Statement

on

Health Savings Accounts

by

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An Unsustainable Path

Government at all levels in the United States currently spends about 7.2 percent of gross domestic product (GDP) on health care, mainly on Medicare and Medicaid. Yet Christian Hagist and Laurence J. Kotlikoff have shown that if benefits expand at the rate of the past 30 years and if the population ages the way demographers predict, government health care spending will equal one-third of national income by mid-century, when today's college students reach the retirement age.[1] If that is not immediately alarming, note that one-third of GDP is about equal to all government spending for all purposes today. If private spending on health care keeps up with public spending, the nation will devote about two-thirds of national income to health care by mid-century — an amount roughly equal to the total consumption of all goods and services today.

So in the public sphere, health care is on a course to crowd out every other government program — from education and roads and bridges to Social Security and national defense. And for the economy as a whole, health care is on a course to crowd out every other form of consumption, including food, clothing, housing, etc.

Clearly we are on an impossible path. And the longer we stay on it, the more painful it will be to get off of it. Yet it is impossible to get off of it unless someone is forced to choose between health care and other uses of money. The question is: who will that someone be?

Choosing Between Health Care and Other Uses of Money

[1] Christian Hagist and Laurence J. Kotlikoff, "Health Care Spending: What the Future will Look Like," National Center for Policy Analysis, NCPA Policy Report No. 286, June 2006.

Busy people are often unaware of how easy it is to spend other people's money on health care. Let me give you a few examples. The Cooper Clinic in Dallas offers an extensive checkup (with a full body scan) for about $2,000 or more. Its clients include Ross Perot, Larry King and other high-profile individuals. Yet if everyone in America took advantage of this opportunity, we would increase our nation's annual health care bill by almost one-third. More than 1,000 diagnostic tests can be done on blood alone; and one doesn't need too much imagination to justify, say, $6,500 worth of tests each year. But if everyone did so we would double the nation's health care bill. Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought professional advice before making such purchases, we would need 25 times the number of primary care physicians we currently have.[2] Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another. At a conservative estimate of, say, $1,000 a test, it would cost more than $1 million for a patient to run the full gamut. But if every American did so, the total cost would run to about 30 times the nation's annual output of goods and services.

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. We are simply collecting information. If in the process of searching we actually found something that warranted treatment, we could spend even more.

One of the cardinal beliefs of advocates of single-payer health insurance is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free, people would have an incentive to obtain each and every service so

[2] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2, Summer 1990, pages 27-28.

long as it had any value at all to them. In other words, everybody would have at least an economic incentive to get the Cooper Clinic annual checkup, order dozens of blood tests, check out all their genes and consult physicians at the drop of a hat. In short order, unconstrained patients would attempt to spend the entire gross domestic product on health care even though, as a practical matter, that would be impossible.

To control the growth rate of health care spending, someone must choose between health care and other uses of money. That is, someone must decide that useful, beneficial health care procedures are not as valuable as other goods and services that could be purchased with the same funds. How can those decisions be made?

In principle there are only a limited number of ways choosing between health care and everything else. Three especially interesting approaches would have these choices made by: (a) government (national health insurance), (b) employers and insurers (managed care) or (c) patients in consultation with their doctors (consumer-driven health care).

Given the large number of devotees of all three approaches, you would think there would be a rich literature on how each allocates resources by comparing the costs and benefits of different types of care. In fact, the reverse is true. The very subject is virtually taboo.[3] Take positron emission tomography scanners, for example. At last count there were more than one thousand in the United States, but only three in Canada.[4] So how did Canada decide that the benefits of the 4th PET scanner (in terms of lives saved, diseases cured, etc.) was not worth the

[3] An exception is John C. Goodman, Gerald L. Musgrave and Devon M Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, Md.: Rowman & Littlefield, 2004).

[4] Of the 12 PET scanners in Canada, two are owned by private providers and seven are available only for research and clinical trials. See Laura Eggertson, **"**Radiologists, physicians push for PET scans," *Canadian Medical Association Journal*, Vol. 172, No. 13, June 21, 2005. Also see ; "What is PET?" Society of Nuclear Medicine, 2006.

monetary cost? Is there some cost-benefit comparison in a paper or official document somewhere? None that I can find.

