

medicaid and the uninsured

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Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?

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EXECUTIVE SUMMARY

Health Savings Accounts are a type of medical savings account that allow consumers to save for medical expenses on a tax-free basis. They are linked with high deductible health plans (HDHPs), and together these insurance and savings options represent a new approach to health care, commonly referred to as consumer-directed care. Health Savings Accounts (HSAs) were federally enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

To establish an HSA a consumer must enroll in an HDHP that meets certain requirements. In 2006, an HSA-qualifying HDHP must have a deductible of at least \$1,050 for single coverage and \$2,100 for family coverage. The plan must also limit the total amount of out-of-pocket cost-sharing for covered benefits each year to \$5,250 for single coverage and \$10,500 for families.

Compared to more traditional insurance plans, HDHPs generally require greater out-of-pocket spending, although the premiums may be lower. HSAs offer consumers a way to save for these higher expected health care costs. A key advantage of an HSA is that it belongs to the individual who establishes it and is portable. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted however, there are no further tax advantages to help defray additional out-of-pocket expenses.

HSA-qualified health plans are currently a small segment of the health insurance market. In 2006, about 1.4 million employees are enrolled in HSA-qualified HDHPs offered by their employers; and at least another 855,000 people are covered in the nongroup market.

While HSAs and their associated HDHPs have been forwarded as one solution to increasing health care coverage and reducing overall health care costs, a key question is whether these HSAs and HDHPs represent a viable health insurance option for low-income families. Analyses of available data and relevant research suggest that HSAs and HDHPs are no more affordable for low-income families than existing plans, and the high deductibles associated with these plans may shift even more health care costs onto them.

KEY FINDINGS:

Premiums for HSA-qualified health plans may be lower than for traditional insurance, but these plans shift more of the financial risk to individuals and families through higher deductibles.

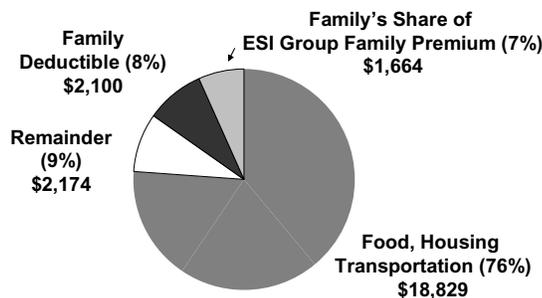
Compared to all group health plans, premiums for HSA-qualified HDHPs were about 30 percent lower in the group market in 2005. They are lower, in part, because the deductibles are much higher. The average deductible for an HSA-qualified health plan offered by employers was nearly six times higher than that for a PPO, the most common plan type.

HDHP premiums may be lower in the nongroup market on average than in the group market. However, because employers do not contribute toward a nongroup premium, the out-of-pocket costs for an individual or family are much greater. The average annual premium for an HSA-qualified HDHP in the nongroup market in 2005 (based on data from policies sold through eHealthinsurance) was \$3,324 for family coverage and would be paid completely out-of-pocket. In contrast, a family's out-of-pocket share for an HSA-qualified HDHP premium offered through an employer averaged \$1,664 in 2005.

Premiums and out-of-pocket costs for HSA-qualified health plans would consume a substantial portion of a low-income family's budget.

For a family with an annual income of about \$25,000, the basic needs of food, housing, and transportation consume three-quarters of their household budget. Assuming their employer contributes to their premium costs, but in this case not to an HSA, this family's share of the average premium for an HSA-qualified HDHP in the group market would require 7 percent of their income. If the family were to save \$2,100, the HSA required minimum family deductible amount, the combined premium and savings account would consume 15 percent of their income—leaving the family about \$2,200 a year for all expenses beyond their basic needs.

**Low-Income Household Expenditures Including HSA-HDHP
Group Premium, with Savings for a Minimum Deductible**



Average income in \$20,000 to \$30,000 range = \$24,767

Source: Group market premium from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005. Calculated based on income/expenditure data from BLS Consumer Expenditure Survey, 2004.

In contrast, for a family without employer-based coverage who is purchasing an HSA-qualified HDHP in the nongroup market, the premium alone would consume 13 percent of the budget. After putting aside \$2,100 in savings to cover health costs under the minimum deductible, such a family would be left with about \$500 for the remainder of their household expenses in a year.

The potential out-of-pocket costs in HSA-qualified high deductible plans could be much higher than those in traditional insurance. By law, the minimum family deductible in 2006 is now \$2,100. However, average deductibles are nearly two to three times higher than the required minimum, depending on whether the plan is in the group or nongroup market.

When the increased out-of-pocket costs for HSA-qualified HDHPs are considered along with the premiums, these plans are unaffordable for low-income families. Many of these families already face significant medical debt and have difficulty paying medical bills. High deductible plans for low-income families would do little to alleviate this burden.

Most low-income individuals and families do not face high enough tax liability to benefit in a significant way from tax deductions associated with HSAs.

According to data from the U.S. Department of the Treasury, a family of four with an income of \$20,000 would receive no benefit from contributing any amount to an HSA. In contrast, a family of four making \$120,000, would accrue \$620 in tax savings from contributing \$2,000 to an HSA. Coupled with the limited ability of low-income families to save money, the failure of HSAs to offer any real financial benefits for these families further reduces the likelihood that these plans will be attractive to low-income families.

People with chronic conditions, disabilities, and others with high-cost medical needs may face even greater out-of-pocket costs under HSA-qualified health plans.

People with chronic conditions and disabilities often experience higher medical costs than those without these conditions. For example, the total health care costs for individuals with asthma, heart disease, and diabetes are more than double that of nonelderly adults in general. As a result, these individuals are much more likely to reach their deductible level each year, which by design, is set at a much higher level in HDHPs.

