

# **Consumer-Directed Health Care and Health Savings Accounts**

**American College of Physicians  
A Policy Monograph  
2005**

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A Policy Monograph of the  
American College of Physicians

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## Introduction

In 2003, health insurance premiums increased by 13.9 percent, representing the third consecutive year of double-digit inflation and the largest annual increase since 1990.<sup>1</sup> In managing these high costs, most employers have opted to increase cost sharing rather than restrict workers' choice of providers or reduce benefits.<sup>2</sup> Still, few consider this approach the ultimate solution to rising health care costs. Rising premiums and a slow economy have pushed employers and other health care purchasers to consider innovative health benefit strategies, such as insurance products that shift more financial risk to consumers or decision-support, disease management, and patient-navigator tools that ultimately control costs by improving quality of care.

The American College of Physicians, representing 116,000 physicians who specialize in internal medicine and medical students, has a longstanding history of advocating for reforms to provide all Americans with access to health insurance coverage. ACP urges all elected leaders and policymakers to focus their attention on the documented problems of uninsured Americans to ensure that all Americans benefit from the provision of health insurance.

With the publication of a series of White Papers on the effects of a lack of health insurance, ACP advances to the next step, searching for a solution. Various proposals exist on how to increase the number of insured Americans. ACP's core principles on access, approved by the Board of Regents in October 2000, can serve as a guideline to evaluate these proposals.<sup>3</sup>

In earlier monographs, ACP examined the effectiveness of a variety of strategies to reduce the number of uninsured Americans. These included an expansion of Medicaid and the State Children's Health Insurance Program (SCHIP);<sup>4</sup> a move toward a system of individually purchased and owned health insurance as an alternative to employer-sponsored insurance;<sup>5</sup> and the use of health insurance tax credits.<sup>6</sup> These analyses helped ACP formulate a comprehensive plan that would enable all Americans to have access to affordable health insurance coverage within the next seven years. The proposal calls for a combination of measures that build on the nation's public and private health care systems, including expanding Medicaid and SCHIP, providing government-sponsored premium subsidies, and establishing new state programs.<sup>7</sup>

In this monograph, ACP examines consumer-directed health plans as a means to increase access to health care. Consumer-directed health plans are designed to transform consumers into more prudent purchasers of health care services by shifting more financial risk to consumers. The design and implementation of any consumer-directed health plan will determine its effectiveness at reducing the number of uninsured Americans. This monograph discusses the structural components needed to improve health care coverage in relation to ACP's core principles on access.

## Background

From 2002 to 2003, the cost of employer-sponsored health care plans rose 14.9 percent, from an annual \$5,239 per employee to \$6,020.<sup>8</sup> As health care prices continue to rise, employers—the primary source of health coverage for most Americans under age 65—continue to seek ways to limit increasing expenditures for employee health care. With the managed care backlash causing more explicit consumer demand for greater choice, purchasers are increasingly adopting strategies to reduce the cost of care without compromising patient freedom of choice.

One innovative strategy to reach this compromise is consumer-directed health care, which has gained increasing attention over the past year. The theory behind consumer-directed health care is that by exposing consumers to the actual price of medical services, the different available options of care, the appropriate information to support decision-making, and the right financial incentives, consumers will become better informed, more involved, and more prudent users of care. The immediate advantage is to reduce or restrain employer health insurance premiums. Ultimately, this modified behavior would also reduce employer expenditures for health benefits and produce a more efficient health care system.

It is interesting to note the roots of employer-sponsored health care (and more generally, third-party payers of health care). The concept of health insurance being offered as a fringe benefit of employment grew out of the wage freezes of World War II. Tax policy was modified to encourage companies to reward employees with extra benefits, such as health care insurance. For example, employers were permitted to fully deduct the cost of employee health coverage. This policy continues to stand, favoring third-party payment for health insurance and encouraging employers to offer health benefits rather than raise wages.

Much of the recent attention paid to consumer-directed health care grew out of frustration with the health system's increasing dependency on third party payers. By shielding consumers from the true cost of health care, third-party payers give consumers little incentive to be economical in their health care decisions.<sup>9</sup> As third-party payers increased their efforts to control health care costs, particularly by the use of managed care, consumers protested their loss of control over health care decision-making, while employers became increasingly dissatisfied with the failure of managed care companies to limit the cost and use of health care services. As the disconnect between payers and consumers grew over the past forty years, spending on health care services consistently grew faster than other parts of the economy. In 1960, more than 55 percent of total health care spending was paid directly by consumers; by 2000 that number dropped to 15 percent.<sup>10</sup> Over the same period, the growth in National Health Expenditures was far higher than the increase in Gross Domestic Product (GDP) in all but five years.

Health benefit managers generally agree that greater cost sharing tends to increase employee sensitivity to health care costs and helps to slow premium trends to some degree.<sup>11</sup> The Rand Health Insurance Experiment, completed in the early 1980s, found that the use of medical services is directly linked to the amount paid out-of-pocket. The study tested a variety of cost-sharing options over an eight-year period, including one that paid 100 percent of the cost of services and one that paid only five percent with a stop-loss limit. For health care other than children, per capita expenses on the free plan turned out to be 45 percent higher than those on the plan with a 95 percent coinsurance rate. Of note, the lower use of services did not have a negative effect on health outcomes.<sup>12</sup>

## **Types of Consumer-Directed Health Plans**

The consumer-directed movement is driven by increasing consumer involvement in health care decision-making. Price sensitivity is an after-effect of this new role, resulting from increased access to health information, improved resources for making health care decisions, and more control over health care dollars. The consumer-driven health care trend is already apparent in many aspects of our health care system. The increasing use of the Internet by consumers to make enrollment decisions, compare physicians, learn about treatment alternatives, and connect with patients with similar conditions is one example. Even the decisions by employers to shift a larger share of costs to employees to offset rising health care costs represents an example of how responsibility for health care decisions is shifting more and more to the consumer.<sup>13</sup>

The latest movement in consumer-directed health care has been the creation of consumer-directed health plans, which can either supplement or supplant more traditional models of coverage.<sup>14</sup> Savings accounts linked to health plans that allow workers to put aside money to pay medical bills are becoming one of the most popular forms of consumer-directed health care.

### ***Flexible Savings Accounts (FSAs)***

FSAs, which have been available since the late 1980s, and other defined contribution arrangements, enable workers to set aside pre-tax dollars through salary reduction. FSAs can be paired with any type of insurance. The Internal Revenue Service (IRS) imposes no dollar limit on health care FSA contributions, but employers generally do. Employers can contribute to the account, but few do. Contributions to FSAs are exempt from taxes, as are withdrawals used for deductible medical expenses.<sup>15</sup> These include medical and dental expenses not covered by insurance,<sup>16</sup> including co-payments, non-covered services and supplies, and over-the-counter medications. FSAs are limited to employees and former employees. They may not be opened by individuals.<sup>17</sup> They may only be set up at the discretion of the employer and over the course of a year contributions cannot be adjusted.

