

**HEALTH SAVINGS  
ACCOUNTS UNDER THE  
AFFORDABLE CARE ACT:**  
Challenges and Opportunities for  
Consumer-Directed Health Plans

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Nearly four years after the passage of the Patient Protection and Affordable Care Act (ACA) and nearly one year after its first open enrollment period, many key provisions of the legislation are still just beginning to come into focus. Policy experts—critics and friends of the law alike—expect the law’s rocky rollout and uneven implementation (i.e., the delay of the employer mandate until 2015 and the extension of some non-ACA-compliant individual policies until 2016) to produce significant uncertainty in the non-group health-insurance market for several years.

One critical area of uncertainty before the launch of health-insurance exchanges was how the law would affect a fast-growing alternative to traditional health plans, called Health Savings Accounts (HSAs). HSAs are paired with high-deductible health plans (HDHPs) and allow funds to be used pretax for out-of-pocket health expenditures. Consumers trade off higher deductibles under these plans in return for lower monthly premiums and tax-advantaged, out-of-pocket spending; the savings can be substantial and can be rolled over, year after year. Services above the deductible are often covered entirely by insurance.

The ACA implemented a number of important new regulations on health-insurance products, many of which potentially boded ill for HDHPs.<sup>1</sup> Indeed, many advocates of these types of health plans believed that the administration would implement ACA insurance regulations in a way that would disadvantage consumer-driven products in the new public health-insurance exchanges. Nonetheless, the Obama administration has maintained that HDHPs and HSAs would continue to be available under the law. In a 2010 letter to Congress, President Obama noted:

*“I believe that high-deductible health plans could be offered in the exchange under my proposal, and I’m open to including language to ensure that is clear. This could help to encourage more people to take advantage of HSAs.”<sup>2</sup>*

Former HHS secretary Kathleen Sebelius made a similar claim in a 2011 op-ed in the *Washington Post*:

*“The Affordable Care Act puts states in the driver’s seat because they often understand their health needs better than anyone else.... States have discretion, for example, to offer a wide variety of plans through their exchanges, including those that feature health savings accounts.”<sup>3</sup>*

Initial skepticism from HSA advocates was understandable; but based on our current research, it appears that the Obama administration was true to its word and that HSAs (at least for the moment) remain widely accessible on public exchanges. The report finds that, far from becoming obsolete under the ACA, high-deductible plans are widely available—98 percent of uninsured Americans have access to at least one HSA-eligible plan. Moreover, these plans also make up about 25 percent of total offerings on Obamacare exchanges. We also found that they remain significantly less expensive than traditional plan designs, offering savings of about 14 percent, on average.

Nonetheless, our analysis indicates that it remains difficult for consumers to identify HSA-eligible plans and that much more could be done to simplify their administration and educate exchange consumers on their advantages and limitations.

To improve competition between HSA and non-HSA plans on the exchanges, we suggest a number of reforms for HSA-eligible plans, including:

- 1. Improve transparency.** HSA-eligible plans are often not labeled as such on the exchanges. Mandating identification would go a long way toward making such plans more accessible. Also, exchanges should, like Medicare’s

Part D drug plan, contain a simple “cost calculator,” allowing consumers to estimate annual out-of-pocket costs while comparing the latter with the savings associated with a particular HSA-eligible plan. Over time, consumers can accumulate significant funds in such accounts.

**2. Standardize and simplify.** One easy way to do this would be to allow any plan with a qualifying deductible to be automatically designated HSA-eligible, as opposed to the current thicket of regulations surrounding HSA eligibility. Alternately, policymakers could make any plan with an actuarial value of 70 percent, or less, HSA-eligible—since it is really the full out-of-pocket payment, not merely the deductible, that is relevant when considering a plan’s full expected cost in the event of serious illness.

**3. Improve affordability for low-income consumers.** Catastrophic plans on public exchanges should be redesigned to be eligible for premium tax credits and cost-sharing subsidies, with savings from picking higher-deductible, lower-premium plans refundable into health savings accounts.

Recent evidence suggests that high-deductible health plans in the employer market have played a significant role in moderating premium-cost increases over the last several years—“bending the curve” for employer health care spending.<sup>4</sup> If HSA-eligible plans are structured correctly in ACA exchanges, such plans could play a similar role in the non-group market (as the number of enrollees with individual coverage grows quickly over the next few years).

Slower premium growth on the exchanges would reduce costs to taxpayers while introducing greater pressure for providers to embrace price- and quality-transparency tools—thereby improving value for enrollees. Ultimately, HSAs can provide a valuable financial tool for saving against higher expected health expenses later in life, while helping to improve the overall efficiency of the health care market, too.

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In 2013, Feyman, with colleagues Avik Roy and Paul Howard, released the Obamacare Impact Map, a state by state look at the effects of the ACA. Republican strategist Karl Rove called the map an "indispensable tool" in understanding the law's effects on Americans.

Feyman has written for various publications including National Review Online, FoxNews.com, *The Washington Examiner*, *Health Affairs*, and *Politico*. He has spoken on radio shows around the country and has appeared on Al Jazeera America to discuss the effects of the ACA.

