

How Health Savings Accounts May Change Patients' Experiences with Health Care

By Daniel C. Brown

Introduction

AERICAN HEALTH CARE is in the midst of an ideological struggle between those who want it to be more influenced by market forces and those who believe it is a right whose costs should be shared by society as a whole. Advocates of consumer driven health care seek to put patients in control of their own care, limited only by the same cost considerations that consumers face in most other sectors of the economy. They claim that if patients have incentives to act like demanding consumers—just as they do when buying a car—they will be more judicious with their consumption of services and force health care providers to become more efficient and improve quality of service. This article explores the leading model of consumer driven health care, Health Savings Accounts (HSAs). It concludes that HSAs will probably be less effective at achieving their stated goals than advocates claim, will nonetheless increase competition in some sectors, and may increase costs for the chronically ill to a degree that should concern policy makers now.

Predominant health care funding models have frustrated patients and failed to contain costs.¹ When managed care plans attempted to deny reimbursements for medical services they deemed exorbitant or unnecessary, legislatures reacted to public resentment by mandating a patchwork of minimum services such as forty-eight hour hospital stays after childbirth.² Additionally, many critics of medical care in the United States note that the industry lags behind other sectors in quality control and customer service. Even while many Americans shun the waiting lists and rationing of health care they hear about in Canada and the United Kingdom, they in fact endure delays and inconveniences they would never tolerate if shopping for shoes or a car. Patients in the United States must seek out doctors who

accept their insurance, wait weeks for an available appointment, and finally suffer through inevitable delays in doctors' waiting rooms. Furthermore, medical errors are far more common than many patients find acceptable. Finally, unlike many other technology-intensive sectors of the economy in which prices tend to fall over time, medical services become more and more expensive each year.

Advocates of consumer driven health care see a single cause underlying all these problems: the third party payer approach that has come to support the vast majority of medical care spending in the United States. Whereas in 1960 consumers directly paid 56% of all health care costs, today that number is

down to 15%, with government and private third party payers picking up the difference.³ Critics argue that so long as it is the resources of a third party—the insurer or government—that are spent as a result of treatment decisions, patients will always have an incentive to overconsume health care services. However, patients will not have the incentive to demand the high quality and efficiency that they would if they were spending their own money.⁴ It is meaningless for

third party payers to limit expenditures to “necessary” care only, these critics suggest, because the supply of potentially beneficial treatments is nearly infinite.⁵ And they point to the lasik surgery and vision care industries as examples of how the health care sector can become efficient and customer friendly when it must compete directly for consumers' own dollars.⁶ Only if patients must truly weigh cost considerations along with other factors will they make resource-prudent decisions and also hold doctors and hospitals accountable for quality and efficiency as they do in other sectors.

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control expenditures on their own health care. HSA subscribers receive high-deductible insurance policies, so they receive few⁷ or no benefits unless their annual expenses exceed the deductible, which averages \$1,654.⁸ But plans partially offset the high deductible by giving patients an annual cash-like deposit—averaging \$824⁹—that can only be spent on health-related expenses.¹⁰ The result is that participants must spend up to an average \$830 of their own funds if they expend their entire HSA balance before reaching the annual deductible. However, any HSA balances remaining at the end of the year can be rolled over to the next year and accumulated over time, so the risk that participants will have to draw on their own funds before reaching the annual deductible is highest in the initial years of participation. HSAs are also “portable,” so participants keep their balances even if they change jobs.

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Analysis: Do HSAs change spending behaviors?

Although experience with HSAs is still very limited,¹¹ a number of studies provide some evidence of whether they in fact affect spending behavior, either by reducing overconsumption or by encouraging patients to demand greater efficiency, convenience, and quality.