FSAs do not allow true individual ownership and portability of health plans and therefore cannot be used to save for future health care expenses. Any funds leftover at the end of the year must be spent or forfeited to the employer, which critics believe tends to encourage under-funding and over-utilization of services at the year's end.<sup>18</sup>

### ***Medical Savings Accounts (MSAs)***

Laws authorizing MSAs (also known as Archer MSAs) were first enacted by seventeen states in the early 1990s, and then by Congress under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The tax-advantaged MSAs created under HIPAA were weighted down with excessive and restrictive regulations. The accounts were authorized only as a pilot project and limited to 750,000 accounts, which could be offered only to businesses with less than 50 employees and the self-employed.<sup>19</sup> MSAs had to be linked to a high-deductible health care plan, which was defined as a plan having a deductible of \$1,500 for an individual and \$3,000 for a family, at minimum.<sup>20</sup>

The assumption was that high-deductible health insurance policies would be more affordable, but would still protect people from major health care expenses, and that the tax advantages and lower health insurance premiums would better enable people to pay directly for services up to the deductible and

copayment amounts.<sup>21</sup> Contributions to the account were not subject to taxes and could be made by the employer or the employee, but not by both in the same year. Contributions were capped and could not exceed 65 percent of the deductible for an individual policy and 75 percent for a family policy.<sup>22</sup> Since the accounts were actually owned by the employee, MSAs were more portable than FSAs, and could be rolled over from year to year, building interest over time, and were tax-free, regardless of employment. Unlike FSAs, MSA holders were permitted to withdraw funds for medical as well as non-medical purposes. If withdrawals were for qualified medical expenses, they would not be subject to taxation. However, if withdrawn for non-medical purposes, savings were considered taxable income and subject to income taxes and a 15 percent penalty tax.<sup>23</sup>

In the end, enrollment caps, time limitations, and limited application confined the access and market opportunities of the MSA.<sup>24</sup> By 2001, the most recent year for which data are available, less than 80,000 people had established accounts under the MSA demonstration project, far fewer than the 750,000 account limit established under the law.<sup>25</sup> The MSA pilot project sunseted on December 21, 2003. Individuals who established MSA accounts and remain eligible can continue to make or receive MSA contributions and can continue to receive distributions from MSAs.<sup>26</sup>

### ***Health Reimbursement Arrangements (HRAs)***

In June 2002, while MSAs were still being tested, the Treasury Department authorized tax-favored Health Reimbursement Arrangements (HRAs). Like MSAs, HRAs permit employers to structure a portion of their benefit plans as a durable “fund” that employees can use to pay for covered services or accumulate for future health needs. While more traditional benefits are covered above a preset deductible, HRAs may include first-dollar, preventive care coverage.<sup>27</sup> Unlike MSAs, contributions to HRAs are not capped, and the accounts may accompany any sort of insurance plan, although many employers pair them with a high-deductible health plan to ensure catastrophic protection.<sup>28</sup> Also, funds may be contributed only by the employer, not by the employee, and may be spent only on health care services.<sup>29</sup> Since funds remain the property of the employer, portability and access to the funds from year to year or post-employment is limited.<sup>30</sup>

The increased flexibility and wider applicability of HRAs quickly caught the attention of employers and insurers.<sup>31</sup> Programs similar to HRAs are now being offered by a number of large companies and major insurers such as Aetna, Humana, and United Healthcare.<sup>32</sup>

### ***Health Savings Accounts (HSAs)***

In an attempt to refine MSAs and give consumers even more control over their health care choices, Congress authorized HSAs under the Medicare Modernization Act of 2003 (MMA). These accounts, which became available on January 1, 2004, permit eligible individuals and their employers to make tax-free contributions to the account. However, HSAs are held exclusively by the individual, rather than the employer, and there are no income limits on who can participate. Funds in an HSA grow year-to-year tax-free, and withdrawals from the account are not taxed if they are used to pay for “qualified medical expenses,” which include deductibles, co-payments, and uncovered medical costs, but not the premium cost of most health insurance.<sup>33,34</sup> Funds may only be used to pay for insurance premiums while unemployed, including those associated with

COBRA, qualified long-term care insurance, and health care expenses during retirement.<sup>35</sup> HSA holders may withdraw funds for non-medical purposes, but the withdrawal is taxed, and people under age 65 must pay a ten percent penalty.<sup>36</sup>

To be eligible for an HSA, an individual must be covered by a high-deductible health plan. For single coverage, the qualifying annual deductible must be no lower than \$1,000 and no higher than \$5,000. For a family, the annual deductible must be between \$2,000 and \$10,000. The maximum annual deposit to an HSA (including contributions by both the individual and the employer) is the lesser of the deductible or \$2,600 for a single coverage or \$5,150 for family coverage in 2004. An HSA account holder cannot be covered by other health insurance. However, some insurance coverage is disregarded in determining an individual's eligibility. This includes specific injury insurance and accident, disability, dental care, vision care, and long-term care insurance. An account holder also must not be entitled to Medicare (entitlement = eligibility + enrollment) and cannot be claimed as a dependent on someone else's tax return.<sup>37</sup>

HSA participants between 55 and 65 years of age can contribute an extra \$500 a year pretax to prepare for necessary expenses once covered by Medicare. This "catch-up" contribution rises until it reaches \$1,000 in 2009.<sup>38</sup> Once an account holder is entitled to Medicare, no further contributions can be made. However, funds may continue to be withdrawn tax-free for qualified medical expenses, including payments for certain insurance premiums like Medicare Part A & B, Medicare HMO, and the employee's share of retiree medical insurance premiums. Individuals entitled to Medicare can also make withdrawals for non-medical expenses. Although no penalty is applied here, the amount is taxable.<sup>39,40</sup> Basing HSA eligibility on Medicare entitlement, and not eligibility or age, means that individuals who continue to work after age 65, and who are not enrolled in Medicare, can remain HSA eligible and continue to contribute to the account.<sup>41</sup> In the event of death, HSAs may be bequeathed to a spouse, or (like an IRA) the funds may flow to other heirs.

HSAs represent one of the most generous allowances ever made in the tax code.<sup>42</sup> The accounts are less restrictive than MSAs, but more permanent than HRAs. Improved features of this account include:

- 1) Lower qualifying deductibles than MSAs (\$1,000 single/\$2,000 family);
- 2) Higher permissible contributions than MSAs (up to 100 percent of the deductible in most cases);
- 3) Broader eligibility than MSAs (including employees of any size business, retirees not yet entitled to Medicare, and individuals without employer coverage);
- 4) Both the individual and the employer can contribute to an HSA; and
- 5) Up to \$500 left over from an employer FSA can be rolled over into an HSA.<sup>43</sup>

Over the spring of 2004 and more recently in July 2004, the U.S. Department of the Treasury and the IRS issued guidance reports to clarify specific provisions included under the HSA legislation. The most contentious of these guidances clarifies how an individual can ensure that he/she has coverage under a plan that would qualify as a high-deductible plan and would therefore render the individual eligible for an HSA. Typically, under HSA-linked health plans, the annual deductible must be met before plan benefits are paid. The very point of linking HSAs to a high-deductible health plan is to dissuade individuals from overspending on health care services. By requiring consumers to spend

out-of-pocket for a longer period of time, high-deductible health plans make consumers more sensitive to health care costs and therefore more selective users of health care services. However, lawmakers were concerned that consumers might skimp on the most important services, those that actually pay-off in the long-run, such as preventive care.

To prevent consumers from forgoing cost-effective services, the Treasury Department's spring guidance announced the creation of a "safe harbor" for selective preventive services. It noted that high-deductible health insurance plans that allow first-dollar coverage for several categories of preventive care, including periodic health examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, and obesity weight-loss programs and screening services, qualify to be paired with an HSA.<sup>44</sup> In other words, preventive services, as defined by the IRS, may be excluded from applying to the high-deductible requirement associated with HSAs. Instead, these services may be covered by the plan immediately, before the high deductible is met. This exception is intended to encourage patient access to critical and cost-effective services, such as annual physicals and well-child care.

The March 2004 guidance also discussed how prescription drug coverage plays out under HSAs. Since HSAs must be linked to a specifically defined high-deductible health plan, the guidance clarifies in what cases a health plan that includes a prescription drug benefit would satisfy this requirement. According to the guidance, if a prescription drug benefit is part of a high-deductible plan and subject to the minimum annual deductible of the high-deductible plan, like all other benefits, the individual is eligible for an HSA. Likewise, if an individual is covered by both a high-deductible health plan that does not cover prescription drugs and by a separate prescription drug plan (or rider) that does not provide benefits until the minimum annual deductible of the high-deductible plan has been satisfied, the individual is eligible for an HSA.<sup>45</sup>

However, prescription drug benefits are rarely administered in this manner. Instead, employers commonly "carve out" prescription drug benefits from traditional health benefit packages. "Carved out" benefits are those which are managed and financed separately. They may be insured under a separate plan or offered as a rider to the basic health benefits package offered to employees. "Carved out" benefits are not subject to the same overall rules that regulate regular benefits in a plan, such as deductibles. Instead, the benefit may be subject to a lower deductible than that which applies to other benefits, or a copayment that does not apply to other covered products or services. Benefits that are commonly "carved out," such as dental, vision, mental health, and prescription drugs coverage, require more specialized management than basic health care benefits due to their higher cost or because they are utilized at different rates than other benefits. "Carved out" benefits are administered by someone who specializes in the management of that particular benefit and has the bargaining power to negotiate discounts with manufacturers and providers.