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# HEALTH SAVINGS ACCOUNTS UNDER THE AFFORDABLE CARE ACT: CHALLENGES AND OPPORTUNITIES FOR CONSUMER-DIRECTED HEALTH PLANS

Paul Howard & Yevgeniy Feyman

## BACKGROUND: HDHPs AND HSAs

A common criticism in health-policy circles is the U.S.’s outsize spending compared with that of other OECD countries: on both a per-capita basis and in the aggregate, the U.S. vastly outspends all its OECD counterparts relative to national income. Less well known is the fact that U.S. patients pay a lower share of overall health costs out of pocket than all but four of our developed competitors. Post-Obamacare, that share will fall even further: to 9.1 cents on the dollar by 2022.

Advocates of consumer-driven health care reforms have focused on reducing the rate of growth in U.S. health care spending by increasing the share of out-of-pocket spending. This is based largely on evidence that in other markets (from consumer electronics to automobiles), suppliers fiercely compete for consumer spending; if one firm can offer a lower price for equal quality, consumers will flock to it because the consumer is price-sensitive. In a nutshell, the argument is that when health care consumers spend their own money—with every dollar of spending effectively competing with other highly valued goods and services—consumers tend to purchase health care goods and services far more prudently. Indeed, the idea that “skin in the game” is important to health-spending decisions was vindicated in the famous RAND Health Insurance Experiment, conducted by

the RAND Corporation between 1971 and 1986. In the study, researchers found that an increase in cost-sharing, ranging from 0 to 25 percent, reduced spending by 20 percent, with little effect on health.

High-deductible health insurance has existed in the U.S. for many years, with the idea of savings vehicles rooted in a Nixon-era proposal for “health banks.” Under this proposal, employers would be allowed to deposit cash for employees’ health care expenses in a savings account. By pooling such deposits, health banks would then be able to issue loans—while allowing negative account balances—for major medical expenses. The 1980s saw a number of prototype Medical Savings Accounts (MSAs), and in 1996, the Health Insurance Portability and Accountability Act (HIPAA) established an MSA demonstration project for the self-employed and employees of small businesses.<sup>5</sup> In 2003, the market became much more salient, with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Along with various changes to the Medicare program, the MMA expanded MSAs, rebranding them and making them more broadly available as health savings accounts (HSAs).

MSAs and HSAs both allow tax-free contribution to a personal savings account so long as the holder of the account also maintains a high-deductible health plan—defined as a minimum of \$1,250 in 2014. The main difference is that HSAs are currently available to anyone with a qualifying health plan, while MSAs were restricted primarily to the self-employed and employees of small businesses.

### *Regulatory Impact*

Advocates of HSAs appeared to have good reason to be skeptical of the administration’s initial claims. While new federal regulations pegged limits on deductibles and out-of-pocket spending to HSA requirements (\$1,250 minimum and \$6,350 maximum for individuals; \$2,500 minimum and \$12,700 maximum for families in 2014), plans were also now required to spend at least 80 percent of premiums on benefits, while limiting administrative spending and profit to 20 percent. Minimum

actuarial values required under the law (60 percent) also appeared to disadvantage HSAs because these types of plans, by design, reimburse far fewer health care expenses before insurance coverage begins (pre-ACA, many HDHPs had actuarial values in the 55–59 percent range).<sup>6</sup>

These new requirements, as coupled with mandated “essential health benefits,” indicated two important changes to the existing individual insurance market. First, an important element of health care reform would now be to significantly restrict an individual’s ability to trade higher out-of-pocket costs in return for lower annual premiums.<sup>7</sup> Second is an accompanying raise in the “floor” for insurance coverage, thereby requiring insurers to cover more routine costs (especially preventive care) in even the most basic insurance design.

In addition, the law included more direct changes to HSAs, including a prohibition on using HSA funds to pay for over-the-counter drugs without a prescription and increasing the penalty (from 10 percent to 20 percent) for using HSA funds to pay for nonmedical expenses.

Because HSAs require plans with high deductibles (and, by extension, higher cost-sharing), they would seem to run afoul of both the minimum actuarial value and the “medical loss ratio” required under Obamacare. While both these requirements insulate individuals from higher initial cost-sharing, they would appear to make HSA plans more expensive (by covering more services before the deductible kicks in, they effectively require HSA plans to raise premiums), thus making them less competitive compared with non-HSA plans.

Moreover, an analysis by eHealth, a leading online marketplace for non-group health insurance, found that average deductibles for individual plans have fallen under the current law: from \$4,900 in 2013 to \$3,768 in 2014<sup>8</sup> (of course, numerous studies have found rising premiums in the first year of the ACA). Yet such a decline in deductibles is, at least in principle, far from catastrophic for HSA-eligible plans. It is entirely possible that HSA-eligible plans will re-

main cost-competitive on the Obamacare exchanges compared with traditional insurance designs, especially after taking into account their tax-advantaged status. This is particularly true for so-called young invincibles, who expect to have few routine health care expenses, as well as for people with routine health expenses who earn too much to qualify for ACA's cost-sharing subsidies (which are distinct from premium subsidies; cost-sharing subsidies, available to individuals and families earning up to 250 percent of the federal poverty level, reduce deductibles and out-of-pocket limits, effectively raising the actuarial value). In both cases, HSAs would allow individuals and families to put aside tax-advantaged funds to pay for health expenses incurred before plan deductibles are reached.

