In Search of Affordable Healthcare: Health Savings Accounts (HSAs), Are They the Solution?

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Once again healthcare expenditures were at the forefront of the presidential debate and took center stage as one of the most complex and contentious issues facing our nation. Both candidates attempted to tackle the $1.6 trillion healthcare bill by extending new solutions to the age-old problem -- runaway healthcare costs. Since 1970, per capita spending has increased from $1,300 to $5,450 in 2002 (2002 dollars). The portion of healthcare spending in terms of the gross domestic product has doubled from 7.0% in 1970 to 14.9% in 2002 (Holtz: 10-12) as well as U.S. Census Bureau reports 45 million uninsured (Cochran: 3). Health Maintenance Organizations (HMOs) in the 1990s'were successful in slowing medical expenditures – they slowed the growth to just 2.6% per year from 1992 – 1997 (Holtz: 12). Despite this success, HMO's popularity declined as consumers lost provider choice; were denied care; and felt their benefits diminish as insurer's attempted to control costs and make a profit (Gleckman: 90). Since then, HMO restrictions on benefits have eased and subsequently; healthcare insurance rates have increased an average of 4.5% annually (Holtz: 10). In fact in 2000, employee premiums doubled to average $1,565 (Gleckman: 88-89).

Why do healthcare expenditures continue to increase? Some of the drivers attributing to the high cost of healthcare include; frivolous malpractice claims, advancing medical technology, increasing pharmaceutical costs, consumer's demand for the "best" healthcare regardless of the cost outcome; aging population and some argue because of poorly aligned competition in healthcare (Porter: 65). All of the above items have certainly contributed to the high cost of healthcare. However, another underpinning factor is employer-sponsored insurance, which shields the consumer from actual costs of healthcare. Those fortunate enough to be sponsored by employer-based insurance have been insulated from healthcare increases.

The roots of employer-sponsored health insurance date back to WWII when they were developed to circumvent wage and price controls so to provide healthcare coverage for families while the breadwinner was defending our country. From that point forward, consumers quickly began to expect sponsored healthcare coverage from their employers. That fact coupled with the IRS ruling in the 1960s that fringe benefits were not taxable income, further strengthened employer-sponsored health insurance. Though these tax exclusions are appealing to the employer and employee, many opponents believe they are inequitable, costly subsidies. The 2002 federal tax exclusions for this benefit tallied nearly $128 billion in lost revenue (Holtz: 11).

Presently, 45 million Americans are insured by their employer (Gleckman: 90). As healthcare costs have increased, employers have passed this expense on to employees by increasing deductibles, raising co-payments, as well as in some cases reducing benefits. Figures vary, though employer-based premiums have increased every year by 10% since 1996 (Holtz: 11). As of 2004, the average premium for employee-sponsored coverage for an individual was approximately $3,695 a year or $9,950 per family. Premiums have increased greater than inflations (2.3%) and wages (2.2%) (H&HN: 87-88). These costs do not include deductibles, cost shares, prescription costs, pre-existing conditions, nor non-covered treatments/procedures.

Across our nation, corporations are struggling to pay fair wages and yet incorporate a healthcare plan both they and their employees can afford in spite of healthcare inflation. Prime examples of this struggle are the giant grocery store chains, Safeway, Albertson, and King Soopers in Colorado and Wyoming who are attempting to trim healthcare costs by $21 million (Safeway: 1).

How will Americans reign in medical inflation? President George W. Bush signed into law *The Improvement and Medicare Modernization Act of 2003*, which created an innovative option to obtain healthcare benefits, known as Health Savings Accounts (HSAs). HSAs were created to ultimately lower healthcare costs and to expand healthcare coverage to the 45 million Americans without coverage (Moffit: 1). They rely on a three-prong effect to reduce costs by awarding members a stake in their healthcare, inducing a high-deductible plan with associated lower premiums, and constructing a 401(k)-like investment vehicle to allow one to save, tax free, for future medical expenses (Gleckman: 90-91).