According to the Treasury Department's ruling, if an individual is covered by both a high-deductible health plan that does not cover prescription drugs and by a separate plan (or rider) that covers prescription drugs before the individual has satisfied the minimum annual deductible required by law (for example, prescription drugs are subject to a lower deductible or require only a copayment for each prescription), the person cannot contribute to an HSA. The HSA law states that a person who is eligible for an HSA must be covered under a high-deductible health plan and not, while covered under that plan, "covered under any [other] health plan which is not a high-deductible health plan, and which provides coverage for any benefit which is covered under the high-deductible

health plan.”<sup>46</sup> In other words, if a prescription drug benefit is “carved out” of the high-deductible health plan and subject to a separate, lower deductible, the individual no longer qualifies as having a high-deductible plan for the purpose of creating and contributing to an HSA.

This ruling also drew a distinction between standard prescription drug programs that offer a benefit after a \$15 copayment, for example, and prescription drug discount card programs that simply enable employees to obtain prescription medications at slightly reduced rates. Having the former benefit, even if it’s a rider to a qualifying high-deductible plan, would make the person ineligible for an HSA. This does not mean the person cannot take advantage of that benefit. Rather, he or she could not contribute to an HSA, from which health care costs can be paid. On the other hand, a person whose high-deductible plan includes a prescription drug discount card would be eligible to establish an HSA. Under this latter scenario, the individual would pay out-of-pocket for prescription drugs (the full price minus the card’s discount). These payments would apply towards the plan’s high-deductible and would be covered once the deductible was met.<sup>47</sup>

A special transition rule was issued to accommodate plans that were formulated and issued before the guidance and as a result, included an ineligible prescription drug plan. It noted that people who already bought these types of plans can keep the add-on benefit until January 1, 2006, and still qualify for an HSA.<sup>48</sup>

The Treasury’s Department’s ruling that “carved out” prescription drug plans with lower deductibles make a person ineligible for an HSA angered many insurers and employers who demanded that prescription drugs at least be included under the safe harbor which exempts certain preventive care services from the high deductible. In response to these and other concerns, a supposedly final set of guidances was issued in July 2004. In this most recent ruling, exceptions were made to the prescription drug benefit rule previously announced. It noted that certain prescription drugs can fall within the preventive care safe harbor “when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered.”<sup>49</sup> In other words, certain drugs that have proven to be cost-effective because of their ability to prevent more costly services in the future are not required to fall under the high-deductible requirement associated with HSAs and would not preclude an individual from contributing to an HSA. Included under this definition are cholesterol-lowering drugs to prevent heart disease and angiotensin-converting enzyme inhibitors used to help recover from a heart attack or to prevent reoccurrence in stroke victims. Drugs used as part of a weight-loss or tobacco cessation program also meet the preventive care standard. However, prescription drugs used to treat an existing illness, injury, or condition do not meet the preventive care standard, according to the notice.<sup>50</sup> These drugs, and all others that do not fall under the preventive care “safe harbor,” must be subject to the same high deductible as all other basic benefits if a plan is to be paired with an HSA.

To see an example of how an HSA would look and operate in the real world, see Appendix A.

When Congress originally passed the Medicare bill, the HSA provisions included in the bill were estimated to cost around \$6 billion over ten years. They are now estimated to cost \$16 billion over ten years. This discrepancy is largely due to an understated estimate of expected HSA participation rates.<sup>51</sup>

### ***Other Consumer-Directed Options***

While the focus of this monograph is on variations of health saving accounts, other consumer-centered approaches being tested in the marketplace include:

- “Design Your Own (DYO)” products, where employees can choose their own set of providers and benefit features, essentially designing their own provider network and specifying the services that will be covered.
- Customized plans, where an employer makes a fixed contribution toward the employee’s health insurance premium, and the employee then chooses from among an array of health insurance options with different prices. The employee’s premium reflects the benefit package chosen.<sup>52</sup>
- Providing a network of physicians who offer lower charges for cash-paying patients;<sup>53</sup>
- Tiered co-payment arrangements: widely adopted in prescription drug programs and now being applied to hospital and physician services (although variations in medical service quality and efficiency and underdeveloped assessment tools makes this task difficult);<sup>54</sup>
- Retirement Medical Benefit Accounts (RMBAs): financial services industry lobbyists have already begun promoting the idea of letting workers designate a portion of their 401(k)s and IRAs to an RMBA from which funds could be withdrawn in retirement on a tax-free basis for out-of-pocket medical costs.<sup>55</sup>

While each of these represents a creative way to increase access to health care, critics claim that many of these concepts fail to give consumers any understanding of the true cost of the service.

### **Scope**

While familiarity with consumer-driven health care is high, employers and others are not necessarily eager to embrace it. A survey conducted in 2003 found that although the majority of benefit managers were familiar with consumer-driven health care and strongly or somewhat agree that HRAs will result in lower costs, the majority also believe that the plans will not improve the quality of care or prove popular with employees, and that the plans will attract only healthier employees. The report on the survey concluded that while 30 percent of U.S. workers may be eligible for one type of consumer-driven plan in the spring of 2005—a 15-fold increase over two years—only a small minority of employees who are offered such plans are likely to enroll in them.<sup>56</sup> Less than one percent of insured Americans are currently enrolled in a consumer-directed care plan.<sup>57</sup>

The newly-refined HSAs, with their more generous tax subsidy and enhanced portability, are expected to be more appealing to both employers and consumers than MSAs and HRAs. Although it is too early to gauge the public’s reaction to HSAs, a March 2004 Mercer Consulting survey of nearly 1,000 employers found that two-fifths were likely to offer an HSA option next year, and nearly three-quarters were likely to do so in 2006. About one-fifth of respondents—predominantly very small businesses and very large entities—said they already offer a high-deductible health plan to workers. Many employers (about 61 percent) also reported that they intend to contribute at least in part to an employee’s HSA, deflating some critics’ arguments that HSAs will simply shift more costs to employees.<sup>58</sup> The Joint Committee on Taxation expects HSA use to expand significantly, starting at one million participants in tax year 2004 and rising to three million by 2013.<sup>59</sup>

Within hours of the President's signing of the bill, Aetna announced an HSA product as part of its expansive "suite" of consumer-directed health plans. A few weeks later, Blue Cross and Blue Shield of Minnesota came out with a HSA, while Oxford Health Plans and Health Net are both preparing their own.<sup>60</sup>

Still, the willingness of consumers to take on new financial and care management responsibilities remains unclear since these products are relatively new and current sales and take-up rates are limited.<sup>61</sup> In the near-term, the market for HSAs will likely remain small. Many employees still do not have the high-deductible plans required as a condition for contributing. The law was enacted too late for most companies to make this modification in 2004. Consequently, fewer than 0.5% of the 125 million to 150 million Americans currently covered by employer-sponsored health insurance are eligible to participate in a HSA. Widespread availability of HSAs will most likely begin in 2005, when the next cycle of insurance enrollment starts for many companies.<sup>62</sup> Many employers were also awaiting the publication of final rules by the Treasury Department and the IRS before establishing these plans. In July 2004, the two agencies issued their "final" comprehensive set of guidelines clarifying specific provisions of the HSA law. These documents are in question-and-answer format and include all the various rules published throughout the year. They can be found at: [http://www.irs.gov/irb/2004-02\\_IRB/ar09.html](http://www.irs.gov/irb/2004-02_IRB/ar09.html) and <http://www.treas.gov/offices/public-affairs/hsa/faq1.shtml>.