Our findings indicate that, far from becoming obsolete under ACA, high-deductible plans are widely available: 98 percent of uninsured Americans have access to at least one HSA-eligible plan.<sup>9</sup> Moreover, these plans make up about 25 percent of total offerings on ACA exchanges. We also found that they remain significantly less expensive—about 14 percent less, on average—than traditional plan designs.

### *HDHPs and HSAs in the Employer Market*

Since 2005, the number of individuals covered by HSA-qualified, high-deductible plans has skyrocketed. The annual HSA Census conducted by America's Health Insurance Plans (AHIP), an industry trade group, found that 15.5 million people were covered by these policies in 2013—an increase of 1,309 percent since 2005. Enrollment was up nearly 15 percent over 2012 alone.<sup>10</sup> Altogether, this makes up 7 percent of the under-65 commercial health-insurance market—a small but significant share. Most of the growth, and most of current enrollment, is concentrated in the small-group and large-group markets. An important reason for this growth has to do with the high cost of American health insurance, especially in the individual insurance market, where individuals have—pre-Obamacare—purchased it without the significant tax benefits that accrue to employer-provided coverage.

While national health expenditures have grown below trend over the past few years, cost growth remains significant. As the Milliman Medical Index shows, total health care costs for a typical family with employer-sponsored coverage grew 31 percent from 2009 to 2013.<sup>11</sup> While comparisons with HSA populations are difficult because of the potential for selection bias, an American Academy of Actuaries (AAA) review of several studies found that HSA-eligible plans had large first-year savings compared with those of control groups, with trend rates about 3–5 percent lower afterward (one study conducted by Cigna included five years of longitudinal data). Thus, it is likely that HSA-eligible plans experience lower cost growth than other plans.<sup>12</sup>

Because tax incentives ensure that health insurance is a required element of compensation packages for large employers (and many small ones), employers tend to turn to cost management (rather than rescinding employer-sponsored insurance offers) as a way to keep costs down. Typically, employers do so by increasing deductibles and other cost-sharing elements of insurance. This explains why nearly a quarter of firms offer some type of high-deductible product for their employees.<sup>13</sup> Here, the guiding rationale for employers is that higher out-of-pocket requirements will slow total cost growth. Indeed, recent research, in addition to the AAA study cited earlier, credits much of the slowdown in private insurance-premium growth to the expansion of higher-deductible plans in the employer market.<sup>14</sup> The analysis of a full-replacement HSA showed that health care spending was 25 percent lower in the first year of adoption than it would otherwise have been;<sup>15</sup> the reduction ameliorated over the next few years but still kept spending lower than otherwise. The largest ever study of HDHPs found 14 percent first-year savings.<sup>16</sup>

While this all points to significant cost savings from HDHP adoption, these studies generally monitor the employer-sponsored market. Whether similar cost-reducing trends can persist in the individual market is uncertain.

## THE NON-GROUP MARKET: HDHPs AND HSAs

HDHPs and HSAs have clearly become an increasingly important element in the employer market. When it comes to the individual (or non-group) market, HDHPs are arguably even more important. Recent estimates from the National Health Interview Survey<sup>17</sup> show that the share of people with HDHPs in the non-group market is 57.8 percent; in the employer market, the number is 30.3 percent.<sup>18</sup> Altogether, however, the non-group market is simply too small to matter much in total spending patterns. Indeed, the individual market in the U.S. has been largely negligible for at least the past decade. By most accounts, the individual market consists of between 12 million and 40 million people,<sup>19</sup> and while the individual market's total share varies depending on the source, it has remained relatively stable over the past decade, with most insured people receiving coverage through their employers.

Under ACA, the effective tax treatment of individual insurance will change sharply. Going forward, premium tax credits will ensure that the individual market becomes a much more significant element of U.S. health-insurance enrollment. As noted in Figure 1, the April 2014 projections of the Congressional Budget Office (CBO) estimate that the non-group market (including the health-insurance exchanges) will grow 96 percent over the next 11 years, from 10.7 to 16.5 percent of the nonelderly population.

With the individual market becoming a much more routine source of coverage for more Americans, trends in the individual market will be able to more profoundly affect the health care system at large. And higher-deductible exchange plans—HSAs and non-

HSAs—will require enrollees to become far more cost-conscious, with deductibles much higher than those in traditional employer plans. “Bronze” plans, the least-expensive tier, for instance, have average deductibles of \$5,000, while the “silver” tier averages \$2,900 for single coverage.<sup>20</sup> In the employer market, 34 percent of workers were in plans without deductibles—of those who faced deductibles, average deductibles amounted to only around \$1,100 for single coverage.<sup>21</sup>

Today, as consumers are exposed to a growing number of high-deductible plans, they can be expected to demand greater cost and quality transparency from providers, accelerating beneficial impacts on the wider market for health insurance and health care, while significantly affecting long-term health care cost trends, too.

This positive outcome assumes that consumers have the information necessary to choose intelligently among competing plan designs—and to understand how to make the most of their HSA-eligible coverage.