Health Savings Accounts and HDHPs are likely to be more attractive to healthy individuals and families who have had few major medical expenses. If the healthiest increasingly enroll in HSA-qualified HDHPs while persons with chronic conditions and those with higher medical expenses remain in existing health plans, the premiums for traditional coverage will rise accordingly for the least healthy.

Cost-sharing reduces the use of health care, especially primary and preventive services, and low-income individuals and those who are sicker are particularly sensitive to cost-sharing increases.

Studies have found that increased cost-sharing leads to decreased health care use. Sentinel research from the RAND Health Insurance Experiment found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health and vision exams and treatment for infections) than people who were enrolled in health plans with no cost-sharing—and the gap was greater for those with low incomes (<200 percent of the poverty level). The study also found that low-income individuals in poor health who were subject to cost-sharing versus those who were not, experienced poorer health outcomes on certain measures, including the risk of dying for those with heart disease risk factors.

Health savings accounts and high deductible plans are unlikely to substantially increase health insurance coverage among the uninsured.

Over two-thirds of the nonelderly uninsured are low-income. Because they earn so little, over half of the uninsured have no tax liability. As such, health insurance proposals that rely on tax deductions as an incentive will have limited impact on the number of uninsured. In addition, high deductible health plans that require higher out-of-pocket spending will not offer the low-income uninsured enough financial protection to offset the premium cost.

CONCLUSION

Health Savings Accounts and associated high deductible plans have generated a great deal of interest among policymakers as a potential mechanism for reducing health care costs and perhaps even expanding access to health insurance. While HSA-qualified health plans have not been available long enough to fully assess their effect, salient research and analyses suggest that the benefit of these plans to low-income individuals and families will be minimal. Despite having lower premiums than more traditionally-structured health plans, HSA-qualified HDHPs are still likely to be unaffordable for most low-income families. These families have limited funds available to cover the higher out-of-pocket spending required of HSA-qualified HDHPs and are also unlikely to benefit from the tax-deductibility of HSA contributions.

By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but, in some circumstances, can also lead to poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care.

Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?

Introduced in 2003 as part of the Medicare Prescription Drug Improvement and Modernization Act, health savings accounts (HSAs) represent a new approach to health insurance. An HSA is a savings account that permits the owner to save for medical expenses on a tax-free basis. HSAs are linked with high deductible health plans (HDHPs), which have deductibles of \$1,000 or more for single coverage. HSAs and HDHPs are part of a new trend in health care, commonly referred to as “consumer-directed” or “consumer-driven” health care, that aims to involve consumers more directly in health care decisions by giving them a greater financial stake in the purchase of health care services.

While the number of people enrolled in HSA-qualified health plans is still relatively small, many federal proposals have been offered recently to promote HSAs both in the private market and in public programs. In his FY 2007 Budget, the President proposed a number of changes to the HSA requirements that would increase allowable contributions to HSAs and further enhance their tax benefits. These changes, in combination with tax credits for health premiums, have been the President’s primary strategies to expand insurance coverage to more Americans. Accounts similar to HSAs are also being promoted in the Medicaid program. Called Health Opportunity Accounts (HOAs), they were included as part of the 2006 Deficit Reduction Act, which mandated changes to the Medicaid program. The legislation allows up to ten states to develop high deductible coverage in Medicaid, coupled with HOAs. In contrast to HSAs, HOAs would be funded by the states and contributions by individuals would not be permitted. However, much like an HSA, the individual would pay for any health care expenses out of the account and then out-of-pocket until the deductible is met. The Centers for Medicare and Medicaid Services also recently announced that HSA-like coverage will be offered to Medicare beneficiaries beginning in 2007 or 2008.

To date, there has been relatively little experience with HSAs and high deductible plans in the private market. Given the public policy attention and focus though, it is important to understand the impact these new plans will have on different populations. This issue brief examines the potential implications of HSAs and HDHPs for low-income individuals and families. It focuses on the following basic questions:

- How affordable are premiums and out-of-pocket costs for those with low incomes?
- Can low-income families afford to save for greater out-of-pocket health care costs?
- How likely are those with low-incomes to benefit from HSA tax savings or refundable tax credits?
- How might HSAs and high deductible health plans affect people with chronic conditions or disabilities?
- How might HDHPs affect a low-income family’s health decisions?
- Are HSAs likely to expand the number of Americans who have health insurance coverage?

Background

Health Savings Accounts allow people to save for out-of-pocket health care costs on a tax-free basis. Health Savings Accounts, which are established specifically for paying out-of-pocket medical expenses, encourage people to save by making contributions and withdrawals tax-free. Those who set up an HSA may claim a deduction from their federal income taxes for the full amount they have saved. In order to qualify for this federal tax benefit however, a person or family must choose a health insurance plan with a high deductible; the deductible being the dollar amount at which the insurer begins to cover some or all of the medical bills. Under current law, funds in HSAs are to be used for the beneficiary's share of health costs (i.e., costs not covered by the health plan, including the out-of-pocket expenses of a spouse or dependent) and generally cannot be used towards the cost of premiums.