As we move into a market, which the media is deeming “consumer driven healthcare”—HSAs foot the bill. The intent is to move away from employer-sponsored insurance and turn medical care into a product/service that consumers’ purchase like any other (Gleckman: 91). What’s the catch? The member’s health plan is based on a high deductible and a corresponding low premium.

To qualify, HSAs must meet the threshold of a *minimum* deductible of $1,000 for an individual and $2,000 for a family (Appleby: 1). It is anticipated that people who are healthy or think they won’t get sick will take on greater risk (higher deductibles) and save with lower premiums. Hence, one may have a $3,000 deductible and a low $15 monthly premium vice the traditional plan of a $250 deductible and a $315 monthly premium (Gleckman: 92). If medical expenses continue to rise as they have historically, under a HSA the worker absorbs the expenses through the higher deductible. Hence, the increase is passed to the employee vice the employer.

The theory behind the HSA is the more one must spend of their funds; the likelihood is greater they will make financially smart decisions. HSAs inject discipline into the market. For example, one may not visit the emergency room for a minor problem such as nausea or an earache, perhaps choose a generic drug over the brand name, as well as scrutinize the health risks and their options closer (i.e. exercise and diet vice a surgical procedure or expensive drugs) (Franklin: 88-89). Until one has fully met their deductible, they are liable for all expenses incurred. Advocates of HSAs tout studies indicating an ability to reduce unnecessary healthcare expenditures by

20%-30%. According to Emory University health economist Kenneth E. Thorpe, HSAs could reduce medical care by 5% to 10%, equating to $8,000 over the long term, based on internal competition of the healthcare industry striving to reduce costs to be competitive in the eyes of the consumer (Gleckman: 91).

Who qualifies for a HSA? In order to qualify, you must be under the age of 65 and purchase a high-deductible health plan. As stated earlier, a high-deductible plan is defined as a minimum of $1,000 deductible for an individual and $2,000 minimum for a family. The annual out-of–pocket expenses cannot exceed $5,000 for an individual and $10,000 per family (Franklin: 87-88). Probably the greatest benefit of HSAs is their contribution power. Employees and employers may deposit funds tax-free into an account for their current and future medical expenses. The contributions made by the employer are not taxable to the individual (Treasury: 1-2). Annually, individuals may invest/contribute $2,600 and families, $5,150 towards bonds, stocks, or mutual funds to accumulate interest, much like an IRA. Each year these amounts are adjusted by inflation (Blackman: 1). Anything not spent in one year will accrue and carry over year to year for future medical needs. Furthermore, HSAs are portable, in which as one moves from job to job, the fund continues to offer the same benefits (Treasury: 9-11). There are even “catch-up” payments for folks 55 and older, allowing contributions of an additional $500 in 2004. Then when one turns age 65, the HSA may be used to pay Medicare premiums, tax-free (Blackman: 1). There are HSA withdrawal penalties of 10% if funds are used for non-medical reasons and the amount is subject to income tax (Appleby: 2).

One of the basic tenants of HSAs is it offers consumers the ability to shop for care --more choice and control over one’s own healthcare plan. However, it does not solve the age-old problem of determining which healthcare product is better nor does it addresses the lack of information available when choosing a healthcare plan much less a provider. Missing from healthcare reform is the objective to increase patient outcomes thus creating competition and ultimately lowering costs. (Porter: 69). Past healthcare reforms divided or completely eliminated healthcare value vice increasing it. This is commonly referred to as zero sum competition (Porter: 66). Currently, competition focuses on healthcare plans, physician groups/networks, and hospitals vice diagnosis, prevention, or treatment of health conditions. Additionally, reforms have concentrated on cost shifting from payer to payer, reducing consumer choice, increasing bargaining power of healthcare systems versus efforts to improve healthcare, as well as placing an emphasis on defensive medicine and allowing the legal system to prevail (Porter: 66-69).