### **Future Proposals**

In his FY05 budget, President Bush proposed a further expansion of HSA tax breaks. Under the proposal, HSA account holders would be allowed to take a separate, additional deduction for the premium costs of a high-deductible health insurance policy, as long as the policy is purchased in the individual health insurance market and not through an employer. This deduction would be available without regard to whether an individual itemizes deductions.<sup>63</sup> In March 2004, legislation (H.R.3901) was introduced in the U.S. House of Representatives to amend the tax code to accommodate the President's proposal. In the Senate, Senator Larry Craig (R-ID) announced at a hearing that legislative efforts on the issue were underway.<sup>64</sup> Neither chamber of Congress addressed this issue before adjourning for summer recess.

The proposed deduction is estimated to cost around \$25 billion over ten years. This estimate takes into account the fact that the deduction would greatly enhance the already generous tax benefit of the HSA, thereby increasing its popularity and use. The Administration projects that the combined cost of the HSA provisions in the Medicare drug legislation and the proposed deduction would be nearly \$41 billion over ten years.<sup>65</sup>

Beginning in January 2005, the federal government will allow Federal Employees Health Benefits Program (FEHBP) providers to begin offering HSAs as an option for employees in qualified high-deductible health plans. About 3.1 million individuals, out of 8.5 million federal employees, retirees, and dependents, currently covered by the FEHBP will be eligible.<sup>66</sup>

## ACP Core Principles on Access

In 1995, ACP stated that since MSAs alone would not achieve the College's "goal of universal access to health care services," ACP could only support MSAs as a "supplemental mechanism for financing health care services that may improve access to health care services for some people."<sup>67</sup> ACP acknowledged that MSAs had some attractive features: among them, empowering patients in health care decision-making, enhancing cost-consciousness on the part of patients, providing some financial protection for some people who currently do not have coverage, and potentially reducing administrative costs and paperwork. However, the College found that MSAs have the potential to hurt access to health insurance for some Americans. Allowing employers to contribute to tax-free personal savings accounts for their employees could segment the insurance market, thereby raising premiums for people who remain in traditional health insurance plans, the College stated.<sup>68</sup>

ACP recommended that for MSAs to be most effective, changes in the tax code would be required to permit tax-deductible contributions by employees and employers and to allow interest and earnings to accumulate without taxation. ACP also recommended that funds should be able to be withdrawn without penalty for medical expenses, for the purchase of health or long-term care insurance, or for other expenditures that could be stipulated in the tax code. As a financial incentive to make cost-effective use of health-care resources, each person would also have to own and control his or her account, regardless of changes in employment. The College subsequently recommended legislation that called for "experimentation and examination of MSAs through research and demonstration projects."<sup>69</sup>

Much has changed since ACP first published its report on MSAs. MSAs were authorized by Congress and tested in the marketplace, albeit temporarily and with little prevalence. In 2003, a modified and improved version of the MSA came into being in the form of the HSA and many of the concerns ACP once had with the account became obsolete. These changes require that ACP reform its position on the issue of medical savings accounts.

In this section, the general characteristics of HSAs will be assessed against core principles that the College adopted for evaluating proposals to expand health insurance coverage.<sup>70</sup> The principles are not intended to be all-inclusive, covering all problems in the health care system. Rather, they highlight critical issues that need to be addressed by policymakers as they consider proposals to reform the health care system. ACP does not expect that any one particular legislative proposal will satisfy each of the core principles. However, the principles provide a benchmark from which to evaluate specific proposals, such as HSAs, and serve as a foundation for taking a new position on the subject.

### ***Principles on Coverage, Enrollment, and Eligibility***

Core Principle #1 recommends expanding access to coverage with an explicit goal of covering all Americans by a specified date. The principle also recommends a uniform benefits package for all Americans. It recommends that coverage and benefits be continuous and independent of residence or employment status.

Core Principle #2 states that sequential reforms that expand coverage to targeted groups should be considered but that such proposals should 1) identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage; 2) include a defined target date

for achieving affordable coverage for all Americans; and 3) include an ongoing plan of evaluation.

Core Principle #3 advocates mechanisms to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool, using incentives to participate or disincentives to discourage non-participation.

**Recommendation #1: ACP believes that HSAs alone will not achieve the goal of universal health care access nor are they likely to have a dramatic impact on costs or access to health care. Additional and comprehensive reforms will still be needed. HSAs should be considered as one alternative within an array of reforms intended to increase access to health care services, improve quality, and reduce costs.<sup>71</sup>**

**Recommendation #2: ACP supports increasing the portability of health insurance, including approaches that combine new options for employees to obtain health insurance coverage that is not tied to their place of employment. However, proposals to expand coverage should not erode coverage already available in the workplace. Therefore, ACP supports making HSAs and other consumer-directed plans more available and attractive to small employers if such reforms are linked to other measures to encourage employers to maintain or expand coverage, including offering more traditional low-deductible insurance products along with HSAs. HSAs should not create new gaps in coverage by encouraging employers to terminate existing employee health benefits.**

**Recommendation #3: Because HSAs must be linked to high-deductible health insurance plans, protective measures should be put in place to ensure that low-income patients are not forced to cut back on needed care or suffer severe financial and/or medical hardships. Safe harbor provisions for low-cost preventive and primary care services in HSA-linked high-deductible plans should be expanded, as should safe harbors for prescription drugs. At the same time, safety net programs for low-income patients should be preserved and expanded, since enrollment in Medicaid, SCHIP, and other public programs would provide the greatest level of protection for those with incomes below the poverty level without the risks associated with relying on HSAs.**

Proponents of HSAs, including the American Medical Association (AMA), support the ability of these plans to provide affordable protection from high medical costs, greater patient control over use of health services, and incentives to utilize health care in a cost-conscious manner.<sup>72</sup> Others contend that HSAs bring cost-cutting competition to the health insurance market and offer a way for workers to save money for medical expenses in their retirement.<sup>73</sup> But supporters most often highlight the unprecedented tax sheltering opportunities that HSAs provide.<sup>74</sup> Supporters maintain that favorable tax treatment of contributions paired with low insurance premiums for high-deductible health insurance may prompt some employers, particularly the self-employed and other small employers not currently providing health insurance benefits, to make contributions on behalf of their employees.

Despite evidence in favor of consumer-directed health care, few view this approach as a long-term solution to the rapidly rising cost of care.<sup>75</sup> Both MSAs and HSAs represent incremental steps taken to ensure that all Americans have access to health care. ACP is a proponent of incremental reforms to expand access and coverage, but believes that incremental and limited reforms, such as MSAs and HSAs, must be part of a broader and more comprehensive plan to provide all Americans with affordable health insurance coverage. Such broader reforms should include providing incentives for businesses to offer health coverage options that include HSAs as well as more conventional insurance products, allowing small businesses to buy into the FEHBP, providing tax credits to low-income uninsured Americans to subsidize coverage, and expansion of existing safety net programs for the poor. At the same time, ACP believes that incremental steps should focus primarily on our most vulnerable and needy populations. Existing evidence seems to suggest that HSAs, paired with high-deductible health plans, will not by themselves make affordable coverage available to our lowest income and most vulnerable populations, and may actually exacerbate the uninsured problem in the United States.

The available evidence suggests that the increased availability of HSAs may deter employers from providing health insurance coverage for employees and prompt some employers to drop existing coverage. A recent analysis from the Center on Budget and Policy Priorities, which cited the work of MIT economist Jonathan Gruber, suggests that plans to enhance HSAs could actually increase the number of Americans without health insurance if the availability of HSAs encourages some employers to drop health care coverage for workers. According to the report, since the proposed additional deduction would only be available to those who purchase a policy in the individual market, it would encourage some employers to drop coverage or not even offer it in the first place. It estimated that employers currently covering 2.1 million workers would drop coverage, while 1.2 million of these workers (a little more than half) would become uninsured. Another 190,000 workers would become uninsured as a result of decreased employer contributions, bringing the total number of people who would lose coverage as a result of employer actions taken in response to the establishment of the proposed deduction to about 1.4 million. The report concluded that the number of employees who would lose coverage because of actions taken by employers (whether a drop in coverage or a reduction in employer contributions toward premiums) would likely *exceed* the number of uninsured individuals who would gain coverage as a result of the proposed deduction (1.2 million vs. 1.1 million).<sup>76</sup> Approaches that encourage greater use of HSAs must therefore be coupled with other reforms to increase the likelihood that small businesses will maintain or increase the contributions they make to providing health insurance coverage to employees, such as offering them the ability to pool together to buy coverage through the FEHBP, as ACP proposes in our plan. As noted earlier, the FEHBP will have HSAs in the menu of plans available to federal employees.