The PET scan example is not unique. Around the world, managers of government-run health care systems rarely discuss rationing decisions and how they are made.[5] The advocates of single-payer national health insurance are even worse. Scan their literature and you will search in vain for any discussion of how we should trade off health care benefits against monetary costs.[6]

The advocates of managed care are not much better. Think how many trees have been felled to support the huge volume of literature on this subject. But where in all this text is there a discussion of how managed care organizations are suppose to make cost-benefit tradeoffs? I have yet to find it.[7]

Surprisingly, the advocates of consumer-driven health care (CDHC) are also reluctant to broach this subject. In fact, some of the most ardent supporters of Health Savings Accounts (HSAs) on Capitol Hill flatly deny that their purpose is to facilitate choices between health care and nonhealth care consumption. Indeed, this is the main reason why the law discourages people from removing their end-of-year HSA balances for nonhealth purposes.[8]

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[5] An exception is the Oregon Medicaid program, which prioritized 300 services and pledged to provide only those that the budget would allow. See Martin A. Strosberg, Joshua M. Wiener, Robert Baker and I. Alan Fein (editors) *Rationing America's Medical Care: The Oregon Plan and Beyond, edited by* (Washington, D.C.: The Brookings Institution, 1992).

[6] See Marcia Angell and the Physicians' Working Group, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Physicians for a National Health Program, August 13, 2003.

[7] There is of course a large and growing literature on cost effectiveness (e.g., how much does a procedure cost in terms of years of life saved?). These studies can serve as the basis for decision-making but they do not tell us how to make decisions.

[8] Withdrawals for nonhealth purposes are subject to income taxes and a 10 percent penalty (before age 65). As a result, the tradeoff is not on a level playing field. For a family in the 25 percent tax bracket, $1 of health care trades against 65¢ of other goods, at least in the current period.

There is, however, this difference: Whether the supporters admit it or not, the United States is the first developed country to set up a formal, institutional mechanism that allows people to choose between health care and other uses of money on a rational basis.[9] As such, HSA accounts have the potential to revolutionize the health care system. Yet they will succeed in doing so only if they free patients to perform consumer functions that they have not been hitherto performing: (1) make tradeoffs between health care and other goods and services; (2) become savvy shoppers in the medical marketplace; and (3) become managers of their own care.

Patients as Choosers

Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We don't want a parent to choose not to have her child vaccinated, or an at-risk expectant mother to avoid prenatal care, or a heart patient to eschew aspirin or beta blockers. The reason: there is overwhelming evidence that the social benefits of the care exceed the social cost.[10] Yet instances where we can be absolutely sure that we know which alternative is the right choice are rarer than one might suppose. At the other extreme, there are literally thousands of cases where only the patient can make the right choice.

Take arthritic pain relief. The annual cost of brand-name drugs runs about $800 more than over-the-counter substitutes and they are riskier (Vioxx and Bextra, for example, have been removed from the market). Is the extra cost and risk worth the marginal improvement in pain

[9] Note, however, that South Africa's Medical Savings Accounts were introduced more than a decade ago and Singapore's medisave accounts are now two decades old. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000; Thomas A. Massaro and Yu-Ning Wong, "Medical Savings Accounts: The Singapore Experience," National Center for Policy Analysis, NCPA Policy Report No. 203 April 1996.

[10] See Tammy O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, Vol. 15 No. 3, 1995; and David M. Eddy (editor), *Common Screening Tests*, (Philadelphia: American College of Physicians, 1991).

relief offered by a prescription drug? Since drugs affect different people differently, we cannot determine for someone else whether the tradeoff is worthwhile. So it is appropriate and desirable for people to make these decisions themselves and reap the full benefits and bear the full costs of decisions they make.

The problem with the current system is that all too often patients have no opportunity to make such choices. The reason: most of the time they are buying health care with someone else's money. Ironically, most of the people who were taking Vioxx should not have been taking it; and the best predictor of whether a patient was taking it was whether a third-party was paying the bill.[11] This example is far from unique. For the health care system as a whole, patients pay only 14 cents out of pocket every time they spend a dollar, on the average. So the economic incentive is to spend on health care until its value to the patient is only 14 cents on the dollar. It's hard to imagine a more wasteful incentive structure.

With HSAs, people will not spend a dollar on health care services unless they get a dollar's worth of value. In this respect, HSAs greatly improve patients' incentives. If there is a problem, however, it is that the law is too rigid — requiring an across-the-board deductible for all services, other than preventive services. The answer to the critics is to allow plans to create high deductibles where the exercise of patient discretion is both possible and desirable and create low deductibles where discretion is not possible or, in any event, not desirable.

