, and he had no other savings. He knew that he had to meet a $4,100 annual deductible before his plan's coverage would begin, and he did not have enough resources to pay for the care that he needed as soon as possible. He was prescribed Lupron, which cost $900 a month, and he had to pay to fill each prescription. Additionally, since the cancer was in a confined area, the doctor recommended surgery. The hospital charges would be more than John could afford—he did not have enough money to meet his deductible, and John knew that even when the plan's coverage began, he would still face substantial copayments for some services.

Comment:

It is very likely that people will incur medical expenses that are near the amount of their deductible or that exceed it. Eighty-five percent of Americans have health care expenses during the year, and in 2003 (the last year for which data are available), the average was $3,601.[8]

Increasing Disparities:

Some racial and ethnic minority groups are especially likely to be affected by this problem. African Americans, American Indians, Latinos, and some Asian-American subpopulations generally have lower incomes and are less able to set aside money in HSA plans.[9] Moreover, racial and ethnic minorities are more heavily concentrated in the lowest tax brackets; putting money into an HSA actually saves them *less* than individuals with higher incomes, meaning that they have less incentive to set aside money from their already limited incomes.

For both of these reasons, minorities with HSAs are less likely to be able to afford health care costs when illness strikes. This is a dangerous combination of factors for people that already suffer from worse health (including higher rates of death from cardiovascular disease and cancer). While some minorities might be drawn to HSAs because of their lower premiums, such plans threaten to widen the health disparities gap for racial and ethnic minorities.

EXAMPLE 3:

People may have little control over their health care costs, and the out-of-pocket costs they actually owe may be much higher than the plan's stated limits

Scenario:

Mary, a cost-conscious consumer with some health problems, heard that a high-deductible plan coupled with an HSA would give her "flexibility and control over her health care dollars." She intended to consider both price and quality as she shopped for her family's health care. She thought the plan's $4,675 annual cap on out-of-pocket expenses would protect her family from unaffordable costs. She had enough money in her HSA to meet her $4,100 deductible and, confident that she could come up with $575 for copayments once her plan's coverage began, she felt safe.

Mary's plan used a preferred provider network, and she intended to use only in-network services. However, when Mary was hospitalized for a diabetic coma, she was dismayed to find that she had little control over her health care costs. The ambulance took her to the nearest hospital, which was not in her plan's network. When Mary was admitted to the hospital, only the prices that an in-network facility would have charged were counted toward her deductible and out-of-pocket maximum, but the actual cost of her care was much higher. Additionally, the hospital assigned the anesthesiologists and specialists who took care of her; Mary was in no condition to ask what they would charge for her care. She did not realize that these professionals were also outside of her plan's network and that they charged more than the plan-approved rates. Once she got out of the hospital, Mary needed services, such as dietary counseling and some diabetes supplies, that were not among her plan's benefits. Altogether, Mary's annual out-of-pocket costs were $10,000, more than twice the out-of-pocket limit for which she was prepared.

Comment:

Consumers can experience high out-of-network costs in any preferred provider organization (PPO), whether or not it is a high-deductible plan. However, high-deductible plans and HSAs are often marketed as a way that cost-conscious consumers can control their health care costs, and consumers are misled both about their ability to "shop" for care and about their ability to limit their own out-of-pocket costs. Participants in focus groups organized by the U.S. Government Accountability Office reported confusion about expenses that would and would not be covered by their high-deductible health plans. Some plans offered preventive visits without charge, but participants noted that laboratory tests associated with preventive visits were not covered. They also reported that they did not know whether services were provided by an in-network or out-of-network provider, especially in emergency situations, and they were therefore left with large bills.[10]

Moreover, high-deductible plans burden consumers with greater health care costs than they face in traditional plans. Already, more than half of Americans with employer-based coverage pay more than $2,000 a year for care out of their own pockets. Using high-deductible policies increases the amount that they must pay out-of-pocket.[11] A recent survey found that two out of five adults in high-deductible health plans spent 10 percent or more of their family incomes on premiums and out-of-pocket medical expenses, compared with one of five of those enrolled in plans with lower deductibles.[12] And on average, the out-of-pocket spending limits in high-deductible plans are higher than in lower-deductible plans.[13]

Increasing Disparities:

Racial and ethnic minorities are disproportionately more likely to suffer from chronic diseases, such as diabetes, asthma, cancer, and heart conditions, that often require more frequent, costly, and sometimes urgent care.[14] They are also much more likely to report being in fair or poor health.[15] Ironically, despite these factors, minorities spend much less on health care, which suggests that cost may pose a significant barrier to obtaining care.[16] The use of HSAs could exacerbate existing health disparities by encouraging low-income minorities to enroll in plans with high deductibles, creating additional financial barriers to care and leaving many of them unable to afford care for the conditions they are more likely to face.

Conclusion

HSAs and high-deductible health plans represent a tremendous gamble for health care consumers: While such plans may benefit people who remain healthy, people who become ill often have a hard time paying for their care. People may forgo care due to cost, only to find that they have a serious condition that would have improved with earlier treatment. Even if people save a significant amount of money in their HSAs, they may not have sufficient funds to pay for care when illness strikes. And lower-paid workers have less ability to save money in HSAs than higher-paid workers.