Reducing “overconsumption”

The limited data suggests that adoption of HSAs may tend to reduce overall health care spending, at least somewhat. For example, in one study of three large employers that adopted HSA options alongside traditional plans, Anthony Lo Sasso and colleagues found expenditures of those in the HSA plans were significantly below those in the traditional plans.¹² At the one site where year-on-year data was available, those who enrolled in the new HSA plan had total expenditures that were 30% less than the previous year, when they had been enrolled in traditional plans.¹³ At a second site, expenditures for employees in the HSA plan were 50% less than those who remained enrolled in the traditional PPO plan, but data limitations prevented the authors from determining whether those in the HSA plan were

spending less on average than they as a group had spent in previous years.¹⁴ The third site did not report expenditure data.

Other experiences show more modest results. In a study of a single employer by Stephen Parente and colleagues, overall expenditures for those in HSA plans were approximately 3% less than those for Preferred Provider Organization (PPO) participants, but 13% more than participants in a competing Health Maintenance Organization (HMO) offering.¹⁵ Discovery Health, a consumer driven health plan in South Africa, has found that patients submitted claims for 16% fewer prescriptions than those on traditional plans, suggesting that HSA-type schemes discourage patients from requesting or filling prescriptions they view as less necessary.¹⁶

Studies examining shopping behavior

While the limited data support the possibility that overall expenditures might be reduced under HSA plans, there is very little data to show whether or not HSAs in fact encourage patients to comparison shop to find the best deal for their money. HSA opponents, including Consumers Union’s Gail Shearer, argue that the frequent need for urgent or timely treatment, the control that doctors must exercise over decision-making, and the inadequate information and decision-making ability of consumers make such comparison shopping unworkable.¹⁷ Supporters answer that much of medical care is not delivered on an emergency basis, and that as many as 70 million American patients can and regularly do access medical information on the internet, even using it to challenge their doctors’ preferred courses of treatment.¹⁸

South Africa’s Discovery Health has found that those on HSA-type plans spend at least 11% less on prescription medications, and 48% of participants had asked their pharmacists about the availability of generic alternatives to more expensive name brand equivalents.¹⁹ While such data is at best anecdotal, it does suggest that participants in HSA plans are more likely to comparison shop for cheaper, equally effective alternatives, at least in the case of pharmaceuticals.



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On the other hand, such data does not directly refute Shearer's claim either, since drugs are not usually prescribed on an emergency basis, and patients often have the option of asking their pharmacist about generic equivalents after their doctor has made the prescribing decision. And since generics are supposed to deliver the same effective ingredients as their name brand equivalents, the patients' decisions really only turn on one variable: price. It is a far more complex decision—even with the expertise of a well qualified doctor—to choose between a cheaper, less effective drug with serious side effects, and a newer, much pricier alternative with none of those disadvantages. Decisions can be all the more complex with surgical and other alternatives. In such situations, patients might very well simply defer to their doctors' recommendations rather than comparison shop as the consumer driven health care model assumes.

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Another concern is whether patients truly view HSA deposits as their own money. HSAs will only facilitate the consumer driven health care model if patients are as thrifty as they are with their own funds. Since the deposits can only be spent on qualified health-related expenses, patients will only view the HSAs as their own money if they understand and believe that balances can accumulate and be rolled over indefinitely for any future qualified expenses.

At least some of the available data suggest patients may not view the deposits that way. For example, at one of the employer sites in the Lo Sasso study, new participant spending from HSA accounts followed a distinct U-shaped pattern over the calendar year, with expenditures spiking in November and December.²⁰ In fact, December spending was 60% higher than the monthly average that had remained flat through October.²¹ While it would be normal for new participants to have higher than average spending in the initial months due to pent-up demand, there would be little reason for expenditures to spike at the end of the year unless participants did not believe they could truly keep the deposits, especially since 90% of those participants had opted to remain in the HSA plan the following year.