### *HSAs: Opportunities and Concerns*

While the use of HSA-eligible products in the group market is well studied, the extent to which HDHPs can work well in the individual market has not been examined as thoroughly. The dearth of research in this area is likely a function of the small size and instability of the individual market.<sup>22</sup> Moreover, HSAs offered by employers typically include some contribution from the employer to the HSA. (While about half of employers do not contribute to HSAs, enrollment skews toward those that do, with 68–69 percent of workers with HSAs enrolled in plans with some employer contribution.)<sup>23</sup> This can help offset any

Figure 1: Non-Group Coverage, ACA vs. Pre-ACA Baseline (millions of people)

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
<b>Baseline</b>	24	24	25	25	26	26	26	26	27	27	27
<b>W/ACA</b>	29	34	45	46	47	47	47	47	48	47	47
<b>Change/Baseline</b>	21%	42%	80%	84%	81%	81%	81%	81%	78%	74%	74%

Source: Congressional Budget Office, “Insurance Coverage Provisions of the Affordable Care Act—CBO’s April 2014 Baseline,” Table 2, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf>

potential reduction in higher-value medical spending that can occur because of greater exposure to out-of-pocket costs, especially for lower-income enrollees with chronic health issues. Notably, virtually all HDHPs in the group market covered preventive care for conditions such as diabetes and high cholesterol before any deductible pre-ACA, while 59 percent did so in the individual market.<sup>24</sup> Standardization of preventive benefit coverage under the ACA should, for better or for worse, further ameliorate concerns about prevention and disease management strategies in HDHP/HSA plans.

While it is not clear that, in the general population, a reduction in medical utilization is necessarily harmful, research indicates that people with HDHPs are more likely to skip both low-value *and* recommended medications or medical care. Why this happens is not clear, since many of these services would be covered pre-deductible (under current, as well as pre-ACA designs). At the same time, individuals in HDHPs *are* more likely to engage in cost-conscious behavior, such as discussing costs of treatment with their doctors, asking for generic rather than brand-name drugs, and developing budgets to manage health care expenses.<sup>25</sup>

High out-of-pocket exposure may be of particular concern for people with chronic conditions. One study, surveying families with chronic conditions, found that half the families with HDHPs faced health care related financial burdens, compared with 21 percent of families with a standard plan.<sup>26</sup> Indeed, for individuals with chronic conditions, HDHPs likely are not appropriate insurance vehicles, for HDHPs could expose such individuals to unnecessarily high out-of-pocket expenses. However, as noted previously, exchange deductibles are already significantly higher than deductibles found in employer-provided plans, with about half the uninsured not qualifying for premium tax credits or cost-sharing subsidies. Even for individuals with chronic health conditions, the ACA cap on out-of-pocket spending could make the lower premiums associated with HDHPs/HSAs more attractive—if such individuals expect to exceed out-of-pocket caps on a regular basis. In essence, the ACA's regulations

mean that HDHPs should be expected to become a major offering.

If paired with a savings vehicle like an HSA, HDHPs are likely to become more attractive for low-income enrollees, too. This would empower even low-income enrollees to accumulate savings for routine (e.g., pharmacy drug costs), as well as catastrophic, events. Indeed, such an approach has already been used with some success in Indiana's Healthy Indiana Plan for low-income enrollees who otherwise would not qualify for public coverage.

Another frequently voiced criticism of HDHPs is that of favorable selection: people who select them are disproportionately healthy and thus have a combination of low baseline health care costs and higher incomes. The literature is somewhat mixed on this topic.<sup>27</sup> However, a study cited earlier<sup>28</sup> controls for this because it analyzes a full-replacement HSA, still finding significant and sustained savings across a variety of medical spending categories.<sup>29</sup> Nevertheless, data from the 2012 National Health Interview Survey indicates that younger enrollees (those more likely to be healthy) are disproportionately represented in HDHPs, with 18–34-year-olds making up 19.5 percent of those with HDHPs and 11.7 percent of the general population. High-income earners are also overrepresented—those in families with incomes over \$100,000 make up 36.8 percent of HDHP enrollees and 24.9 percent of the population.<sup>30</sup>

## FINDINGS

In our analysis, we examined data on a per-plan, per-county basis (i.e., the unit of observation was each unique offering across counties).<sup>31</sup>

As Figure 2 illustrates, HSA-eligible plans make up a full 25.27 percent of all plan offerings nationally. And while an HSA-eligible plan is far more likely to be a PPO plan than any other type, this is mainly a function of the plans being offered overall: PPOs make up 50 percent of offerings and 52 percent of HSA plans. In general, each plan type's probability of being an HSA plan is roughly equivalent—HMOs,

Figure 2: HSA vs. Non-HSA Landscape, by Plan Type

Plan Type	Plan Offerings	Share/Total Plans	HSA Offerings	Share/HSA Offerings
EPO	7,879	8.64%	1,752	7.60%
HMO	27,544	30.22%	7,376	32.02%
POS	6,886	7.55%	1,604	6.96%
PPO	45,905	50.36%	12,403	53.84%
Unknown	2,939	3.22%	263	1.14%
<b>Total</b>	<b>91,153</b>	<b>100.00%*</b>	<b>23,038</b>	<b>25.27%**</b>

Source: Authors' analysis of data from HealthSherpa.com  
 \*Figure represents all plans offered nationally.  
 \*\*Figure represents HSA-eligible plans as a share of all plans offered nationally.