High-deductible plans also require large out-of-pocket expenditures before coverage kicks in. This could be particularly dangerous, since the high cost of health care has been known to limit access to health care among both the uninsured and insured. According to a recent report, three out of ten (29 percent) of those who were continuously insured reported that they did not get the care they needed because of cost, up from 21 percent in 2001.<sup>77</sup> For lower-income people with chronic conditions, the high out-of-pocket burden associated with HSAs may cause them to forgo needed care, since they would have to spend thousands of dollars annually out-of-pocket to receive needed care.

Experts have predicted that money set aside through HSAs to pay for future medical bills will likely be insufficient. According to a senior manager of health benefits at accounting and consulting firm Ernst & Young, medical costs are so inflated and growing at such a fast pace that the rate of savings permitted under these accounts will be inadequate for future health care purchases. For example, if a perennially healthy 40 year-old manages to roll over \$1,000 of his HSA contribution every year, he would have \$46,000 when he retired at age 62, assuming the money earned 6% annually. But if costs continue to rise about 10 percent, an HSA will not provide enough in savings to pay a year's worth of medical bills for the average 62 year-old.<sup>78</sup>

HSAs, along with most consumer-directed health plans, are not suitable for all groups. Families with young children probably will benefit more from traditional managed-care options such as preferred provider organizations, while many low- and middle-income persons simply may find contributions to the accounts unaffordable. While this unique plan design generally entails greater choice of health plans and providers, it also entails far greater personal financial risk for consumers.<sup>79</sup>

The College remains concerned about the effect HSAs may have on those most in need of health care coverage, particularly the sickest and lowest income populations. On-going efforts are needed to ensure these proposals do not reduce health insurance protections or make coverage unaffordable for those most in need.

Karen Davis, of The Commonwealth Fund, suggested that federal tax policy could be revised for low-income workers who face financial and medical hardships under such arrangements. She recommended that income-related tax credits replace the current tax deduction for medical expenses that exceed 7.5 percent of adjusted-gross income. She suggested a tax credit of 75 percent to 90 percent of expenses over 10 percent of income for those with low incomes.<sup>80</sup>

**Recommendation #4: The federal government and other groups should continue to monitor the use of HSAs and other consumer-directed health plans on access to health insurance for people with existing health problems and people with low and moderate incomes. The effect such plans have on the ability of vulnerable populations to obtain health insurance and access to health care services should also be monitored to ensure that such groups are not indirectly harmed. Further demonstrations should be required to test the adequacy of adjustments made to the original MSA law. Elements to be especially monitored include: the problem of adverse selection; access to basic, preventive services; affordability of premiums; consumer and employer awareness and understanding of these savings options; and potential for consumers to save for future health care expenses.**

ACP supported a limited MSA trial demonstration because it felt that if it were done carefully and rigorously, it would provide policymakers with information about how people choose insurance, how much they are willing to pay out-of-pocket, how much co-insurance affects their decision-making, how much a retirement fund affects their decision-making, what services people forgo, and whether forgoing services is a detriment to health in the long run.<sup>81</sup> Unfortunately, this did not happen.

While federal legislation authorizing HSAs addressed many of the underlying problems hampering participation in MSAs, it did so prematurely, without

an accurate assessment of who was using the accounts and what affect they were having on vulnerable groups. Congress authorized HSAs before MSAs were widely adopted and tested. As the MSA demonstration neared its completion, participation levels remained disappointingly low.<sup>82</sup>

One such issue that has yet to be solved is that of adverse risk selection, which ACP voiced concern over in its position on MSAs.<sup>83</sup> HSAs must still be paired with a high-deductible health plan, which automatically puts low-income and less healthy individuals at a disadvantage. As healthier, more affluent workers shift to HSAs in substantial numbers to take advantage of the tax shelter opportunities, older and sicker workers will likely remain in comprehensive insurance, since the high-deductible policies that accompany HSAs are too risky. As healthier individuals leave the low-deductible market, leaving behind a less healthy, more expensive group, premiums for comprehensive insurance will increase, quickly making insurance unaffordable for many. Past research by RAND, the Urban Institute, and the American Academy of Actuaries found that premiums for comprehensive insurance could have more than doubled if MSA use had become widespread.<sup>84</sup>

While there are ways to mitigate adverse selection, most solutions have not been widely adopted. For example, employers could risk-adjust premiums to account for any selection bias. However, risk-adjustment is a rather uncommon practice, with only about one percent of employees nationally enrolled in risk-adjusted plans. Adverse selection also could be avoided if employers made consumer-directed plans the only choice available. Again, few employers have chosen to do this up to this point and few experts believe that consumer-directed plans will supplant current insurance offerings.<sup>85</sup>

**Recommendation #5: ACP supports changes to increase health insurance, including, but not limited to, making HSAs more available. The College calls on Congress to continue to explore ways to enhance health insurance portability, including approaches that combine new options for employees to obtain health insurance coverage that is not tied to their place of employment. Such new options should be carefully designed to expand and improve upon existing employer-based coverage, not to erode coverage that is already available through the workplace.**

Proponents claim that the goal of HSA legislation is to make health care more portable, rather than job-specific, for the individual. ACP supports this goal but views HSAs as one of many ways to achieve it. For instance, providing eligible low-income individuals with advance refundable tax credits to buy into health plans offered through the FEHBP would make coverage more portable and available without limiting their choices only to HSAs. Safety-net programs such as Medicaid and SCHIP also have the advantage of providing individuals with portable coverage that is not linked to their place of employment, since coverage is simply a function of where they live and their eligibility for the programs, not where they work.

**Recommendation #6: Because the tax advantages of HSAs provide greater financial incentives for those who can already best afford to purchase individual health insurance and fewer financial benefits to lower-income consumers, ACP recommends that greater use of HSAs be combined with advance refundable tax credits for lower-income uninsured Americans and expansion of existing public safety net programs for the poor.**

Critics often question the fiscal wisdom of HSAs. Because many people who take advantage of them already have health insurance, many contend they are not a very cost-effective way to help the uninsured. Others claim they are just another tax-shelter for the wealthy. Tax-favored HSAs shield saving and investment income from taxation, which predominantly benefits those with higher incomes. The Government Accountability Office (GAO) found that even under the restrictions on MSAs, various insurers marketed MSAs more for their tax shelter advantages than as health insurance policies.<sup>86</sup> Consumer-directed health plans should not intentionally or unintentionally offer discriminately large subsidies to families or individuals who are already able to afford health insurance.

The proposed supplemental HSA deduction could exacerbate the inequities inherent to HSAs. High-income taxpayers would receive the largest tax benefit from the proposed deduction, since they are in the highest tax brackets, while low- and moderate-income workers would see little or no tax benefit. A recent analysis found that for moderate- and middle-income taxpayers in the 10 percent or 15 percent tax brackets, the deduction would reduce the cost of health insurance policies by only 10 percent or 15 percent, which is too little in most cases to make health insurance affordable. Meanwhile, workers who do not earn enough to owe income tax would receive no benefit from the deduction. According to the authors, three-quarters of all U.S. households, and about 90 percent of the uninsured, are in the 10 percent or 15 percent tax bracket or earn too little to owe income tax. Furthermore, although it has been estimated that nearly eight million people would use the proposed tax deduction, only about 1.1 million of these participants, or about 13 percent, would previously have been uninsured.<sup>87</sup>

Core Principle #4 suggests that flexibility should be allowed for states to investigate different approaches to expanding coverage, controlling costs, identifying funding sources, and reducing barriers to access and quality. State-based approaches should contribute to the overall goal of providing all Americans with access to affordable coverage.