Figure 1
**HSA-Eligible
High Deductible Health Plan Requirements
2006**

	Single	Family
Minimum Deductible	\$1,050	\$2,100
Maximum HSA Contribution the lesser of deductible or:	\$2,700	\$5,450
Out-of-Pocket Limit	\$5,250	\$10,500

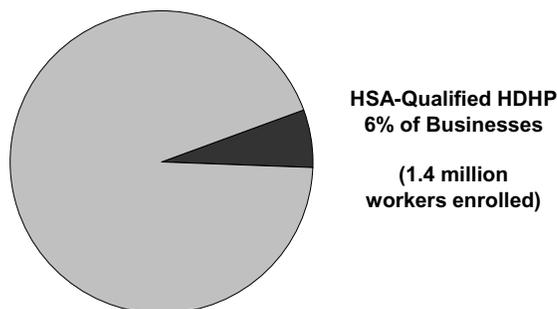
HSAs may only be used in conjunction with high deductible plans that meet certain requirements. An HSA-qualifying HDHP must have a deductible of at least \$1,050 for single coverage and \$2,100 for family coverage in 2006 (Figure 1). After the deductible is met, health insurance policies typically require additional cost-sharing in the form of co-payments and co-insurance. An HSA-qualified plan in 2006 must also limit the total amount of out-of-pocket cost-sharing for covered benefits each year to \$5,250 for single coverage and \$10,500 for families. However, HSA-qualified plans may impose annual and lifetime limits on benefits that are not counted toward the established out-of-pocket limits (e.g., a limit of 30 inpatient mental health days per year or a \$2,000,000 limit on all covered benefits).

Those who choose an HDHP are assuming more financial risk personally because they must pay for most medical costs out-of-pocket until they reach their plan's deductible. An HSA-qualified HDHP policy can cover services that are considered preventive care, such as prenatal care, immunizations, and cancer screenings, before a person or family meets their deductible, but cannot cover the costs of other types of services until the deductible has been met.¹

An HSA is a necessary reserve to help pay for the greater out-of-pocket expenses required by an HDHP, particularly for those with low incomes. A key advantage of an HSA is that it belongs to the individual who establishes it, and it is portable.² Funds that are not withdrawn in a year can be rolled over and used in future years. For 2006, the maximum annual HSA contribution is the lower of the HDHP's deductible amount or \$2,700 for single coverage and \$5,450 for family coverage. Once the HSA is exhausted, there are no further tax advantages to help defray additional out-of-pocket expenses.

HSA-qualified health plans are currently a small segment of the health insurance market, but are expected to grow. High deductible health plans that meet the HSA requirements are still relatively rare. While only two percent of firms with health benefits offered an HDHP that qualified for an HSA in 2005, the share grew to six percent this year (Figure 2). In 2006, about 1.4 million employees are enrolled in HSA-qualified HDHPs offered by their employers; and at least another 855,000 people are covered in the nongroup market.^{3, 4}

Figure 2
**Percent Offering HSA-Qualifying HDHPs
Among Businesses with Health Benefits, 2006**

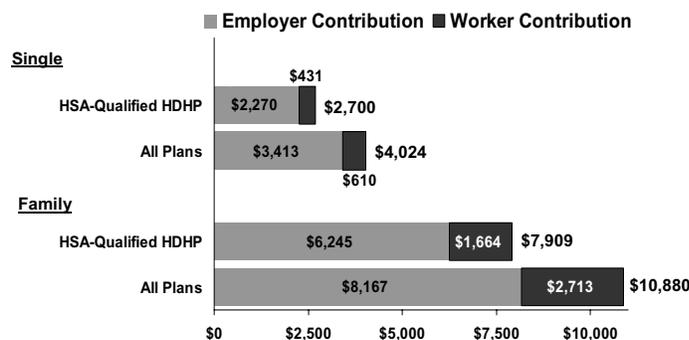


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

How Affordable are Premiums and Out-of-Pocket Costs for Low-Income Families?

Premiums for HSA-qualified health plans may be lower than for traditional insurance, but these plans shift more of the financial risk to individuals and families through higher deductibles. Premiums for HSA-qualified high deductible health plans may be less expensive than traditional coverage because of the greater cost-sharing assumed by the consumer. Compared to the average employer-sponsored family premium of \$10,880 (across all types of group plans), the cost of an HSA-qualified high deductible group plan averaged \$7,909 in 2005 (Figure 3). The employee share was about a fifth of the premium, amounting to \$1,664 a year—about \$1,000 less than the employee share for all health plans.

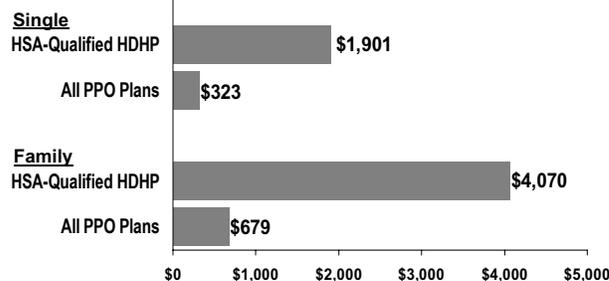
Figure 3
Annual Premiums and Contributions for Covered Workers, HSA-Qualified High Deductible Health Plans vs. All Plans, 2005



Note: Employer contribution does not include firm's contribution to an HSA. All differences between HDHP and the averages across all plans are significant ($p < .05$) except for single workers' contributions. Totals may not sum exactly due to rounding. SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

At the same time, the deductibles for HSA-qualified HDHPs—averaging \$4,070 for family coverage—were nearly six times higher than those for the most common type of health plan, PPOs (Figure 4).⁵