PPOs, EPOs, and POSs all had about a 25 percent probability of being HSA-eligible. Nevertheless, the probability of a plan being HSA-eligible *and* being a given plan type was still significantly higher for PPOs (about 13 percent).<sup>32</sup>

In general, we also found that HSA-eligible plans can also offer a good deal for consumers—with significant savings on premiums, compared with traditional plan designs, averaging 14 percent across all counties with at least one HSA-eligible plan available, though ranging as high as 46 percent. Notably, in 257 of 3,143 counties surveyed, HSA-eligible plans were more expensive, on average, than traditional plans. This may partly be driven by the catastrophic plan tier, which typically has lower premiums but is not HSA-eligible. Lower premiums, however, bring higher deductibles: on average, deductibles are 29 percent greater for HSA-eligible plans (again, in counties with at least one HSA-eligible plan available), a difference of about \$1,350.

While the difference in deductibles is significant, the reality is that the typical American does not face *any* health expenditures in a given year. With an HSA available, he or she can deposit the premium savings (about \$441 for a 27-year-old), or some portion of it, into an interest-bearing HSA account, including 401(k)-style plans, hedging against periods when the enrollee, or the enrollee's family, faces more significant health expenditures.

As with many elements of health care, national averages often obscure important inter- and intrastate variations. Figure 3 illustrates this important varia-

tion. While HSA-availability trends vary less within a state than between states, between-county differences can be salient. On the savings side, meanwhile, there is even more variation (compared with availability). Within Texas, for instance, HSA-eligible plans in McLennan County are, on average, 13.3 percent less expensive than other plans; in Cameron County, the savings reach 43 percent.

Still, this focus on HSA availability as a *share* of total plans masks other important metrics. Many counties have more HSA-eligible plans in total than as a share of all plans, for instance. As Figure 4 illustrates, total availability varies significantly by state as well. Thus, one could reasonably argue that counties with more HSA plans (but a lower share) have greater HSA availability than counties with fewer plans but a larger relative share.

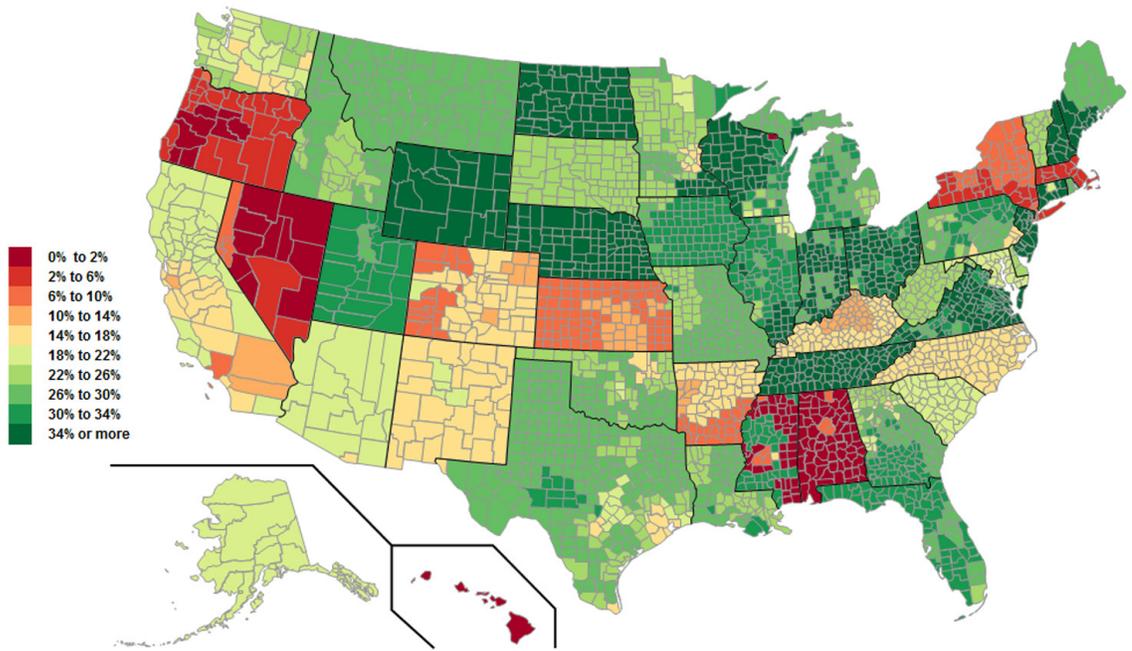
## REFORMS: EXPANDING CHOICE AND ENHANCING COMPETITION

The results of our analysis naturally lead to several reform proposals going forward.

