Development of health saving accounts

Health & Medical Saving Accounts

Background

The historical, economical and societal circumstances that led to the introduction of employer based health insurance are all well known. The same factors that surrounded the introduction and implementation of the government based health insurance programs are also very well known. Although not explicitly mentioned, it is clear from the economic indicators and numbers that no one have successfully predicted that the different private and government sectors' interventions in the health care market would lead to the unique situation that dominates the health care market in the USA. Since the growth in national health expenditure has historically outpaced any other economic activity, not to mention the GDP, both the government and the private sector tried to introduce policies and interventions that would control the continuous growth in health care spending. However, the never ending plethora of laws and plans that aim to introduce new solutions for the continuous growth of medical along with the different predictions of continuous growth of health care expenditures in the USA can only mean that the different strategies and interventions failed to achieve their intended short and long term goals (Cuckler et al., 2013). Such interventions included government price setting, promoting competition, premium control, health system integration, managed care, Health Reimbursement Arrangement (HRA), Medical Savings Accounts, flexible spending accounts (FSA), and Health Savings Accounts (HSA) (Gleid and Remler, 2005, Moon et al., 1996).

Since all previous interventions targeted the supplier side with limited realizations, a major change in paradigm to overcome the limitations of previous interventions and help control the growing health care Medical was the introduction of individual based spending control mechanisms (consumer side interventions). One of the most recent examples is the Medical Saving Accounts (MSA) which were first established during the early 1990s in many states. The Health Insurance Probability and Accountability Act (HIPAA) of 1996 contained the provisions of a five year federal MSA pilot project, also known as Archer MSA (for Congressman Bill Archer who supported their amendment). After the federal enactment, twenty six states followed and established similar MSAs. The MSA created under the HIPAA was bounded by many rules that limited its expansion, MSA was discontinued on December 2005 (Bunce, 2012, Moon et al., 1996). Health Savings Accounts (HSA) is a type of MSA and were permanently created as part of the Medicare Prescription Drug Improvement and Modernization ACT (MMA) in 2003 (Hoffman and Tolbert, 2006). The 2010 Affordable Care Act (ACA) contains provisions that are aimed to promote HSAs through clauses that promote High Deductible Health Plans (HDHP) by offering them at lower tiers (Shenkin et al., 2014, U. S. Department of the Treasury, 2014).

Where in other previous interventions individuals were shielded from their health expenses, HSAs are the most recent effort by Congress to shift the financial risk of health care to the consumers by encouraging individuals to be responsible for their own health decisions and the health related spending. Health Savings Accounts (HSAs) combines high deductible health insurance plan (HDHP) with a tax exempted savings account (under certain

conditions) and are characterized by low premiums. Those savings accounts are established exclusively to pay for any qualified medical expenses (bills submitted by hospitals and physicians), and prescription drugs (including over the counter drugs) except copays. The savings accounts are used to pay the deductibles, which once met, the insurance plan carry on the rest of the medical expenses. The amount of money in the savings account earns interest (which are tax free) and can be rolled over to the next year. Individuals who are not covered by a HDHP may not participate except under certain conditions where the coverage is for accidents, disability, dental care, vision care, or long term care and may provide a lower deductible for preventive care (National Academy of Social Insurance, 2014, Shenkin et al., 2014, Strobel, 2004).

HSAs are similar to Flexible Spending Accounts (FSA), Health reimbursement Accounts (HRA) or Individual Retirement Accounts (IRA). Medicare provides a HSAs under the name Medicare MSA which has basically the core structure of HSAs (Centers for Medicare and Medicaid, 2014). Specifically, MSAs and HSAs have many similarities however; there are some key differences;

- The minimum deductible level for MSA qualified health insurance plans is $1, 700 for an individual and $3, 450 for families, whereas it is $1, 250 for individuals and $2, 500 for families for HAS (2014 figures).
- The annual contribution level for MSA is limited to no more than 65% and 75% of the health plans deductible for individuals and families respectively. For HSA, the limit is set yearly and up to 100% of the allowable contribution can be made by eligible individuals and families.

- MSA can be funded by the individual or the employer but not both, however, HSA can be funded by individual, family members or employer.
- MSA is only available for self-employed or employer groups between 2 and 50 employees and meet the other eligibility criteria. HSA is more flexible being available to eligible individuals with more employment options that has no other first dollar coverage. Both types require the enrollment in High deductible Health plans (HDHP).

Although HSAs were introduced with two main aims; first, slowing down or even stopping the rise in health care expenditures, and second, increasing the number of insured (through tailoring health care to consumers' individual needs and increasing patients' responsibility), however the scarce studies about HSAs have contradicting results. Some researchers considered HSA as a complex instrument from a consumer's point of view, whereas others considered it simple to implement (Juan and Tran, 2007, Peter and Steinorth, 2012, and Shenkin et al., 2014).

When the HSAs was federally established in 2003, 250 million Americans became eligible to join it, however by 2013 only 20% of small and 40% of large companies offered an HDHP to their employees, representing a remarkably low uptake (Shenkin et al., 2014, Juan and Tran, 2007). Among the different factors that may play a role in the slow taking of HSAs is the penalty (10-20%) for using the savings from the HSAs for non-medical purposes in case of critical requirements for liquidity as well as the decreased utility due to reduced current consumption of other goods (Gleid and Remler, 2005).

Evaluation of HSAs can be done from a micro-perspective including moral hazards and adverse selection, and a macro-perspective in how the political goals were achieved. Cardon and Showalter (2006) came to the conclusion that HSAs would have different results on the health care expenditure based on different scenario simulation (cardon and Showalter, 2006). Jung and Tran (2007) found a decrease in total health expenditures due to HSAs with estimates ranging from a decrease of 8% to an increase of 1%. Glied and Remler (2005) concluded that HSAs will not have remarkable effect in expanding coverage among uninsured since the majority of individuals and families do not have the high marginal tax rate to benefit enough from the tax deductibility provided by HSAs (Glied and Remler, 2005). Feldman (2005) estimated a reduction of the uninsured by about 16. 5%. Collectively, literature is inconclusive about the effect on the proportion of uninsured in the population nor the amount of health care savings. (Peter and Steinorth, 2012).

If we consider that the weak construction of the HSAs that seems to favor the young, the healthy and the wealthy, HSAs may lead to market fragmentation which will augment the adverse selection problem with the consequent rise in health care premiums for other plans. At the same time, it seems that the amount of tax exemption was not appealing for certain high income groups as it did not add significant increase in their capital gain (tax exempted savings) and the associated utility.

In conclusion, the HSAs represent another ring in the chain of laws and interventions that are aimed to control the rising health care spending and decrease the number of uninsured, however the poorly structured provisions

of HSAs are limiting the degree of penetration within different population groups. The reality that HSAs failed to address the different socioeconomic classes and their specific medical and financial needs played its role in limiting the popularity within the high income categories and reduced the likelihood that it would be appealing to low income families. Another reason may be related to the fact that if failed to alter the balance between the demand and the utility of individuals and offer an attractive alternative to the highly similar already existing plans.

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