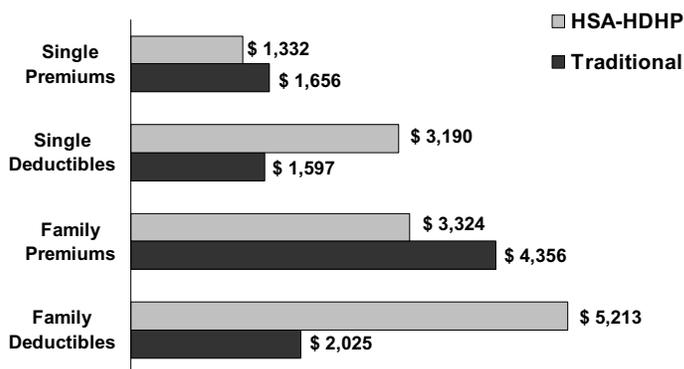
Figure 4
Annual Deductibles in Employer Group Plans, HSA-Qualified High Deductible Health Plans vs. All PPO Plans, 2005



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

Average health premiums are less expensive in the nongroup market than in the group market largely because they typically offer less coverage and require even greater cost-sharing. In a recent GAO analysis of HSA-eligible plans sold in the nongroup market by eHealthinsurance, the average annual premium in 2005 was \$3,324 for family coverage, while the deductibles were higher than HSA-HDHPs' deductibles in the group market, averaging \$5,213 for family policies (Figure 5).⁶ However, because an employer does not contribute in any way to these health plan costs, plans purchased in the nongroup market cost families considerably more out-of-pocket.

**Annual Premiums and Deductibles
in the Nongroup Market: HSA-Qualified HDHPs vs.
Traditional Plans, 2005**



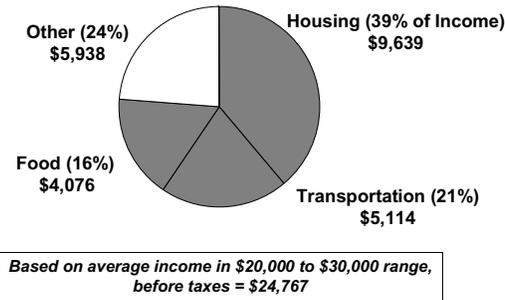
SOURCE:GAO analysis of eHealthinsurance information, 2006

The potential out-of-pocket costs in HSA-qualified high deductible plans could be much higher than those in traditional insurance. For example, looking just at low-income, privately insured adults who had any medical expenses in the year prior to the introduction of HSAs (2003)—half of them had total medical expenses of at least \$1,079 with \$265 of these costs paid out-of-pocket.⁷ If these individuals enrolled in an HSA-qualified HDHP in 2006 (and used health services as they had before, at the same cost) their out-of-pocket liability with the minimum deductible could potentially increase several fold. By law, the minimum individual deductible in 2006 is now \$1,050, however, average deductibles are about two to three times higher than the required minimum, depending on whether the plan is in the group or nongroup market.

Premiums and out-of-pocket costs for HSA-qualified health plans would consume a substantial portion of a low-income family's budget. Low-income is commonly defined as a family income less than twice the poverty level (equal to \$30,134 for a family of three in 2004). For purpose of example here, we use the average income for families with incomes between \$20,000 and \$30,000, which was \$24,767 in 2004, to portray a household budget.⁸ After basic housing, food, and transportation expenses for an average family in this income range, only about \$6,000 remains for other household expenses, such as child care, clothing, educational costs, taxes, various kinds of insurance, and out-of-pocket health care costs (Figure 7).

Figure 7

**Annual Expenditures in Households
with Incomes between \$20,000-\$30,000 (2004)**

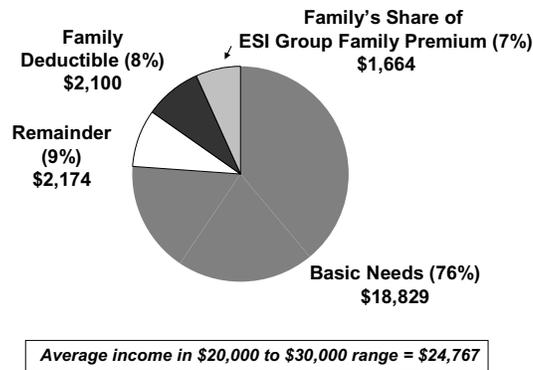


Source: Calculated based on income and expenditure data from the Bureau of Labor Statistics' Consumer Expenditure Survey, 2004.

If a low-income family paid the average cost for their share of an employer-sponsored HSA-qualified HDHP (\$1,664 in 2005⁹) it would consume 7 percent of their income—albeit, a smaller out-of-pocket amount than their share would be for the average employer benefit across all types of plans (11%). The minimum deductible required to qualify for the HSA tax benefit is now \$2,100 for a family policy. Assuming the employer contributes to their premium costs, but in this case not to an HSA, the savings needed to cover the deductible would require 8 percent of this low-income budget, on top of their out-of-pocket costs for the premium (Figure 8).

Figure 8

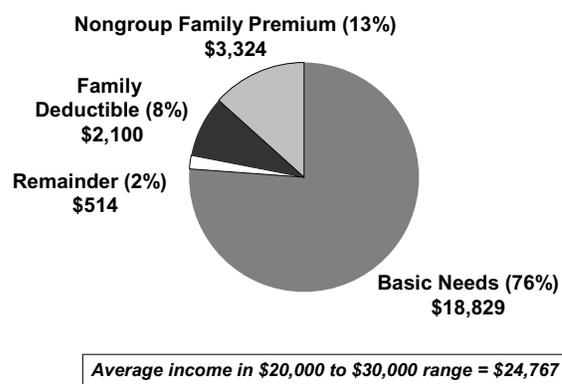
**Low-Income Household Expenditures Including HSA-HDHP
Group Premium and Minimum HSA-Qualifying Deductible**



Source: Group market estimate from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, for 2005. Calculated based on income/expenditure data from BLS Consumer Expenditure Survey, 2004.