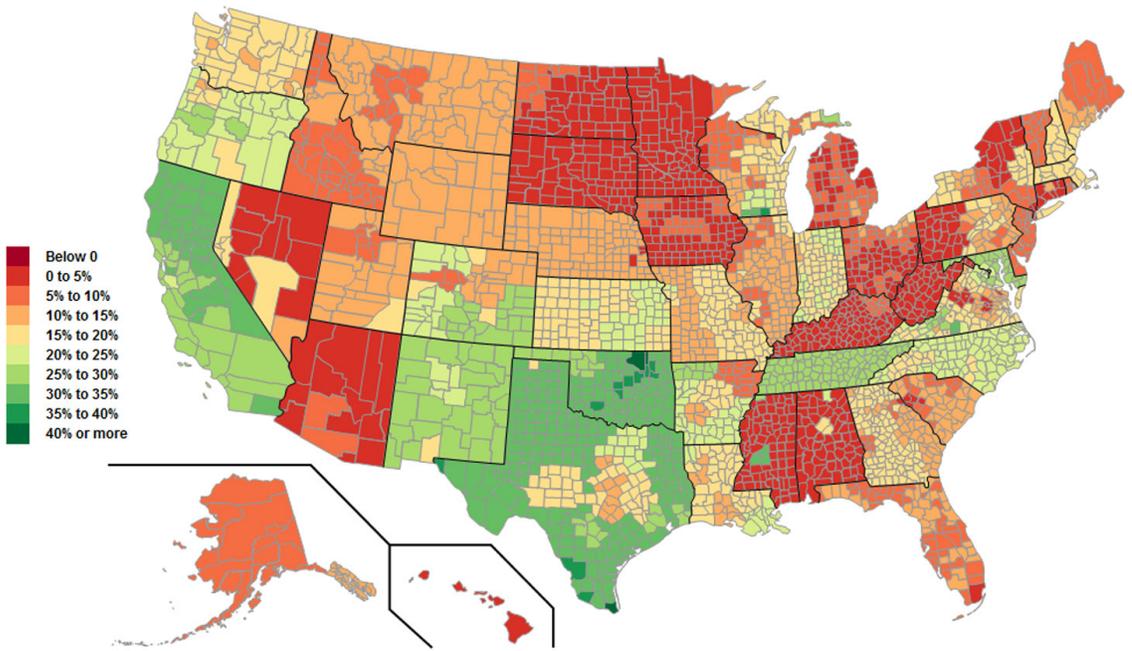
### 1. Transparency

The typical individual-market consumer who is purchasing insurance is unlikely to be familiar with HSA-eligible plans and the benefits they may offer. Indeed, lower use of preventive services suggests that plan design may not be well understood. It is also well beyond typical consumers to determine, on their own, whether a particular plan *is* HSA-eligible; we note that many plans that are HSA-eligible are

Figure 3: HSA-Eligible Plan Share of All Plans, by County



HSA-Eligible Plan Savings, by County



Source: Authors' analysis of data from HealthSherpa.com. For methodology, caveats, and limitations, see the methodological appendix.

Figure 4: Top and Bottom 10 States by Number of HSAs

Top 10 States		Bottom 10 States	
State	Avg. HSA Count	State	Avg. HSA Count
TN	19.73	WV	3.00
FL	19.27	KY	3.00
UT	18.00	NC	2.98
AZ	14.80	AR	2.95
IL	13.16	KS	2.26
NJ	12.76	OR	1.67
ND	12.49	MS	0.93
PA	12.18	NV	0.65
WI	11.31	AL	0.04
OH	10.44	HI	0.00

Source: Authors' calculation based on data from HealthSherpa.com. HSA count is an average of HSA-eligible plans across all counties (the numerator is total HSA-eligible plans; the denominator is total counties).

not clearly identified as such (only 42 percent of eligible plans were clearly labeled as HSA-eligible).<sup>33</sup> Moreover, even when the plan was HSA-identified, there was little, if any, information on how the HSA actually operates (with the exception of plan marketing brochures).

Some states' exchanges contain additional information on their websites (or link to benefit brochures) adequately labeling plans—though this was the exception rather than the rule. Public health-insurance exchanges should, accordingly, make a more concerted effort to identify HSA-eligible plans and clearly provide relevant information to consumers. Health-insurance companies should do the same.

Another helpful component would be a web-based “cost calculator” to allow consumers to estimate annual health expenditures, compare potential premium savings with those of a traditional design in the same benefit category, and, not least, assess total savings benefits associated with annual contributions and estimated income. Better access to formularies, including which drugs are covered under preventive benefits, is also crucial. This would give shoppers an easy way to estimate the relative benefits and costs of HSA plans. As noted earlier, standardization of preventive benefit designs (for both drugs and medi-

cal services) should alleviate many criticisms of HSA plan designs.

## 2. Standardization

Complex benefit requirements pose an unnecessary obstacle to consumers. To make regulations simple enough for the typical consumer to digest, we also recommend regulatory reforms to simplify the process of determining HSA eligibility. In principle, the only eligibility category should be deductible level (set at \$1,250 in 2014), rather than the myriad rules and exclusions adopted by the Internal Revenue Service (IRS). In particular, the requirement—that consumers obtain a prescription for over-the-counter drugs before using HSA funds for such purposes—is particularly pernicious, since OTC drugs are less expensive than similar drugs obtained with a prescription (to say nothing of the added time required for physicians to spend with patients who would otherwise easily self-diagnose). Encouraging consumers to purchase OTC drugs, rather than their prescription equivalents, may not save much money but would surely go a long way toward encouraging more cost-conscious behavior.

An even more ambitious idea might be to tie HSA eligibility to the actuarial value of plans, instead of

deductibles. In practice, deductibles may be a crude measure of actual out-of-pocket expenses. A plan with a \$1,000 deductible can easily have an out-of-pocket limit of \$3,000 or more. Actuarial value is, instead, likely a better proxy of the share of health expenses that an average enrollee in a given plan would have to pay in the event of serious illness.