Equally intriguing was a phenomenon in the Parente study, in which HSA plan participants' spending was lower than that of

traditional plan participants overall but nonetheless spiked significantly in the second year.²² The authors suggest that as HSA balances increase, participants may decide to purchase services that they would not have paid for out-of-pocket.²³ But if they make such sharp distinctions between their own funds and HSA deposits, they may not behave like "consumers" until the deposits have been exhausted. The phenomenon suggests that patients may have a particularly short-term view of the HSA deposits quite distinct from how they view their own out-of-pocket spending. If widely held, such a view would undermine a key underpinning of the HSA model because patients' incentives to curb overconsumption and to comparison shop for health alternatives would be significantly reduced. Employers and plans would likely increase coinsurance requirements of the high deductible insurance component and decrease annual HSA deposits, leaving participants at risk of higher out-of-pocket expenses in order to achieve the shopping behavior on which consumer driven health depends.

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Health care spending numbers and their limitations on the benefits of Health Savings Accounts

Even if plans and employers could tinker with annual HSA deposit amounts and coinsurance requirements so that patients have strong incentives to economize and comparison shop, and even if the plans were widely adopted, the scale and distribution of health care costs raise questions about how powerful the effects could be system-wide. The nation's overall expenditures are far from evenly distributed across the population. Instead,

the vast majority of health care spending is attributable to a small minority of the population. Although average spending per patient is \$2,628 per year,²⁴ 50% of Americans require less than \$350 in services each per year and account for only 3% of nationwide health care spending.²⁵ At the other end of the spectrum, 10% of Americans are responsible for 71% of all health care spending nationwide,²⁶ with per capita expenditures ranging from \$4,115 per person per year to more than \$27,914 per person per year for the top 5% of spenders.²⁷

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What does this mean for controlling total health care expenditures? Even assuming that overconsumption is a predominant spending problem and that the HSA model will encourage patients to spend less, the scheme can only be effective until a patient reaches the annual deductible threshold. After that, incentives to spend are roughly the same as or even stronger than they are in the traditional model. Yet, even assuming an annual deductible of \$2,000 per year, which is substantially higher than the average,²⁸ 88%²⁹ of all health care expenditures are made on account of patients who require more than that amount every year. For those higher-expense patients, HSAs do not even purport to offer incentives for reduced spending, so it is difficult to see why their expenditures would be reduced.³⁰

Consumer driven health care advocate Regina Hertzlinger envisions that “focused factories”—programs focused on costly, unmet health care needs, including management of chronic disease and disabilities—would spring up to reduce costs for higher cost patients as well.³¹ The model is based in part on using technology to allow various providers to integrate their care for a single patient, reducing redundant tests and services. Despite the appeal of such predictions, the HSA model simply provides no incentive for such innovation, except to the extent certain services could quickly be brought under the annual deductible threshold. Thus, even though the HSA model might reduce costs for employers and health plans with disproportionately high numbers of low to moderate spenders, it is difficult to see how it could have much effect on overconsumption nationwide.

The picture is somewhat less gloomy for the prospects of consumer driven health care’s second theoretical effect—improved efficiency and quality system-wide due to comparison shopping by demanding consumers—but its effects would still likely be limited. The key in this analysis is the expense of so many medical tests, therapies, and procedures. As health care analyst George Halvorson questions, how many surgical procedures cost less than the \$2,000 assumed deductible?³² Even routine diagnostic tools such as MRIs, CT scans, chemotherapy, and the like can cost considerably more.³³ If one procedure inevitably brings the patient over the annual deductible threshold, then there is no incentive for her to comparison shop for that procedure or any other subsequent health care in the same calendar year. Competition might cause some providers to reduce their prices for some services, but it is difficult to imagine price reductions so deep and widespread that a

significant number of procedures would be newly brought into the effected range.