In contrast, for a family without employer-based coverage who is purchasing an HSA-qualified HDHP in the nongroup market, the premium would be fully paid out-of-pocket and consume 13 percent of their budget. After putting aside \$2,100 in savings to cover health costs under the minimum deductible, such a family would be left with about \$500 for the remainder of their household expenses (Figure 9). Both of these examples however, are conservative estimates of the financial risk low-income families face with higher deductibles because deductibles in HSA-qualifying HDHPs are currently much higher than the required HSA minimum, averaging between \$4,000 and \$5,200 in 2005.¹⁰

Figure 9
**Low-Income Household Expenditures Including HSA-HDHP
 Nongroup Premium and Minimum HSA-Qualifying Deductible**



Source: GAO. *Consumer-Directed Health Plans*. 2006. Calculated based on income/expenditure data from BLS Consumer Expenditure Survey, 2004 and nongroup premium costs for 2005. Does not total to 100% due to rounding

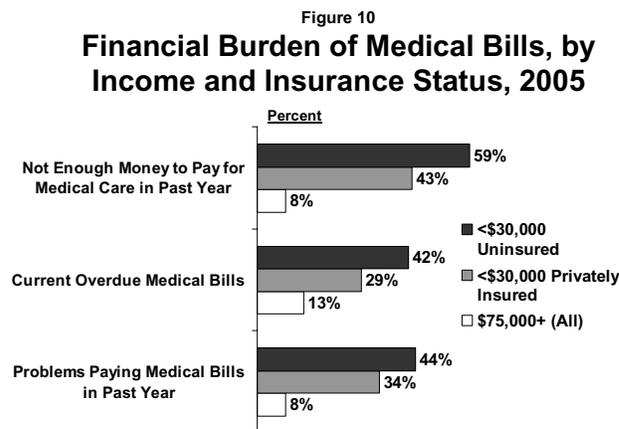
Low-income individuals and families bear a disproportionate financial burden for health insurance. While the cost of a nongroup family premium consumes about 13 percent of a low-income family’s budget, it would require less than four percent of a family’s budget with an income of \$100,000 (\$100,000 was at the 80th percentile of U.S. family incomes in 2004). And, while a \$2,100 deductible consumes another eight percent of a low-income family’s budget, it would represent only two percent of a \$100,000 family budget. Or framed in a different way: in order for a family with an annual income of \$100,000 to experience the same financial burden as a low-income family, they would need to pay \$13,000 for premiums and put aside another \$8,000 to cover costs under a proportionally equivalent deductible.

Can Low-Income Families Afford to Save for Greater Out-of-Pocket Health Care Costs?

Low-income families have limited ability to save for future health care costs and are less likely to receive assistance from their employers. Most individuals and families with HSA-qualified HDHPs would want to be able to save enough to cover medical expenses up to the deductible amount. However, according to a recent GAO study, the share of all HSA-eligible plan enrollees who had opened and contributed to an HSA was about 50 to 60 percent.¹¹ And, low-income families have the most difficulty saving money. Among all near-poor families (with a median annual income of \$26,000 in 2004) 56 percent say they are unable to save money and only 30 percent have a retirement account; 13 percent do not even have a transaction account, such as a checking account. The lowest income families (in the bottom 20th percentile with a median income of \$11,000) have even fewer reserves: 66% report being unable to save money, only 10 percent have a retirement account, and nearly a quarter do not have a checking or other kind of transaction account.¹²

Low-income workers who have employer-sponsored coverage are also less likely to benefit from employer contributions to HSAs. Employers may contribute to HSAs on behalf of their employees; and employers' contributions to health accounts averaged \$1,139 for family coverage in 2006. But, one-third of employers offering HSA-qualified HDHPs did not contribute to the HSA on behalf of their employees. Employee cost-sharing requirements, specifically deductibles, tend to be higher in businesses that employ more low-wage workers compared to businesses with mostly high-wage workers.¹³ Thus, low-wage workers may also be less likely to work for employers that contribute to HSAs.

Many low-income families are already burdened by their current out-of-pocket health care costs. Almost 30 percent of privately insured low-income adults reported in 2005 that they had overdue medical bills and 34 percent were having problems paying them (Figure 10).



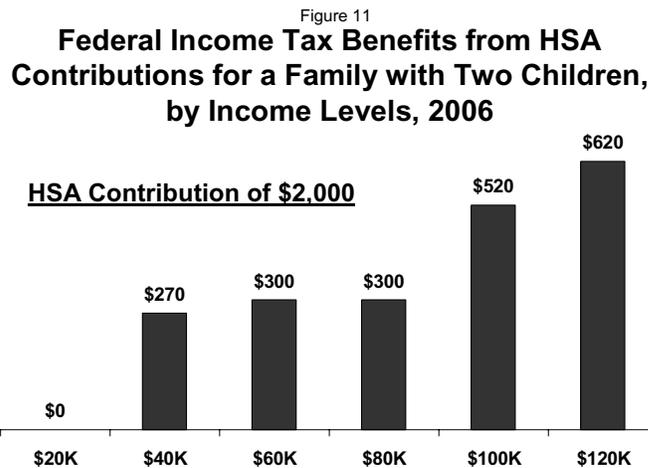
Source: USA Today/Kaiser Family Foundation/ Harvard School of Public Health . Health Care Costs Survey (conducted April 25-June 9, 2005)

Over 40 percent of low-income adults with private coverage also said that there was a time in the past year when they did not have enough money to pay for medical care, with almost 60 percent of the low-income uninsured reporting that care had been unaffordable for them in the past year. Among those low-income adults who said they had problems paying their medical bills, 54 percent reported using all or most of their savings and 44 percent had been unable to pay for basic necessities like food, heat, or housing. Shifting to an HSA-qualified HDHP would most likely increase financial burden. Few families at this income level would have enough discretionary income to be able to save the \$2,100 needed to cover the minimum deductible for an HSA.