**Recommendation #7: HSAs should not create a further strain on state budgets. Studies should be commissioned to study the effect of tax-sheltered HSAs on federal and state revenues.**

Tax deductions for HSA savings and withdrawals could result in substantial reductions in federal and state tax revenues if HSAs grow in popularity. States with tax codes that conform to the definition of taxable income in the federal income tax code could experience substantial revenue losses if persons could reduce their taxable incomes by amounts deposited in HSAs and if employer contributions, interest earnings, and withdrawals are also tax free. The effect would be even greater if the Administration's proposed supplemental deduction becomes law.<sup>88</sup>

Core Principle #5 recommends that mechanisms be created to make prescription drugs more affordable. Barriers to access to affordable prescription drugs should be identified and addressed.

**Recommendation #8: Enrollment in an HSA should not limit a person's ability to access affordable prescription drugs. ACP should urge Congress to take action to further exempt prescription drugs from the high-deductible requirements of HSAs. Establishing an HSA should not con-**

**fine an account holder to limited, specific prescription drug benefits. Similarly, access to a prescription drug benefit program that is subject to a separate lower deductible than other benefits should not preclude an individual from being eligible for an HSA. This is particularly important for those most in need of prescription drug benefits, such as older individuals and those with chronic conditions.**

The Treasury Department offered transitional relief for HSA account holders whose high-deductible plan currently carves out prescription drug coverage. But beginning in 2006, employers and health plans must make the appropriate changes so that prescription drugs are brought under their overall medical high-deductible thresholds. ACP appreciates the most recent clarifications set forth by the Treasury Department, explaining that certain prescription drugs may fall under the safe harbor that enables certain preventive care services to be offered at lower deductibles. ACP is also pleased that enrollment in certain prescription drug discount programs, such as a drug discount card, would not preclude an employee from creating an HSA.<sup>89</sup> These rulings allow for a broader interpretation of the HSA law and therefore enhance the ability of HSA-holders to access affordable prescription drug coverage.

However, ACP is concerned that these exceptions are limited and believes they should be further expanded. The increasing value, yet soaring cost of prescription drugs warrants that individuals, particularly those that are the least healthy and have the lowest income, have access to affordable prescription drugs. Congress should, therefore, take action to further exempt prescription drugs from the high-deductible requirements of HSAs.

To be eligible for an HSA, an individual must be enrolled in a high-deductible health plan. The individual cannot be covered by any other health plan unless that health plan provides coverage for “permitted insurance” or “permitted coverage.” “Permitted insurance” includes coverage under which substantially all of the coverage provided relates to liabilities incurred under workers’ compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. “Permitted coverage” (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision care or long-term care. Currently, prescription drug benefits are not included on the list of permitted insurance or permitted coverage.<sup>90</sup> ACP urges Congress to consider treating prescription drugs like other “carved out” benefits and adding prescription drugs to the list of “permitted coverage.”

According to testimony by Kate Sullivan, Executive Director of Health Care Policy at the Department of Treasury, subjecting prescription drugs to the same high deductible as other benefits would result in higher health plan expenses and premiums or force employers to adopt even higher deductibles for their HSA options. This could dampen employees’ enthusiasm for these accounts by making health care more unaffordable. Many employers report that they are unlikely to adopt HSAs until this matter is resolved.<sup>91</sup>

### ***Principles on Disease Prevention***

Core Principle #11 suggests that incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.

**Recommendation #9: HSAs should provide patients with incentives to select more cost-effective and higher-quality options. Employers and health insurers should provide first-dollar coverage for preventive care to encourage healthy choices and to deter people from forgoing medical care to build savings.**

Consumer-directed health plans encourage consumers to limit out-of-pocket spending on health care. With an HSA, in particular, accountholders recognize that any dollars spent out-of-pocket on health care could be growing in a tax-deferred savings account. To limit spending, some consumers may make more prudent health care decisions, such as electing preventive services and choosing the most efficient physicians and hospitals, the most effective technologies, and the most suitable generic alternatives to needed prescription drugs. But others may forgo needed care as a way to reduce expenditures. Since HSAs must be linked to high-deductible health plans, which typically offer less comprehensive benefits and require larger out-of-pocket expenditures before coverage kicks in, there is always the threat of underinsurance and underutilization of critical health care services. This is particularly the case among low- and moderate-income people, who can least afford out-of-pocket expenses. A study by The Commonwealth Fund found that older individuals enrolled in less comprehensive high-deductible plans are twice as likely as older people with comprehensive employer-based coverage to fail to see a doctor when a medical problem develops or to skip medical tests or follow-up treatment.<sup>92</sup>

Therefore, HSAs should include incentives to encourage healthier behavior and choices among consumers and to discourage skimping on necessary care. Studies have revealed that it is not the HSA or the high-deductible plan that saves money, but rather the change in consumer behavior and smarter decision-making that result from the combination of education and incentives.<sup>93</sup> Employers or even the federal government might consider offering employees incentives to choose higher-quality plans or providers. Financial incentives in the form of premium breaks or more targeted cost-sharing might encourage more rapid consumer engagement in these products.<sup>94</sup> High-deductible health plans associated with HSAs could use a system of tiered copayments, where consumers decide for themselves whether goods or services are worth the additional cost. For example, consumers who choose generic versus brand name medications or a physician that has proven to be efficient and a provider of high quality care versus one that has not would pay lower copayments.

Social marketing might also be an effective way to convince consumers to change their behavior with respect to using information on quality to make health care decisions. Educational campaigns should inform the public that significant quality problems exist in the U.S. health care system; that quality varies across plans and providers; that quality does not equal choice of providers and does not relate to the amount of services delivered; and that standardized information on quality from credible sources can assist consumers in making health care decisions.<sup>95</sup> Physician and consumer incentives will eventually be aligned under such a system. As consumers seek out the most efficient and effective treatments, the providers who best meet consumer demands will prosper and grow, forcing other providers to improve their services, thus creating incentives for increased efficiency and quality throughout the system.

The Treasury Department recently clarified that high-deductible health insurance offered with HSAs can include first-dollar coverage for several categories of preventive care, including periodic health examinations, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs and screening services. ACP should ensure this option is taken advantage of by promoting the value of preventive health services.

### ***Principles on Patient Rights***

Core Principle #9 supports the patient's right to a choice of physician. It states that research should continue on ways to provide patients with meaningful quality measurements that will factor into their choice of physician.

**Recommendation #10: Since HSAs put consumers in control of the limited resources that are available for their health care, it is essential that consumers be provided with the understandable information necessary for such decision-making:**

- **Employers, health insurers, and regulators should make sure that valid and reliable information and appropriate decision-support tools are made available to facilitate informed consumer decision-making and ensure consumer protections in the marketplace;**
- **Both public policy and private sector responses are needed to guide the development of standardized measurement, data collection and dissemination, and decision support tools to assist diverse consumers to navigate an increasingly consumer-oriented health care system;<sup>96</sup>**
- **Information and decision-support tools must be accurate, accessible, and understandable to consumers. This can include simply reducing the amount of information presented.<sup>97</sup>**

One significant obstacle that could hinder the effectiveness of emerging consumer-directed health care strategies is inadequate health care information.<sup>98</sup> While the arrangements have the potential to increase consumer choice and lower premiums, they place a new burden on consumers that must be recognized.

Health plans that encourage consumer involvement must ensure that consumers have access to information regarding the health care system, including provider performance, best treatment options, available health plan choices, and ways to improve one's own personal health. But, consumers need more than just the correct information. They must also be able to process and comprehend this information and accept the high level of responsibility needed to properly use it.<sup>99</sup> Research shows that consumers who are engaged in their care and part of decision-making and helping to determine the goals of their own care have better health outcomes.<sup>100</sup> Decision support tools help consumers know what factors to consider in a choice, how to weigh them, and the implications of their choices.

Critics often question whether giving consumers this level of responsibility is unrealistic given the complexity of health care information, choices, and the system itself.<sup>101</sup> Health care is unique in that it is inelastic. Unlike other common products, health care services are so important that cost may not matter to the consumer. Some critics of consumer-directed health care go as far as to claim that the patient is practically incapable of making a cost/benefit calculation when it comes to health care decisions. Others raise concerns about forcing a patient to make cost-choice trade-offs at the time that care is needed, when patients may be too sick to make an informed choice.<sup>102</sup>

Even if we assume that the majority of health care decisions are not of the life-and-death sort and are planned well in advance, consumer-driven health plans still demand more planning than many people are willing to give.<sup>103</sup> The decision skills required of consumers may be beyond the level or effort that many consumers are willing or able to expend. The amount of effort, skill, and knowledge needed to make such choices could discourage voluntary enrollment and possibly lead to selection bias.