Although HSAs and high-deductible plans are often marketed as ways to give consumers "control" over their health care budgets, people who are sick actually have little control over their health care costs. What's more, after they meet their plans' deductibles, they often face high out-of-pocket expenses for services that are not covered by their plans and for out-of-network care that, especially in an emergency, may be unavoidable.

And while HSAs and high-deductible health plans are a gamble for all individuals, they are especially risky for many racial and ethnic minorities. Because racial and ethnic minorities tend to be heavily concentrated in lower income groups and are especially likely to suffer from chronic diseases, these groups stand to gain the least from any HSA tax savings. Lastly, a disproportionate number of minorities already forgo care due to the cost, and the increased use of high-deductible plans will make this problem even worse.

Endnotes

[1] These features are roughly based on average high-deductible health plans eligible for use with an HSA that were offered by employers in 2005, according to the Kaiser Family Foundation's Employer Health Benefits 2005 Annual Survey. In that survey, the average deductible was $1,901 for a single employee and $4,070 for a family. The average out-of-pocket maximum was $2,551 for a single employee and $4,551 for a family. And the average annual employer contribution to an HSA was $553 for a single employee and $1,185 for a family. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey* (Washington: Kaiser Family Foundation, September 2005).

[2] Under federal law, the maximum HSA contribution is either the lesser of the deductible or $2,700 for single coverage or $5,450 for family coverage in 2006. This amount is adjusted for inflation annually.

[3] Costs are based on an actual bill for a patient at Fairfax Hospital in Virginia. Patients with heart problems may also receive echocardiograms, which increase the cost by about $200. A person admitted for overnight observation for heart problems might get a bill of $7,000 or more.

[4] Sarah Collins, Jennifer Kriss, et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: Commonwealth Fund, September 2006).

[5] Centers for Disease Control and Prevention, *Early Release of Selected Estimates Based on Data from the 2005 National Health Interview Survey* (Atlanta: Centers for Disease Control and Prevention, June 2006).

[6] Ibid.

[7] U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003, "Table 3.2: Percent of Families in Which a Member Was Unable or Delayed in Receiving Needed Medical Care, United States, 2003" (Rockville, MD: U.S. Agency for Healthcare Research and Quality, 2003), available online at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/acc/2003/acctocare_3_2_2003.htm.

[8] David Kashihara and Kelly Carper, *National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population* (Rockville, MD: U.S. Agency for Healthcare Research and Quality, November 2005).

[9] Median income, using three-year-average medians from 2003 to 2005, is significantly lower for African Americans, American Indians, and Latinos. According to the U.S. Census Bureau's 2005 Current Population Survey, three-year-average median income was lowest for African Americans ($31,140), followed by American Indians ($33,627) and Latinos ($35,467). Non-Latino whites, in comparison, had a median income of $50,677. Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *U.S. Census Bureau, Current Populations Reports, P60-231, Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington: U.S. Government Printing Office, August 2006), Table 2.

[10] U.S. Government Accountability Office, *Consumer-Directed Health Plans: Early Experiences with Health Savings Accounts and Eligible Plans* (Washington: Government Accountability Office, August 2006), p. 27.

[11] In 2003, 55.7 percent of individuals with private group coverage had family-level health care spending that exceeded $2,000. For families that individually purchased insurance (instead of getting it through their employer), 77.9 percent spent more than $2,000 out-of-pocket. D. Bernard and J. Banthin, *Out-of-Pocket Expenditures on Health Care and Insurance among the Nonelderly Population, 2003, Statistical Brief #121* (Rockville, MD: U.S. Agency for Healthcare Research and Quality, March 2006), available online at http://www.meps.ahrq.gov/papers/st121/ stat121.pdf. A GAO study examined the health plans of three employers that each offered both high-deductible and traditional PPO health plans in 2005. The study showed that enrollees using extensive health care would pay more under the employers' high-deductible, HSA-qualified plans than under the employer's traditional PPO plans. (U.S. Government Accountability Office, op. cit.

[12] Sarah Collins, Jennifer Kriss, et al., op. cit.

[13] Government Accountability Office, op. cit., p. 13.

[14] Marsha Lillie-Blanton, Osula Evadne Rushing, and Sonia Ruiz, *Key Facts: Race, Ethnicity & Medical Care, Update June 2003* (Menlo Park, CA: Kaiser Family Foundation, 2003).

[15] P. F. Adams and P. M. Barnes, *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2004* (Hyattsville, MD: National Center for Health Statistics, August 2006). According to the survey, 13.2 percent of Latinos, 14.6 percent of African Americans, and 16.5 percent of American Indians reported being in less than good health, compared to 8 percent of white, non-Latinos.

[16] Average out-of-pocket expenditures per person for those with expenses in 2003 were $388 for Latinos and $488 for African Americans, compared to $810 for non-Latino whites. Analysis based on Medical Expenditure Panel Survey Component Data, *Total Health Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2003* (Rockville, MD: Agency for Healthcare Research and Quality, 2003).

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