How Likely are Those with Low-Incomes to Benefit from HSA Tax Savings and Refundable Tax Credits?

Most low-income individuals and families do not face high enough tax liability to benefit in a significant way from tax deductions associated with HSAs. A key benefit of HSAs is the ability to deduct contributions to HSAs from an individual's income taxes. However, information from the U.S. Department of the Treasury illustrates how limited the tax benefits from HSA contributions are for low-income families. A family of four with income of \$20,000 would receive no benefit from contributing to an HSA. In contrast, a family of four with income of \$120,000 gains \$620 in tax savings from a \$2,000 HSA contribution (Figure 11).

The tax structure of HSAs creates inequities in the costs borne by low-income families compared to those with higher incomes. By providing tax savings to higher income families, HSAs effectively reduce what these families pay for health services. In essence, a family making \$120,000 or more a year that contributes to an HSA reduces the cost of out-of-pocket health care spending by their marginal tax rate, about 30 percent. In contrast, a family with less than one-fifth the income must pay the full cost of any out-of-pocket health care expenses, regardless of whether they contribute to an HSA.

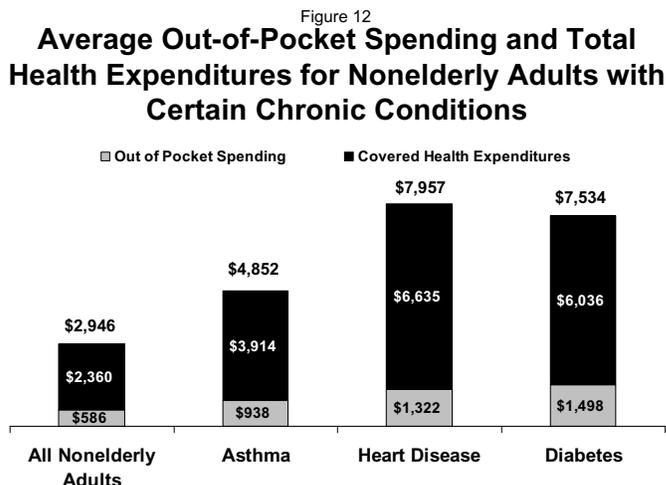


Source: U.S. Department of the Treasury. "HSA Tax Savings: Reduction in Federal Income Tax from HSA Contributions in 2006, Illustrative Examples." Available at <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa-examples.pdf>

How Might HSAs and High Deductible Plans Affect Persons with Chronic Conditions and Disabilities?

People with chronic conditions, disabilities, and others with high cost medical needs may likely face even greater out-of-pocket costs under HSA-qualified health plans. Groups likely to be affected by a major shift to HSA-qualified HDHPs in the marketplace are people with chronic conditions and moderate to severe disabilities who typically have higher annual out-of-pocket costs and total health expenditures. Average out-of-pocket spending among all nonelderly adults in 2003 was \$586. In contrast, average out-of-pocket costs among adults with asthma, heart disease, or diabetes for example, were considerably higher, ranging from \$938 to \$1,498 (Figure 12). Moreover, total health costs among nonelderly adults with diabetes, for example, are more than double the average for nonelderly adults in general (\$7,534 vs. \$2,946).

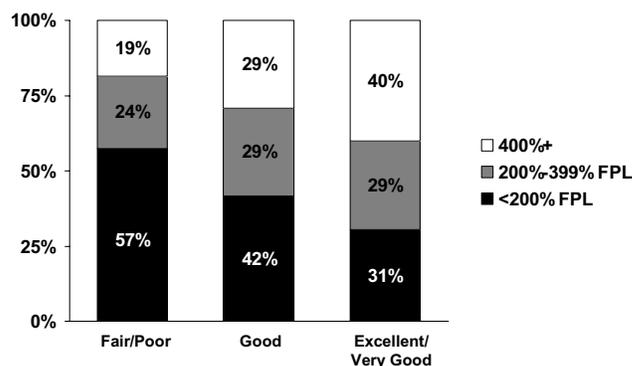
Persons with these kinds of chronic conditions are far more likely to reach their deductible level each year, even a high deductible. They are also the most likely to actually reach the out-of-pocket maximum in a HDHP because they have considerably higher than average total health expenditures each year. To the extent that the deductible and out-of-pocket maximums in HSA-qualified HDHPs exceed those in other plans, persons with chronic conditions would face even greater out-of-pocket costs.



Source: KCMU analysis of 2003 MEPS data

For some with high medical costs, particularly those with higher income, the tax benefits of HSAs can partially offset the higher out-of-pocket spending. However, because disability and chronic illness often affect one's ability to work, individuals in fair or poor health are more likely to be low-income and thus less likely to be able to contribute to HSAs, let alone benefit from their tax advantages (Figure 13).

Figure 13
**Income Distribution of Nonelderly,
 by Health Status, 2005**



Source: KCMU/Urban Institute analysis of March 2006 CPS

Health savings accounts and high deductible plans have the potential to alter the health insurance risk pool, which may ultimately lead to higher premiums for traditional health plans. If healthy individuals who have few major medical expenses increasingly choose to enroll in HSA-qualified HDHPs, while less healthy individuals and those with higher medical expenses remain in existing health plans, premiums in traditional plans will increase. Over time, rising costs for these traditional plans may lead employers to drop them altogether.

