Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs

A combination of Health Savings Accounts (HSAs) and High-Deductible Health Plans (HDHPs) have been a primary strategy of the Bush Administration's health care reform agenda, and some states have also begun to promote this approach to health coverage. Unfortunately, this short-sighted remedy fails to address the dual problems of an increasing number of uninsured Americans and spiraling health care costs. Closer examination of HSA/HDHP arrangements proves that they are the wrong answer to the country's health care crisis, and are particularly unacceptable for women.

How Do HSAs and HDHPs Work?

Health Savings Accounts (HSAs) are tax-sheltered accounts for individuals enrolled in high-deductible health plans (HDHPs). An HSA is not a health insurance policy in itself; it is a savings vehicle for HDHP members, who may use tax-free HSA dollars to purchase health care up to their required deductible. HSAs and HDHPs are part of a family of health insurance products that are often referred to as "consumer-directed health care." Supporters of this type of health insurance reason that a higher deductible will encourage individuals to be wiser consumers, since they are responsible for the cost of health care below the deductibles.

An HSA and HDHP Strategy Is the Wrong Solution for Uninsured Women and Families

Proponents of HSAs and HDHPs maintain that they will increase the efficiency of the health care system and reduce the growth of health care costs. Since HDHP premiums are typically lower than those of traditional coverage, supporters also claim that consumer-directed health plans will be more affordable for the uninsured.[1,2] The goals behind this approach may have merit, but in practice HSA/HDHP arrangements do not improve or expand access to health care for uninsured women and families.

HSA and HDHP arrangements require levels of cost-sharing that are not affordable for lower-income women and their families. Women generally have lower incomes than men and they typically need and use more health services.[3] For health coverage to be accessible and usable for women, it must be affordable. Premiums for HDHPs may be lower than those for traditional coverage, but they account for just a fraction of the cost of insurance and are invariably counteracted by higher deductibles and other forms of enrollee cost-sharing.

As its name implies, an HDHP includes a deductible that is higher than those of traditional health insurance plans. To open an HSA in 2008, individuals must be enrolled in an HDHP with an annual deductible of at least $1,100 for an individual or $2,200 for a family, but policies sold in the insurance market tend to have even higher deductibles than the regulations specify.[4] The health plan will not begin to pay insurance claims until plan enrollees have paid out-of-pocket for health care charges up to the deductible amount. Some HDHPs have two separate deductibles depending on whether care is sought from an in-network or out-of-network provider, making overall deductible spending even higher for women who must see a provider who is not in their plan's network. Even after high deductibles are met, HSA-qualified health insurance policies often require additional out-of-pocket spending in

the form of co-payments and coinsurance, up to a maximum of $5,600 for an individual or $11,200 for family coverage (2008 guidelines).

Women—who are more likely than men to have greater-than-average health care needs—are at increased financial risk with an HSA and HDHP. Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care services than men.[5] If health insurance is to be beneficial for women, it must cover the services that they need without exposing them to significant financial risk.

However, those who need the most health care—including women with disabilities and chronic conditions—are most likely to struggle to meet increased cost-sharing requirements of HDHPs. These individuals often experience higher medical costs and are more likely to spend amounts up to their deductible each year.[6] Healthy people with very low medical expenses, on the other hand, may benefit from an HSA arrangement since their HDHP premiums are lower than those required under traditional insurance plans and they pay trivial out-of-pocket amounts.

HSAs and HDHPs provide an incentive for women to use less cost-effective and preventive care. HSA and HDHP arrangements have implications for women's preventive health service use. Because HDHPs shift more costs to the plan enrollee, they provide an incentive to use less (and therefore spend less on) health care services. HSA guidelines do permit certain preventive services to be exempt from the deductible, but this is voluntary for insurers. For example, prescription drugs—even those that serve a preventive rather than a treatment purpose—are generally not exempt from a deductible.[7]

The majority of American women use a form of contraception that can only be accessed with a prescription. Under most HDHPs, they would be responsible for the full cost of their birth control.[8] This presents an affordability-related barrier to family planning, especially for lower-income women. Participating in an HSA/HDHP could have a negative impact on women's health if they delay or go without necessary care because they cannot afford to meet the high deductible.