In addition, HSA funding—regardless of plan characteristics—should be permitted to pay for premiums, in addition to out-of-pocket expenses. This would effectively equalize tax treatment between employer-sponsored insurance (ESI) and non-group insurance, allowing individuals with chronic diseases to choose the plan and network design most appropriate for their condition.

### 3. Affordability

Longer-term reforms should focus on making HSA-eligible plans even more accessible on public exchanges. Introducing a true “catastrophic” plan tier (one eligible for subsidies and meshing with HSA requirements) with a lower actuarial value—such as the recent proposal from Democratic senators Begich (AK), Heitkamp (ND), Landrieu (LA), and Manchin (WV)—would also improve the landscape for more affordable plan options for the most cost-sensitive consumers (i.e., those who don’t qualify for subsidies).

To further improve the viability of HSA-eligible plans, federal premium subsidies and tax credits should be permitted to fund HSAs, too. For instance, if an individual chooses a plan that costs less than the total subsidy for which he is eligible, he should be able to deposit the remaining subsidy into an HSA. Allowing cost-sharing subsidies to be introduced into an HSA would, similarly, encourage additional com-

parison shopping when the time comes for necessary health expenditures.

## CONCLUSION

Contrary to initial expectations, we find that HSAs remain a viable option on the Obamacare exchanges, although access to HSAs varies significantly by county and state. Far more could also be done to make HSA plan designs more transparent, affordable, and accessible to average consumers, on both state and federal exchanges.

With higher-deductible plans—both in HSA-eligible and traditional designs—poised to become increasingly common in the U.S., we believe that there is a significant opportunity for enhanced consumerism that can both benefit patients and help control runaway health care costs. To their detractors, HSAs/HDHPs have traditionally been blamed for exposing enrollees to higher routine costs; today, ACA-mandated plan designs will indeed cover more routine costs but, ironically, expose patients to far higher costs for hospital and out-of-network care. More flexibility and choice in benefit and network designs would help alleviate such new cost hikes, helping consumers choose plans (HSA or otherwise) that better meet their health care needs.

Finally, though beyond the scope of this paper, federal and state regulators should allow the sale of supplemental insurance (including critical care and disability insurance) on federal and state exchanges, respectively. Such insurance would couple well with higher-deductible plans, reassuring consumers that they could afford to take more financial risk without the threat of being wiped out in the event of serious, prolonged illness.

## METHODOLOGICAL APPENDIX

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The primary analysis for this report was conducted using data from HealthSherpa.com, a consumer guide to health-insurance exchanges. To determine HSA eligibility, we consulted official IRS regulations and received helpful assistance from Todd Berkley of HSAConsultingServices.com. Because cost-sharing information was often incomplete, we used a very narrow definition of HSA eligibility; thus, our results likely undercounted total HSA-eligible plan availability. In the course of analyzing plans, we ignored several subsets of plans. Excluded plans were:

- Child-only plans, because they are designed to provide coverage only for children
- “Morbid obesity” plans, because such plans cover bariatric surgery and thus have artificially inflated premiums
- Plans with vision coverage, which are generally just variations on plans without vision coverage
- Plans with adult dental coverage, because these are also variations on existing plans
- Plans that explicitly include pediatric dental coverage (when a non-pediatric dental alternative was available), for the reasons mentioned above
- Cost-sharing-reduction plans, because such plans are, again, merely variations on existing silver-tier plans

A number of plans did not have deductible information available. This was particularly problematic in evaluating the HSA landscape in New York, which likely resulted in a significant undercount. On the other hand, because of limited information about total plan availability in Connecticut, the results for Connecticut counties likely overstate total HSA availability.

Despite these data-quality concerns, we believe that our analysis is a conservative, accurate description of the HSA-eligible plan landscape under ACA.