Because HSA-qualified HDHPs are so new, little is known about who has been purchasing them. The GAO recently examined the income and age of HSA enrollees using several different sources of data and found that while HSA-eligible plan enrollees have higher incomes than others, no clear age differences were apparent. The median adjusted gross income of tax filers reporting HSA contributions in 2004 was about \$76,000, compared to \$30,000 for all tax filers under age 65.¹⁴

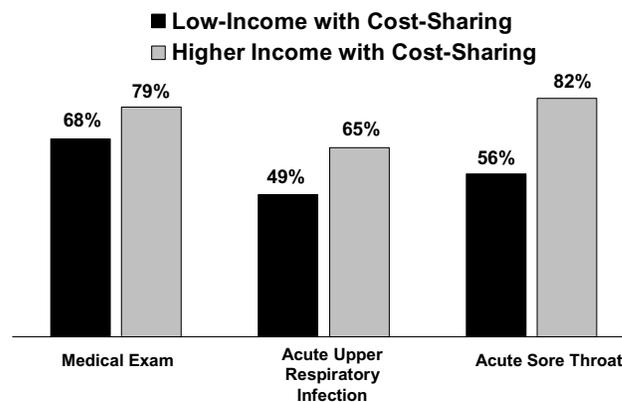
In an earlier GAO analysis of the Federal Employees Health Benefits Program (FEHBP¹⁵) however, they had found that younger people were more likely to choose a new plan, with or without a high deductible; and that the average age of those enrolling in the HSA-qualified HDHP was younger than that of all FEHBP enrollees (46 vs. 59 years old). The age difference was largely due to fewer retirees enrolling in any of the new plans. Although no information was collected on health status differences in this initial study, those retiring from federal service would be older and consequently more likely to experience the onset of chronic conditions than current employees.¹⁶

How Might High Deductible Plans Affect a Low-Income Family's Health Decisions?

Cost-sharing reduces the use of health care, especially primary and preventive services, and low-income individuals and those who are sicker are particularly sensitive to cost-sharing increases.

The sentinel study on the effects of cost-sharing on health care utilization and outcomes is the RAND Health Insurance Experiment conducted in the 1970s and 1980s. The study found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health and vision exams and treatment for infections) than people who were enrolled in health plans with no cost-sharing and the gap was greater for those with low incomes (<200 percent of the poverty level). For example, among children with sore throats, higher income children in a cost-sharing plan received 82 percent as much care as those with no cost-sharing, while low-income children in cost-sharing plans received 56 percent as much care (Figure 14).¹⁷

Figure 14
Probability of Receiving Care Among Children in a Cost-Sharing Plan vs. a No-Cost Plan, by Income



Low-income was defined as <200% of FPL; Higher income was 200%+ of FPL.
Source: OTA, 1993. Summary data from the RAND Health Insurance Experiment.

The evidence from the Rand Experiment on the effect of cost-sharing on health outcomes was mixed, but did find that the poor and those at highest risk for disease were most negatively affected by increased cost-sharing. Specifically, the study revealed that low-income individuals in poor health who were not subject to cost-sharing experienced better health outcomes than other low-income individuals who had a cost-sharing plan in three significant instances: blood pressure measures improved significantly among those with high blood pressure; vision improved; and the estimated risk of dying for those with heart disease risk factors (hypertension, high blood cholesterol levels, and smoking) was reduced by 14 percent.^{18,19}

Shifting financial risk to lower income people may well leave them unable to afford the care they need. However, as they make important health care choices, the financial incentives in HDHPs will not be enough to improve their decision-making if beneficiaries do not understand their options.

Consumers, especially those with low-incomes, need better and more tailored information to make informed health decisions. People have access to more health information than ever today, but in order to make meaningful choices, the amount and quality of this information needs to be substantially improved. For example, while a number of health plans provide some information on the costs of different groups of providers and services, the aggregated information does not allow one to determine the actual cost for a service from a specific provider. Moreover, aside from consumer satisfaction surveys, information about the quality of service is still quite rudimentary and often not adjusted for the severity of a person's condition.

The challenge is to be able to ensure that people will be able to obtain and understand cost and quality information in order to use it wisely. Today health information is mostly found on the internet and yet over 40 percent of adults are not internet users; with low-income persons and those with less than a college education being less likely to use the internet.

An even more fundamental barrier to informed decision-making is the nature of health information generally, which is often complexly written and unclear to people with limited literacy. A recent Institute of Medicine study found that as many as 90 million adults have low literacy skills that may limit their ability to make informed health care decisions. While even well-educated persons with good reading and writing skills may have trouble comprehending medical instructions at some point, health literacy problems are more likely among a number of groups, including persons with low incomes. The majority of adults with low literacy are white, native-born Americans; however, language and cultural differences compound the problem and raise the risk of low health literacy among some racial and ethnic groups.

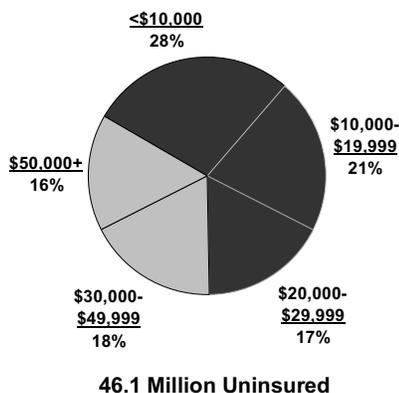
Health literacy is fundamental to self-care and is associated with both better health practices and outcomes. The IOM study found that adults with limited literacy are less knowledgeable about disease management and health-promoting behaviors, use fewer preventive services than adults without such limitations, and report a lower health status.^{20,21}

Are HSA-Qualified HDHPs Likely to Expand the Number of Americans Who Have Health Coverage?