The experience to date with providing consumers with comparative performance information to help them make health care choices has been disappointing. Although consumers show interest in having such information, they have not widely used it to inform their choices.<sup>104</sup> This finding lends support to the theory that the task of interpreting information on health care quality is too complex and the cognitive burden that it imposes on decision makers too high. At the present moment, it is not clear that consumers have been given material that they perceive as understandable, usable, and timely. Information on health care quality must be made more widely available and be more widely used by the public for researchers to understand if and how consumers use it.<sup>105</sup>

Consumers must have adequate support tools to aid their decision-making. Adequate and comprehensible performance data is a critical component of the decision-making process, allowing consumers to essentially “shop around” for health care. Systems of measurement must be accurate and fair, since they ultimately will identify high-quality, efficient physicians. Information on quality also must be consistent across organizations that produce it. Collection and dissemination of this information will require the development of evidence-based protocols to reduce practice variation, the adoption of technology-based information systems, and the education of both patients and physicians about quality improvement and best practices. The system also must become more transparent, where the cost of items and services is disclosed so that consumers can compare prices and make informed decisions.<sup>106</sup>

A system that relies on transparency and performance measurements may also shield physicians from liability risk. As consumers are given more free reign over their health care decisions, they may hold physicians accountable if they are not satisfied with the outcome of their health care choices.<sup>107</sup>

To meet our policy goals—ultimately to maximize the number of people with access to affordable, quality care—ACP must work to ensure that consumers are able to use these arrangements to their advantage, rather than their detriment. Physicians can play an important role in educating patients about their options and the implications of their decisions, such as opting dental coverage over transplant coverage.<sup>108</sup>

The Treasury Department and the IRS have been helpful in establishing and clearly describing the parameters within which HSAs, HRAs and FSAs can exist, particularly in its most recent set of guidelines. Both offices should continue to issue these clarifications in order to educate the public about the many savings accounts available for health care expenses.

As information-gathering and decision-making tools evolve, it is critical that these efforts be evaluated. Research should be targeted at observing the early experiences of consumers, examining the validity of the models, studying the experiences of more vulnerable populations, and evaluating ways to overcome challenges associated with implementation.<sup>109</sup>

### ***Financing***

Core Principle #6 states that reimbursement levels for covered services must be fair and adequate to reduce barriers to care and enhance participation of physicians.

**Recommendation #11: Consumer-directed health care proposals will require changes in the current payment system to reflect the physician’s expanded role of informing and educating the patient about health care choices, economic tradeoffs, and risks involved in each decision.**

As the health system becomes more transparent, the physician-patient relationship will grow stronger. With enhanced freedom to choose and rate providers and compare quality and prices, patients will turn to their physicians not only for information, but for explanations. Physicians will be expected more than ever to explain treatment options, cost-value trade-offs, and risks associated with treatment options. Physicians will have to assist patients with making medical decisions, as well as economic decisions. These additional duties will require more time and resources on the part of the physician, which should be reflected through enhanced reimbursements.

**Recommendation #12: HSAs should be aligned with a payment system that includes incentives that reward physicians who meet or exceed performance standards. The College supports demonstration projects to evaluate the use of incentives, including financial incentives.**

In a purely consumer-driven health care system, one could theorize that physician fees would be negotiated without third-party interference. Market forces would presumably take over, as physicians would try to provide the highest quality at the lowest possible price in response to consumer demand. Yet market forces may not be enough to control the level at which physicians set fees, and in a health care market where there is virtually unlimited demand, lower- and middle-income populations may be unable to find affordable care, which is yet another reason why it is important to preserve and enhance safety net programs.

But we have not yet arrived at a purely consumer-driven health system. Since HSAs and other medical savings accounts are, for the most part, linked to health plans, physicians are not yet able to operate on the basis of fees that they set themselves and even the most informed consumers cannot yet make purely independent health care decisions.

What physicians can do in the meantime is attempt to differentiate themselves from others, so that consumers in each health plan choose them as their provider. Improvements in quality of care will be influenced by the fact that under consumer-directed plans, a patient spends directly out-of-pocket and can switch between low-cost and high-cost options throughout the year according to satisfaction levels. This is quite different from current health plans, where a worker's choice of plan is usually a year-long decision.<sup>110</sup>

Performance measurements can be used to identify those who perform the highest-quality care at the lowest cost. Linking performance to pay would create an incentive for physicians to distinguish themselves from others in order to procure the largest patient population and maximize patient trust. ACP supports consideration and pilot testing of pay-for-performance programs and other innovations in the way that physicians are reimbursed, such as care management fees and global fees for managing patients with chronic diseases. It is not clear how such reimbursement reforms can be linked to HSAs and other consumer-directed plans. As consumer-directed health care becomes more widespread, the role of the insurer will begin to erode. It is therefore important to evaluate a wide variety of innovative payment arrangements and find ways for them to be preserved under a consumer-driven system.

## Conclusion

Consumer-directed health care places some intricate challenges on our health care system. It shifts more responsibility for decision making to consumers and away from employers, insurers and the government. This shift in duties requires that standardized systems of measurement be adopted to ensure that consumers are provided with valid and reliable information that can be used to make prudent health care decisions. Uniform systems of reporting that allow for a fair comparison of health care products and services are still undeveloped, particularly at the small and single-practice level.

Another challenge is getting consumers to use the information provided and ensuring it is not only comprehensible, but relevant and applicable to the consumer's personal health care needs. Although health plans and policymakers are investing heavily in tools to aid consumers make health care decisions, they are, for the most part, still relatively underused and of indeterminate value. These tools will require additional development to be of significant benefit to consumers. ACP will continue to be supportive of the development of the infrastructure needed to support patient decision making. This includes performance measures to assess and compare quality of care provided by individual physicians and the determination of overall rates of compliance with evidence-based guidelines.

Although ACP views HSAs as just one option among many that can help reduce the high cost of health care, ACP strongly values consumer involvement in health care decision making and regards it as a necessary condition for appropriate cost control in the long run.<sup>111</sup> Years of third-party payer systems have conditioned consumers to spend health care dollars indiscriminately. Given the appropriate information and an understanding that resources are limited and trade-offs are required, consumers are capable of expressing their preferences and making careful, intelligent decisions in health care.<sup>112</sup> ACP will continue to work to enhance the role of the consumer in policies aimed at reigning in health care costs and to ensure that consumers are given the appropriate tools to make informative, cost-saving health care choices.

## Appendix A

*The following example, taken from the website of BlueCross BlueShield of Texas, illustrates how a Health Savings Account works. Some explanations and benefits were added to further clarify certain points.<sup>113</sup>*

Liz has individual coverage with a Health Savings Account.

Her high-deductible health plan, a Preferred Provider Organization (PPO) administered by BlueCross, BlueShield, is paired with a Health Savings Account, to which she and/or her employer can contribute an amount equal to her plan's deductible each year. Her Health Savings Account administrator (which may or may not be the health plan administrator) issues Liz a debit card and a checkbook that can be used to pay for eligible health care expenses that are not covered by the PPO.

### **Year One**

Liz's annual contribution to her Health Savings Account = **\$1,500**  
(Liz contributes \$750 and her employer contributes \$750)

Liz's annual deductible is **\$1,500**.  
(the maximum contribution for single coverage in 2004 cannot exceed the deductible or \$2,600, whichever is lower)

Liz had a physical and preventive care lab tests.  
**\$225 was paid by the PPO preventive care benefit** (this amount is not applied to the deductible because of the preventive care "safe harbor").