Shopping wisely for the best quality and price will be and is difficult. Have you ever attempted to cost compare a surgery or cost of a procedure at a hospital or ambulatory surgery facility? Hospitals typically state their charges via a charge master (Gleckman: 94). However, this master list is difficult to interpret and nearly impossible to compare hospital to hospital, much like a mortgage quote or cell phone plan --similar plans but yet very different.

The most important aspect to compare in healthcare is quality, though it is the most difficult and nearly non-existent characteristic. How does one become a discriminating healthcare consumer with the lack of information? Many studies have proven that when providers treat a high volume of like diseases, outcomes increase and costs decrease. A great example is the Texas Heart Institute that has reduced surgical costs 33-50% while attracting complex cases though has flourished in patient outcomes as compared to other medical centers (Porter: 67). Since the advent of HMOs, we have been attempting to distinguish quality-using report cards on providers and hospitals,

however the information available does not include relevant data such as the number of procedures Dr. “X” complete on an annual basis or an institutions’/providers’ disease specific outcomes. Many argue the outcome of treatments/procedures are too complex to measure and are not meaningful or valid. However, if outcomes are not measured it only creates uninformed decision-making on part of consumers and payers and further exacerbates our healthcare dilemma. In New York, data was collected on cardiac bypass surgeries statewide and made readily available to consumers, hospitals, and insurers. After four years of this highly published information, NY had the lowest risk-adjusted mortality surgeries compared to any other state (Porter: 72).

There are several report cards and sources of basic information, though one must be cautioned to take the time to fully understand the information and compare like services, for like statistics, they may be misleading. As this market matures, the below links are four good starting points:

NCQA's Health Plan Report Card (http://www.ncqa.org/) is an interactive tool designed to help you find the health plan that's right for you. NCQA is a private nonprofit organization committed to improving the quality of our nation's healthcare. NCQA sets standards for the quality of care and service that health plans provide to their members. Health plans that meet their standards receive NCQA Accreditation, which is nationally recognized as a seal of approval. NCQA's Health Plan Report Card can help you answer questions about health plans that would be difficult or impossible to answer on your own-Does this health plan provide good customer service? Will I have access to care I need? Does the plan check doctors' qualifications? If I get sick, which plan will take better care of me?

U. S. News and World Report **(www.usnews.com):** publishes an annual report, “America's Best Hospitals**”** which ranks the top 50 hospitals in each of 17 specialty areas; 205 hospitals ranked overall. Rankings are based on mortality rates, available technology and services, nursing staff levels, and a physician survey.

Guide to Hospitals Consumers' Checkbook **(***www.healthgrades.com):* 5,000 hospitals are rated. Mortality rates for 10 common medical conditions and two types of surgery; adverse-outcome rates for seven types of surgery; all compared to national averages. HealthGrades' mission is to improve the quality of healthcare nationwide. The site sells comprehensive reports on individual hospitals: $24.95 per 3 reports.

Check Drug prices: www.destinationRx.com and www.pharmacyChecker.com allow you to compare medication prices.

Will HSAs become a revolution in healthcare or just another misaligned reform initiative? Will high deductibles and cost-conscious consumers reduce money spent unnecessarily for healthcare? Some say people will scale back healthcare they should receive (Franklin: 89). For example, in 2003 employers increased prescription co-payments, 21% of patients reduced their drug intake due to affordability (Gleckman: 94). Several insurers recognize this potential problem and are including free preventative care in their plans to preclude this phenomenon. Can the average American family afford a deductible of $2,000 and out-of-pocket expenses of up to $10,000? Many opponents believe HSAs are only for the affluent and healthy and that HSAs will further drain healthy workers out of the traditional insurance pool, thus creating further healthcare expenditure problems (10-4).

Is this reform correctly aligned for success despite it ignoring value driven competition and the important focus to improve outcomes? Only time will tell if HSAs will help to solve the American healthcare crisis.

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