Health savings accounts and high deductible plans are unlikely to increase health insurance coverage among the uninsured. The large majority of uninsured have no health coverage because they cannot afford it, even when it is sponsored by their employer. Health insurance proposals that rely solely on tax deductions will have little impact on the number of uninsured because most of the uninsured come from low-income families. Two-thirds (66 percent) of the nonelderly uninsured live on family incomes of less than \$30,000 (Figure 15). Because they earn so little, more than half of the uninsured (55 percent) have no tax liability.²²

Over 80% of the uninsured, 37 million people, come from working families; yet they are uninsured in large part because they do not have access to employer-sponsored insurance of any kind. While only a small share of workers decline health benefits when available, over half (55%) of poor employees have no health benefits offered to them either through their own or their spouse's employer; and over a third (35%) of near-poor employees do not have the option of job-based coverage.²³

Figure 15
**Nonelderly Uninsured
by Family Income, 2005**



Source: KCMU/Urban Institute analysis of March 2006 CPS

Conclusion

Health Savings Accounts and associated HDHPs have generated a great deal of interest among policymakers as a potential mechanism for reducing health care costs and perhaps even expanding access to health insurance. While HSA-qualified health plans have not been available long enough to fully assess their effect, salient research and analyses suggest that the benefit of these plans to low-income individuals and families will be minimal. Despite having lower premiums than more traditionally-structured health plans, HSA-qualified HDHPs are still likely to be unaffordable for most low-income families. These families have limited funds available to cover the higher out-of-pocket spending required of HSA-qualified HDHPs and are also unlikely to benefit from the tax-deductibility of HSA contributions.

By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises; they already have more “skin in the game”. In fact, even among those with private insurance, over 40 percent of low-income adults report not having had enough money to pay for medical care in the past year. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but can also lead to poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care.

Endnotes

¹ Lyke, Bob. 2006. "Health Savings Accounts: Overview of Rules for 2006." Report from the Congressional Research Service. January 31, 2006.

² Persons with an HSA who change jobs and elect an HSA eligible plan with the new employer can receive contributions from a new employer into their existing HSA and continue to add to the savings themselves. If individuals with an HSA move to a new job and accept a health plan that is not HSA qualified, they can use their HSA to pay for out-of-pocket health care costs but they can no longer receive or make contributions into it.

³ Kaiser Family Foundation and Health Research and Education Trust. 2006. *Survey of Employer-Sponsored Health Benefits, 2006*. Available at <http://www.kff.org/insurance/>.

⁴ America's Health Insurance Plans. 2006. "Over 3 Million Enrolled in High-Deductible/HSA Plans." Press Release, January 26, 2006. Obtained on Feb. 14, 2006 from <http://www.ahip.org/content/pressrelease>.

⁵ Kaiser Family Foundation and Health Research and Education Trust. 2005. Employer Health Benefits 2005 Annual Survey. Available at <http://www.kff.org/insurance/7315.cfm>.

⁶ U.S. Government Accountability Office. 2006. *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans*. Report No. GAO-06-798. Washington, DC: August 2006.

⁷ Estimates of total and out-of-pocket medical expenses among low-income adults were derived for this analysis by Kaiser Commission on Medicaid and the Uninsured analysts using 2003 data from the Medical Expenditure Panel Survey (MEPS), unpublished data.

⁸ 2004 data for U.S. family expenditures are the most current available. Obtained from the US Department of Labor, Bureau of Labor Statistics. Consumer Expenditure Survey Tables, found at www.bls.gov/cex/#tables (Table 46).

⁹ The most current Consumer Expenditure Survey data are for 2004. Premium data for HSA-HDHPs were first available for 2005.

¹⁰ Kaiser Family Foundation and Health Research and Education Trust, 2005; and U.S. GAO, 2006. Report No. GAO-06-798.

¹¹ U.S. Government Accountability Office. 2006. *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*. Report No. GAO-06-514. Washington, DC: April 2006; and U.S. GAO. 2006. Report No. GAO-06-798.

¹² Bucks, BK, AB Kennickell, and KB Moore. 2006. *Recent Changes in U.S. Family Finances: Evidence from the 2001 and 2004 Survey of Consumer Finances*. Federal Reserve Board Report.

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¹⁴ U.S. Government Accountability Office, 2006. *Consumer-Directed Health Plans*.

¹⁵ FEHBP covers about eight million federal enrollees and their dependents.

¹⁶ U.S. Government Accountability Office. 2006. *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*. Report No. GAO-06-271. Washington, DC: January 2006.

¹⁷ Office of Technology Assessment, U.S. Congress, *Benefit Design in Health Care Reform: Background Paper – Patient Cost-sharing*. Washington, DC: US Government Printing Office, OTA_BP_H_112, September 1993.

¹⁸ Lurie, N, et al. 1989. “How Free Care Improved Vision in the Health Insurance Experiment.” *AJPH*, Vol. 79(5): 640-2; May 1989.

¹⁹ Office of Technology Assessment, US Congress. 1993

²⁰ Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion*. Edited by L Nielsen-Bohlman, A Panzer, D Kindig. Washington, DC: National Academies Press.

²¹ Parker, RM, SC Ratzan and N Lurie. 2003. “Health Literacy: A Policy Challenge for Advancing High-Quality Health Care.” *Health Affairs* 22(4), July/Aug 2003, p 147-153.

²² Glied, SA and DK Remler. 2005. “The Effect of Health Savings Accounts on Health Insurance Coverage.” Commonwealth Fund Report No. 811; April.

²³ Clemans-Cope, L, B Garrett, and C Hoffman. Forthcoming in 2006. “Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005”. Kaiser Commission on Medicaid and the Uninsured, Issue Brief.

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