She injured her back and saw a specialist who is part of the PPO network.  
**Charges amounted to \$315, which Liz paid from her HSA using her debit card. This amount was also applied to the deductible.**

She had six physical therapy visits for her back with a physical therapist who is part of the PPO Network.  
**Each therapy session cost \$175, for a total of \$1,050. Liz paid for this with her debit card and the total was applied to her deductible.**

Liz broke her leg.  
**Total charges were \$3,000. Liz paid \$135 from her debit card, which satisfied the annual \$1,500 deductible, leaving \$2,865. PPO benefits paid 80 percent (\$2,292) and Liz paid her 20 percent coinsurance (\$573) (the high-deductible was met, so the benefit kicked-in).**

Liz used all the funds in her Health Savings Account.

## **Year Two**

Liz and her employer each contributed \$750 to her Health Savings Account for a total of **\$1,500**.

She had an annual physical and several preventive care lab tests. **\$280 was paid by the PPO preventive care benefit** (but did not count toward the deductible).

She had an eye exam and purchased a year's supply of contact lenses. **Total charges were \$320, which Liz paid with her debit card. This expense does not count toward the deductible** (since vision care is considered "permitted coverage" under the law, it's exempt from the deductible without making Liz ineligible for an HSA or using HSA funds to pay for it).

Liz is found to be at risk for heart disease. She is prescribed a cholesterol-lowering drug to prevent the condition. **\$200 was paid by the PPO preventive care benefit**.

Liz has an ear infection and is prescribed penicillin. **Total charges were \$100, which Liz paid with her debit card. The total was also applied to her deductible** (prescription drugs used to treat an existing illness do not meet the preventive care standard and must be subject to the same high-deductible as all other basic benefits).

Midway through the year, Liz decided to change jobs. Her Health Savings Account is portable and she continued to keep the remaining **\$1,080 in her HSA**.

## Glossary

AMA	American Medical Association
COBRA	Consolidated Omnibus Budget Reconciliation Act: gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.
FEHBP	Federal Employees Health Benefits Program: a system of competing private health plans in which the government contributes a relatively fixed amount toward the employee's coverage and employees pay a premium based on the cost of the individual plan they choose. Created in 1959, it currently provides health insurance benefits to more than eight million federal enrollees and dependents. It is often looked to as a model because of its ability to constrain cost growth reasonably well with limited government intervention.
FSA	Flexible Savings Account: a defined contribution account available since the late 1980s that lets workers set aside pre-tax dollars and make tax-free withdrawals for medical expenses. FSAs can be paired with any type of insurance, can only be set up at the discretion of an employer, and includes no limits on contributions. At the end of the year, account holders lose any unused funds to their employer.
GAO	Government Accountability Office (formerly the Government Accounting Office): an independent and nonpartisan agency that provides Congress and executive agencies with studies of programs and expenditures of the federal government. The GAO is commonly known as the investigative arm of Congress, since it evaluates federal programs, audits federal expenditures, and recommends ways to make government more effective.
HIPAA	Health Insurance Portability and Accountability Act of 1996: an amendment to ERISA that provides rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections that limit exclusions for preexisting conditions; prohibits discrimination against employees and dependents based on their health status; and allows a special opportunity to enroll in a new plan to individuals in certain circumstances.
HRA	Health Reimbursement Arrangement: authorized in 2002, these arrangements permit tax-free contributions and withdrawals. Contributions can be made only by employers, and funds can be spent only on health care services. Deposits and contributions are not capped, funds may roll-over from year to year, and the arrangement may accompany any type of health insurance plan and include first-dollar coverage. Any unused dollars are rolled over into the next year.

HSA	Health Savings Account: authorized under the Medicare Modernization Act of 2003 and made available in January 2004, HSAs permit tax-free contributions from employees and employers of any size business, tax-free growth of savings, tax-free withdrawals for qualified medical expenses, and taxed withdrawals for non-medical expenses. HSAs are owned by the employee and must be paired with a high-deductible health plan. The accounts are less restrictive than MSAs (lower qualifying deductible; higher contribution limit) and more permanent than HRAs.
IRS	Internal Revenue Service
MSA	Medical Savings Account: authorized as a pilot project under HIPAA in 1996, these tax-advantaged accounts were available only to small businesses and had to be linked to high-deductible health plans. Contributions were tax-free, but capped, and could be made by an employee or employer (not both). Accounts were owned by the employee and could be rolled over from year to year. Withdrawals could be made for medical and non-medical purposes, although the latter was taxed. The pilot ended in December 2003 with participation rates much lower than expected.
RMBA	Retirement Medical Benefit Account: a proposed account to which workers could designate a portion of their 401(k)s and IRAs and from which funds could be withdrawn in retirement on a tax-free basis for out-of-pocket medical cost.
SCHIP	State Children's Health Insurance Program: created under the Balanced Budget Act of 1997, SCHIP allows each state to offer health insurance for children up to age 19 who are not already insured. SCHIP is a state-administered program, and each state sets its own guidelines regarding eligibility and services.

***ACP CORE PRINCIPLES FOR EVALUATING PROPOSALS TO INCREASE ACCESS TO HEALTH INSURANCE COVERAGE***

1. Include an explicit goal that provides all Americans with adequate health insurance coverage by a specified date.
  - a. Include a mechanism for determining scope of benefits.
  - b. Include a uniform minimum package of benefits for all.
2. Consider sequential reforms to expand coverage.
  - a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.
  - b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.
  - c. A sequential plan identifies an ongoing plan of evaluation.
3. Include strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.
4. State flexibility to investigate different approaches that contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package.
5. Create mechanisms to make prescription drugs more affordable. Does not allow formularies that are determined solely or principally on the basis of cost.
6. Financing should be adequate to eliminate barriers to care:
  - a. Highest priority towards assuring adequate financing for “critical access” institutions and providers with a higher burden of uncompensated care.
  - b. Reimbursement level for covered services must be fair and adequate to reduce barriers to care. Mechanisms to improve ease of administration should be included to enhance physician participation.
  - c. Substantial portion of federal budget surpluses should provide funds to expand health insurance coverage.
  - d. Financing for public insurance programs should be progressive. Explicit means testing should be discouraged.
7. Should address sources of patient and physician dissatisfaction with the system:
  - Micro-management of clinical decision-making
  - Diversion of health care dollars away from patient care to administrative inefficiencies
  - Excessive pressure on physicians to reduce time spent with patients
  - Duplicative and inconsistent coverage and payment policies by payers
  - Lack of continuity of care
  - Erosion of physician-patient relationship
  - Unnecessary or excessive administrative burdens
  - Excessive documentation requirements
  - Lack of choice of insurance plans and physicians
8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care:
  - a. Public and private research bodies should support research on information systems to make administration and financing more efficient.
  - b. Reforms should be enacted to limit excessive medical liability costs.
  - c. Should include a description of mechanisms to assure that health care dollars are directed principally for patient care, not administrative tasks.

9. Patients should have a choice of physicians:
  - a. Should be designed to respect the importance of patients being able to select a primary care and specialty care physician of their choice.
  - b. Patients should be able to stay with the physician of their choice from year-to-year.
  - c. Patients should have sufficient and prompt access to specialty care with a real choice of specialist.
  - d. Use of hospitalists should not be mandated.
  - e. Requiring a reasonable but higher level of patient co-payments for open-ended access to a physician of their choice is an acceptable mechanism to control costs while providing patients with greater choice of physician than would be available through closed network or staff model health plans.
  - f. Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician.
10. Decisions on expansion of the scope of practice of non-physician health care professionals should be based on evidence that they have the requisite skills and training:
  - a. Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider.
  - b. Physician-directed health care teams, with sufficient built-in controls.
11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.
12. Should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
  - a. Should be designed to address barriers to care in inner city, rural, and other underserved communities.
  - b. Should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.
13. Should promote accountability at all levels of the system for quality, cost, access, and patient safety:
  - a. Should include incentives for physicians and other health care professionals to participate in the design systems of accountability (non-punitive and educational approaches should be favored).
  - b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
  - c. Should foster innovation and improvement, including innovation in use of Internet technologies with safeguards to protect the confidentiality of medical information that is transmitted electronically.
  - d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and pre-determined benefits.
14. Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system:
  - a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
  - b. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences.

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