[11] A recent study found that two-thirds of patients on Cox-2 inhibitors were not at risk for gastrointestinal conditions like ulcers or bleeding, and most of them had not tried cheaper alternatives. See Emily R. Cox et Al., "Prescribing COX-2s for Patients New to Cyclo-oxygenase Inhibition Therapy," *American Journal of Managed Care*, Vol. 9, No. 11, pp. 735-42, November 2003. A separate study found that seniors with generous drug coverage but moderate risk of gastrointestinal problems were more likely to be on a COX-2 inhibitor than seniors with high gastrointestinal risk but no drug coverage. See Jalpa A. Doshi, Nicole Brandt and Bruce Stuart, "The Impact of Drug Coverage on COX-2 Inhibitor Use In Medicare," *Health Affairs*, Web Exclusive W4-94, February 18, 2004.

How do patients react when they are asked to manage their own health care dollars? We actually have far more experience with consumer-directed health care than many scholars realize. For example, we have more than a decade of experience with Medical Savings Accounts (MSAs) in South Africa, and in this country seven years experience with the MSA pilot program, four years of experience with Health Reimbursement Arrangements (HRAs) and two and a half years with HSAs. The problem is: the data mainly resides with insurers who regard it as proprietary and, therefore, the results are reported by entities with a financial self-interest in the outcomes.

Even so, reported results of MSAs in South Africa (Discovery Health)[12] and HRAs in the United States (Aetna)[13] are consistent with common sense. Patients cut back in areas where there is presumed to be a lot of waste and substitute less expensive treatment options for more expensive ones. That is, there are fewer trips to primary care physicians; brand-name drug purchases are down; generic purchases are up, etc. These findings were also evident in an Employee Benefit Research Institute study.[14] Consumers were more cost-conscious — about one-third of consumers with high-deductible or consumer-driven health plans avoided or delayed seeking care.

A McKinsey study (based on a year's experience with HSAs) found that CDHC patients were twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option. Further, chronic patients were 20 percent more likely

[12] Matisonn, "Medical Savings Accounts in South Africa."

[13] "Aetna HealthFund First-Year Results Validate Positive Impact of Health Care Consumerism," Press Release, Aetna, June 24, 2004.

[14] 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, Issue Brief No. 288, December 2005.

to follow treatment regimes very carefully.[15] A South African study suggests that CDHC patients can control drug costs as well as managed care, but without the cost of managed care.[16]

Early critics of CDHC worried adverse selection of young, healthy workers would destroy traditional risk pools. Yet there is no evidence that CDHC attracted disproportionate numbers of young people. When adjusted for retirees who were not eligible, a recent GAO report of government workers found those joining CDHC plans were about the same age as enrolling in more traditional plans.[17] Two additional GAO reports came to similar conclusions.[18] A recent survey by the health insurance industry trade group found adult enrollees evenly distributed with nearly one-quarter between the age of 40 and 49 and one quarter above that age group and one-quarter below.[19]

Assurant Health (formerly Fortis) reported on its enrollees with health savings accounts in 2005. It found:[20]

- Nearly one-third (30 percent) had less than $50,000 annually in family income.
- About 44 percent had previously been uninsured shortly before obtaining an HSA.

[15] "Consumer-Directed Health Plan Report – Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[16] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002.

[17] GAO, "Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan," U.S. Government Accountability Office, Publication GAO-06-143, November 2005.

[18] GAO, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," US Government Accountability Office, Publication GAO-06-271, January 2006; GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," US Government Accountability Office, Publication GAO-06-798, August 2006.

[19] Hannah Yoo and Teresa Chovan, "January 2006 Census Shows 3.2 Million People Covered By HSA Plans," America's Health Insurance Plans, AHIP Center for Policy and Research, 2006.

[20] "Who's Taking Advantage of Health Savings Accounts (HSAs)? Who's Taking Advantage of Health Savings Accounts (HSAs)?" Assurant Health Quick Facts, 2006. Available. Internet. http://www.assuranthealth.com/corp/ah/AboutAssurantHealth/HSAFactSheet.htm. Accessed September 22, 2006.

- More than half (61 percent) were older than age 40.
- More than two-thirds (69 percent) were families with children.