HDHPs have unique implications for women's health services, particularly maternity care. HSA-qualified health plans have specific consequences for maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. Pregnant women enrolled in an HDHP might be exposed to high out-of-pocket costs, particularly when complications arise. Many HDHP policies available on the individual insurance market exclude coverage for maternity care altogether, so that expenses for these services would not even count towards the deductible.

For plans that do cover maternity care, prenatal visits are typically subject to an HSA-qualified deductible (unlike other preventive services such as well-child care), which might keep some women from obtaining timely prenatal care. Nine-month pregnancies tend to span two insurance plan contract years and so may be subject to two annual deductibles, compounding the affordability issue. A 2007 study demonstrated the range of out-of-pocket maternity care costs that women could face under several different HSA/HDHP options—from a low of $3,000 for an uncomplicated pregnancy with vaginal delivery to a high of $21,194 for a complicated pregnancy with a Cesarean section delivery.[9]

Lower-income women will not benefit from the tax advantages of HSAs. Most lower-income women and families do not face high enough tax liability to benefit in any significant way from the HSA tax advantages. Deposits to an HSA account reduce a participant's taxable income by the amount of the contribution; since tax rates increase as income increases, the deduction is a better deal for the more affluent.

Reports on the income level of HSA account holders support this notion; nonelderly tax filers who reported HSA activity in 2005 had an average adjusted gross income of about $139,000, compared to about $57,000 for other filers.[10] Furthermore, though HSAs were designed to be used as a tax-saving method to accumulate funds for health care expenses, some evidence suggests that these accounts are more often being used as tax shelters by higher-income individuals.[11]

LESSONS FROM THE STATES:

Indiana Experiments with a 'Health Savings Account'-Type Product for Medicaid Enrollees

In late 2007, Indiana received federal approval for a new Medicaid health coverage program called the Healthy Indiana Plan (HIP). The program, which is the first of its kind, provides very low-income uninsured adults—those with incomes between 22 percent and 200 percent of the federal poverty level—with a health insurance product that mimics an HSA/HDHP arrangement. HIP members are required to pay between 2 and 5 percent of their annual income into a savings account. The state makes up the difference so that the total yearly contribution into the account is $1100; this contribution distinguishes HIP from a typical employer-sponsored HSA/HDHP arrangement, as employer HSA contributions are optional.

Insurance coverage does not begin until a HIP member has spent down the account, though some preventive services are covered separately. The target population is a very low-income group and the costs to participate in HIP are high enough to question affordability—someone making about $15,000 a year, for example, would be required to pay around $50 a month for the program. Penalties for nonpayment are steep: members are booted from the program for a full year if they miss a payment by more than 60 days.

By late March 2008, HIP had enrolled just over 3,000 applicants, and roughly two-thirds of these enrollees have been women.[12] While it is still too early to know whether and how HIP has impacted access to health care for Indiana's poorest women, there are several reasons to watch this state experiment closely. Key questions include: Will low-income women be able to afford the required contributions? Will the HSA/HDHP-like arrangement discourage women from seeking necessary and cost-effective medical care? Since enrollment in HIP is capped, what will happen when a pregnant woman (who must transition from HIP to traditional Medicaid for the course of her pregnancy) wants to get back onto the program postpartum? And most importantly, will HIP actually expand quality health insurance to those who need it most?

An HSA and HDHP Strategy Is the Wrong Solution for America's Health Care Crisis

In addition to the problems that HSA arrangements pose for women and families, this strategy is unlikely to deliver on its promise to help solve America's health care crisis.

HSAs and HDHPs will do little to curb the rising costs of health care. Most of America's health care costs are incurred by only a small percentage of very sick or injured individuals, whose treatment costs exceed HDHP deductibles (and are therefore still paid for by the health plans).[13] Simply put, HSA and HDHP arrangements will not contain those high-end expenditures.

Additionally, if consumer-directed plans disproportionately attract healthier and wealthier individuals—as research demonstrates they have done—sicker and poorer Americans will be concentrated in traditional, comprehensive insurance plans.[14] This divides the pool of insured people so that risk (or cost) is no longer spread between those with high and low medical expenditures, and premiums for those in traditional plans will be driven even higher as a result.

