Health Savings Accounts: Why They Won't Cure What Ails U.S. Health Care

Executive Summary of Invited Testimony, Committee on Ways and Means U.S. House of Representatives Hearing on "Health Savings Accounts"

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Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems currently confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and premiums, wide variation in the quality and

- People in HDHPs are far more likely to delay, avoid, or skip health care because of cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- People in these plans are more cost-conscious consumers of health care: they are more likely to ask for lower-priced drugs and more likely to discuss with their doctors different treatment options and the cost of care.
- Few Americans in any health plan have the information they need to make decisions. Just 12 to 16 percent of insured adults have information from their health plan on the quality or cost of care provided by their doctors and hospitals.

Patients' Use of Information Alone Is Not Likely to Dramatically Reduce Health Care Costs or Improve Quality

- It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care system will be driven by patients' choice of provider. Patients are in the weakest position to demand greater quality and efficiency.
- Most health care costs are incurred by very sick patients, often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances.
- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.

HSAs Will Not Solve Our Uninsured Problem

- Economists Sherry Glied and Dahlia Remler estimate that under current law, fewer than 1 million currently uninsured people are expected to gain coverage as a result of HSAs. This is primarily because 71 percent of uninsured Americans are in a 10-percent-or-lower income tax bracket and would thus benefit little from the tax savings associated with HSAs.

New Proposals to Expand HSAs May Fragment Group Insurance Markets, Increasing the Number of Uninsured

- Additional tax incentives proposed by the Administration's 2007 fiscal year budget aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, with premium tax deductibility and tax credits. Economist Jonathan Gruber estimates that the Adminstration's proposals would actually increase the number of uninsured Americans by 600,000. While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would drop coverage. Some 8.9 million people would lose their employer-based health insurance.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and lowering costs. These strategies include:

- Expanding group insurance coverage, with costs shared among individuals, employers, and government. This could be done by expanding employer-based coverage, eliminating Medicare's two-year waiting period for coverage of the disabled, letting older adults "buy in" to Medicare, and building on Medicaid and the State Children's Health Insurance Program (SCHIP) to cover low-income parents, young adults, and single adults.
- Ensuring affordable coverage for families by placing limits on family premium and out-of-pocket costs as a percentage of income (e.g., 5% of income for low-income families).
- Greater transparency with regard to provider quality and the total costs of care.
- Pay-for-performance incentives to reward health care providers that deliver high quality and high efficiency.
- Development of "value networks" of high performing providers under Medicare, Medicaid, and private insurance.
- High cost care management and disease management.
- Improved access to primary care and preventive services.
- Investment in health information technology.