The results on enrollee satisfaction have been mixed. A recent GAO report found strong satisfaction[21] as did reports by Lumenos[22] and Aetna.[23] However, reports by McKinsey and EBRI reported lower satisfaction than those enrolled in traditional health plans.[24] It's not clear what this means. A study in the *Annuals of Internal Medicine* found satisfactions is not related to quality.[25] In fact, this phenomenon is not uncommon among consumer goods. Satisfaction is generally more closely related to good communication and met expectations.[26] Moreover, surveys where enrollees rate their CDHP lower than managed care may be sampling unrepresentative enrollees or people who perceived they've lost benefits when switched to a full-replacement CDHC plan.[27] Or it may point to the need to have better consumer education and about the merits and uses of the plans in addition to greater price transparency.[28]

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[21] GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," US Government Accountability Office, Publication GAO-06-798, August 2006.

[22] "Survey Reveals Lumenos Customers More Satisfied than Members of Traditional Health Plans," Press Release, Lumenos, 2004.

[23] About 90 percent of enrollees said plan met expectations and would enroll again. See "Aetna HealthFund Fact Sheet," Aetna, 2006. Available at http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_factsheet.html. Accessed September 22, 2006.

[24] 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, Issue Brief No. 288, December 2005. "Consumer-Directed Health Plan Report – Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[25] John T. Chang, "Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care," *Annals of Internal Medicine*, Vol. 144, No. 9, May 2, 2006.

[26] Holman W. Jenkins, "No, Consumer Theory Isn't a Cure-all for Health Care," *Wall Street Journal*, September 20, 2006.

[27] Devon Herrick, "Experts Doubt Survey Findings on Health Plan Owners' Satisfaction," *Health Care News*, February 1, 2006.

[28] "Brokers Predict Massive Change: Results from the 2006 NAHU/Chapter House Benefit Buying Trends Study," National Association of Health Underwriters/Charter House, 2006.

What about preventive care? McKinsey, Aetna, National Center for Policy Analysis (Discovery Health) and Humana[29] all report an increase in preventive care — even as they report other, significant cost-reducing changes in patient behavior. Note, however, that many CDHC plans contain extra incentives to seek and obtain preventive care. Discovery Health tried to determine whether skimping on care in the short run caused higher costs in later years and found no evidence to support the claim.[30]

Creating Opportunities for the Chronically Ill[31]

The chronically ill are responsible for an enormous amount of health care spending. In fact, almost half of all health care dollars are spent on patients with five chronic conditions (diabetes, heart disease, hypertension, asthma and mood disorders). This is where HSAs have the greatest potential to reduce costs and improve the quality of care.

Healthy people tend to interact with the health care system episodically. Once in awhile they go to the emergency room or take a prescription drug. On these occasions, they gain knowledge that improves their skills as medical consumers. But it may be several years before they use that knowledge again, by which time it may be obsolete.

The chronically ill are different. Their treatments are usually repetitive, requiring the same procedures, visits and/or medicines, week after week, year after year. Consequently, cost-

[29] "Healthcare Consumers: Passive or Active?" Humana, June 28, 2005.

[30] Refuting the criticism that the reduction in spending reflects MSA holders' tendency to forgo appropriate health care would require a randomized longitudinal study with far more clinical data than is currently available. However, a comparison of catastrophic claims under the two different health plans did not show more catastrophic claims under the MSA plan than under the non-MSA plan. Apparently MSA-holders are not healthier as a group. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000

[31] John C. Goodman, "Making HSAs Better," National Center For Policy Analysis, Brief Analysis No. 518, June 30, 2005.

saving discoveries by these patients are not one-time events. Rather, they pay off indefinitely. Suppose a diabetic patient learns how to cut the costs of her drugs in half, by comparing prices, shopping online, bulk buying, pill splitting or switching to a generic brand. Such a discovery could be financially very rewarding to a patient who must pay these costs out of pocket.

Numerous studies have found the chronically ill can reduce costs and improve quality by managing their own care. But health care management is difficult and time-consuming. So patients should reap both health rewards and financial rewards from making better decisions. Insurers should be able to create versatile HSA accounts for patients with differing chronic conditions. They should be able to adjust the accounts' funding to fit specific circumstances. A typical Type II diabetic, for example, might receive one level of HSA deposit from his employer; a typical asthmatic patient another.

The problem is: The HSA law requires employers to deposit the same amount to each employee's HSA account, irrespective of medical condition. This is a strange requirement because employers who give employees choices of health plans are risk-rating their premium payments whether they are aware of it or not. If the sickest employees all choose Plan B and the healthiest choose Plan A, then the employer will invariably pay more premiums per employee to Plan B. Although employers risk-rate their premium payments, they are not allowed to risk-rate HSA deposits.