An HSA and HDHP strategy is also unlikely to reduce the number of uninsured Americans. In 2006, nearly two-thirds of the nonelderly uninsured were poor or near-poor, with incomes at or below 200 percent of the federal poverty level ($40,000 for a family of four in that year).[15] These lower-income families are unlikely to have the resources to participate in a health plan with high levels of cost-sharing; less than half of all households with at least one uninsured member have sufficient assets to meet the minimum HSA-related deductible.[16]

Moreover, since many lower-income families earn too little to have any tax liability, coverage proposals which rely on tax deductions— such as the HSA initiative—will provide little or no benefit to low-income people who are uninsured. Indeed, recent surveys of HSA-qualified health plan enrollees demonstrate that adults in these plans are no more likely to have been uninsured prior to enrollment than those enrolled in traditional coverage plans.[17]

What Can Advocates Do?

Advocates can demonstrate why HSAs and HDHPs are not the answer to the nation's health care crisis.

Women and their families face greater financial risk with HSAs and HDHPs than they do under traditional insurance plans, and so it is important to understand both the limits of coverage and the financial and other responsibilities placed on enrollees. Financially-concerned HSA enrollees might forgo necessary health care and those with higher-than-average medical expenditures—including women—may take on significant financial risk. Contrary to the claims of its proponents, consumer-directed health care will not lead to reductions in the uninsured or in America's overall health care costs.

For reading information, see:

Karen Pollitz, et al., Henry J. Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans* (June 2007), http://www.kff.org/womenshealth/upload/7636.pdf.

Beth Fuchs and Julia A. James, National Health Policy Forum, George Washington University, *Health Savings Accounts: The Fundamentals* (April 11, 2005), http://www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf.

Paul Fronstin and Sara R. Collins, The Employee Benefits Research Institute, *Issue Brief No. 315: Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey* (March 2008), http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3897.

U.S. Government Accountability Office, *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes* (April 1, 2008), http://www.gao.gov/new.items/d08474r.pdf.

References

1 United States White House, *State of the Union: Affordable and Accessible Health Care* (January 2006), http://www.whitehouse.gov/news/releases/2006/01/20060 b131-7.html.

2 U.S. Department of Treasury, *Health Savings Accounts* (January 2008), http://www.ustreas.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-07.pdf.

3 Elizabeth Patchias and Judy Waxman, The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

4 In 2006-2007, over 60 percent of all individual market single-coverage plans that qualified for an HSA or Medical Savings Account (MSA) had an annual deductible of $2,500 or higher. Likewise, over 60 percent of all family-coverage HSA or MSA-qualified plans had an annual deductible of $5,000 or higher. See: America's Health Insurance Plans (AHIP), *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (December 2007), http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

5 *Women and Health Coverage*, *supra* note 3.

6 A Harvard Medical School analysis of 2003 Medical Expenditure Panel Survey (MEPS) data found that women's median health expenditures are $997 higher than men's. While only one third of insured men under 45 spent $1,050 or more each year in medical costs, over half of insured women reached this figure. See: Steffie Woolhandler and David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, Society of General Internal Medicine, 22(6): 879-881 (June 2007), http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2071952.

7 A survey of insurers offering consumer-driven health plans found that less than 6 percent of these plans included coverage for prescription drugs as a preventive, exempt benefit. See: America's Health Insurance Plans (AHIP), *A Survey of Preventive Benefits in Health Savings Account (HSA) Plans* (July 2007), http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf.

8 William D. Mosher, et al., Advance Data From Vital & Health Statistics, *Use of Contraception and Use of Family Planning Services in the United States: 1982-2002*, 350:15 (December 10, 2004), http://origin.cdc.gov/nchs/data/ad/ad350.pdf.

9 Karen Pollitz et al., Henry J Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans* (June 2007), http://www.kff.org/womenshealth/upload/7636.pdf.

10 U.S. Government Accountability Office, *Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes* (April 1, 2008), http://www.gao.gov/new.items/d08474r.pdf.

11 Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, *GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals* (September 20, 2006), http://www.cbpp.org/9-20-06health.htm.

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15 Henry J. Kaiser Family Foundation, *Distribution of the Nonelderly Uninsured by Federal Poverty Level, States (2005—2006), US (2006),* http://www.statehealthfacts.org/comparebar.jsp?ind=136&cat=3 (last visited July 7, 2008).

16 Paul D. Jacobs and Gary Claxton, Health Affairs: The Policy Journal of the Health Sphere, *Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans* (April 15, 2008), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.3.w214.

17 *Consumerism in Health Care Survey*, *supra* note 14.

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