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- <sup>2</sup> "Letter to Congressional Leaders on Health Insurance Reform," March 2, 2010, <http://www.whitehouse.gov/the-press-office/letter-congressional-leaders-health-insurance-reform>.
- <sup>3</sup> Kathleen Sebelius, "How the Affordable Care Act Empowers States," *Washington Post*, February 10, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/09/AR2011020905682.html>.
- <sup>4</sup> Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Health Care Spending," Brookings Institution (fall 2013), [http://www.brookings.edu/~media/Projects/BPEA/Fall%202013/2013b\\_chandra\\_healthcare\\_spending.pdf](http://www.brookings.edu/~media/Projects/BPEA/Fall%202013/2013b_chandra_healthcare_spending.pdf).
- <sup>5</sup> Victoria Craig Bunce, "Medical Savings Accounts Progress and Problems under HIPAA," Cato Institute, August 8, 2001, <http://www.cato.org/sites/cato.org/files/pubs/pdf/pa411.pdf>.
- <sup>6</sup> Jon R. Gabel et al., "More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* 31, no. 6 (2012): 1339–48.
- <sup>7</sup> Defined as co-pays, deductibles, or coinsurance. Premiums are not considered out-of-pocket spending.
- <sup>8</sup> "Health Insurance Price Index for October–December 2013," eHealth, February 2013, <https://www.ehealthinsurance.com/affordable-care-act/wp-content/themes/ace/price-index/data/quarterly-index.pdf>.
- <sup>9</sup> Uninsured by county were calculated using the Census Bureau's Small Area Health Insurance Estimates (SAHIE).
- <sup>10</sup> "January 2013 Census Shows 15.5 Million People Covered by Health Savings Account / High-Deductible Health Plans (HSA/HDHPs)," America's Health Insurance Plans, June 2013.
- <sup>11</sup> "2013 Milliman Medical Index," Milliman, May 2013, <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/mmi-2013.pdf>.
- <sup>12</sup> David M. Tuomala et al., "Emerging Data on Consumer-Driven Health Plans," American Academy of Actuaries, May 2009.
- <sup>13</sup> "Employer Health Benefits 2013 Annual Survey," Kaiser Family Foundation and Health Research & Educational Trust, August 20, 2013, p. 145, <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf>.
- <sup>14</sup> Chandra et al., "Is This Time Different? The Slowdown in Health Care Spending."
- <sup>15</sup> See Paul Fronstin and M. Christopher Roebuck, "Health Care Spending After Adopting a Full-Replacement, High-Deductible Health Plan with a Health Savings Account: A Five-Year Study," Employee Benefit Research Institute, July 2013, [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_07-13.No388.HSAs2.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-13.No388.HSAs2.pdf).
- <sup>16</sup> Melinda Beeuwkes Buntin et al., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," *American Journal of Managed Care* 17, no. 3 (2011): 222–30.
- <sup>17</sup> Robin A. Cohen and Michael E. Martinez, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2013," Centers for Disease Control and Prevention, September 2013, <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201309.pdf>.
- <sup>18</sup> It is important to note that HDHPs have been growing faster in the employer market—with the share growing 77 percent from 2008.
- <sup>19</sup> Authors' analysis of Current Population Survey and American Community Survey data for 2012 from the University of Minnesota Population Center (IPUMS) data set. The CPS shows 30.2 million individuals with individually purchased coverage in 2012, while the ACS shows 38 million. An analysis from the Society of Actuaries in 2013 revealed an estimate of about 12 million individuals in the non-group market in 2013. In its baseline estimates for the effects of PPACA on insurance coverage, the Congressional Budget Office estimates 25 million non-group beneficiaries in 2012. In general, estimates of the size of the non-group market can vary because of the relatively small size of the market compared with total population.
- <sup>20</sup> "Deductibles, Out-of-Pocket Costs, and the Affordable Care Act," HealthPocket.com, December 12, 2013, <http://www.healthpocket.com/healthcare-research/infostat/2014-obamacare-deductible-out-of-pocket-costs#.U4YPCPlDWS0>.

- <sup>21</sup> “Employer Health Benefits 2013 Annual Survey,” Kaiser Family Foundation and Health Research & Educational Trust, August 20, 2013.
- <sup>22</sup> A 2004 study found that the median length of individual coverage was eight months between 1996 and 2000. See Erika C. Ziller et al., “Patterns Of Individual Health Insurance Coverage, 1996–2000,” *Health Affairs* 23, no. 6 (2004): 210–21.
- <sup>23</sup> “Employer Health Benefits 2013 Annual Survey,” Kaiser Family Foundation and Health Research & Educational Trust, August 20, 2013, pp. 143–44.
- <sup>24</sup> “Health Savings Accounts and Preventive Care,” Council for Affordable Health Insurance, April 2009.
- <sup>25</sup> See Paul Fronstin and Sara R. Collins, “Findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey,” Employee Benefits Research Institute and the Commonwealth Fund, March 2008; and Paul Fronstin, “Findings from the 2013 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey,” December 2013, [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Mar/Findings%20From%20the%202007%20EBRI%20Commonwealth%20Fund%20Consumerism%20in%20Health%20Survey/Fronstin\\_consumerism\\_survey\\_2007\\_issue\\_brief\\_FINAL%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2008/Mar/Findings%20From%20the%202007%20EBRI%20Commonwealth%20Fund%20Consumerism%20in%20Health%20Survey/Fronstin_consumerism_survey_2007_issue_brief_FINAL%20pdf.pdf).
- <sup>26</sup> Alison A. Galbraith et al., “Nearly Half of Families in High-Deductible Health Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden,” *Health Affairs* 30, no. 2 (2011): 322–31.
- <sup>27</sup> For a more thorough discussion, see “Analysis of High Deductible Health Plans,” RAND Corporation, [http://www.rand.org/pubs/technical\\_reports/TR562z4/analysis-of-high-deductible-health-plans.html](http://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html).
- <sup>28</sup> Fronstin and Roebuck, “Health Care Spending After Adopting a Full-Replacement, High-Deductible Health Plan with a Health Savings Account.”
- <sup>29</sup> The “generalizability” of this analysis to the overall population is unclear. Importantly, the treatment group had an average age significantly lower than the average age of Americans, based on the American Community Survey.
- <sup>30</sup> Authors’ analysis of National Health Interview Survey data from 2012, using the University of Minnesota Population Center’s IPUMS data set.
- <sup>31</sup> This means that plans would be counted more than once. That is, if one plan is offered in three counties in a state, while another plan is only offered in one, the former would be counted three times. For the purposes of exploring total available offerings, this is preferable to examining offerings solely on a per-plan basis.
- <sup>32</sup>  $P(A \text{ and } B) = P(A) * P(B)$ .  $(0.2623) * (0.5036) = 0.132$ .
- <sup>33</sup> Clear labeling was defined as having some variant of “HSA,” or indicating “health savings” in the plan name.



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