The health care goods and services for which economic forces would create new, efficient markets would be limited to those whose annual costs³⁴ are less than the annual deductible and that are consumed by patients whose total expected expenditures for the year do not exceed the deductible. While this limitation is important to note, it must also be acknowledged that numerous health care goods and services likely meet both criteria. After all, roughly 80% of the population spends less than \$2,000 per year,³⁵ and certainly numerous minor procedures and



products fall within that price range. Assuming the above-noted concerns over how patients view HSA deposits could be reasonably resolved, then lower-cost, higher-quality, more convenient industries might very well spring up around a whole host of health care products and services, just as has occurred in the vision care and lasik surgery industries. Such innovation would benefit a large segment of the population, including those with no health care coverage at all. It is important to note, though, that despite all these benefits, such changes would not significantly reduce the national scale or growth of health care costs as a whole, nor the efficiency or quality of goods and services whose costs remain above the deductible threshold.

Perhaps one of the most contentious issues surrounding HSAs is the “adverse selection” problem.

Adverse selection: Will HSAs create a death spiral for traditional health plans and increase costs for the chronically ill?

Perhaps one of the most contentious issues surrounding HSAs is the “adverse selection” problem. The dispute in large part turns on what the proper role of private health plans is, and whether it is more important for the health care system to protect patients from major out-of-pocket expenses or instead to maximize efficiency.

Critics argue that HSAs are really just a tool to let the wealthy shelter more income from taxes. The adverse selection concern arises because HSAs would likely be more attractive to the healthy and wealthy than to the sick and poor.³⁶ Since HSA plans often charge lower monthly premiums and offer the prospect of deposits that can accumulate over time, those who do not expect to have many medical expenses—such as the 50% of the population who consume less than \$350 in health care per year—would opt for HSAs over traditional plans in the hope of reducing their costs and recouping some of their premiums through accumulated account deposits. Those with chronic or more frequent health care needs would tend to stay with traditional plans, believing they would quickly use up HSA deposits and fearing increased out-of-pocket expenses before the high deductible is met each year. HSAs would be more attractive to the wealthy because they offer a way for employers to offer compensation-like benefits—account deposits—that are shielded from taxation. They also allow taxpayers to shield some of their

own income by contributing part of their salaries to HSAs, over and above the direct contributions made by employers.³⁷ The tax shelter is of course of proportionately more benefit for those in higher marginal income tax brackets.

The ultimate fear is that if HSAs become a widespread phenomenon, they will attract mainly the participants that formerly contributed their monthly premiums to traditional plans but rarely ever utilized the plans’ benefits. Left in the traditional plans will be those who receive much more in benefits than they ever pay in premiums. A rough analysis of cost distributions over the population, as was discussed above, suggests that HSAs might be a rational choice for approximately 80% of the population, while the spending patterns of the remaining 20% would cause them to prefer to stay with traditional plans. Yet traditional plans manage to survive only because the healthier, low utilizers effectively subsidize the higher utilizers with chronic or catastrophic illness such as cancer or heart disease. Attracting away the low utilizers would cause traditional plans to have to raise premiums drastically until participants’ premiums approached the benefits they receive back as a group.³⁸ Since few could afford such high premiums, and because at the extreme there would be no reason to pay them, traditional plans would face bankruptcy and shut down. In the end, then, HSAs would not truly be just another “choice,” but would eventually be the only choice. Assuming HSA plans even accept the sicker patients who lose their traditional health coverage, those patients would face significantly higher costs than before HSAs were introduced in the first place.

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HSAs are still far too small a piece of the health care coverage pie to gauge whether these dire predictions would come true. But early evidence does show that adverse selection is occurring.³⁹ Laura Tollen and colleagues studied more than 10,000

participants in Humana's health care plans and found that while demographic factors such as age, sex, and family size were not good predictors of plan preference, those with low prior utilization (up to 60% less than average) showed a strong tendency to gravitate away from the traditional plan and toward the HSA plan.⁴⁰ Lo Sasso's study found a similar trend—HSA plan enrollees had 50% less expenditures in the previous years than the average employee—and also found that those with salaries over \$80,000 were twice as likely to choose an HSA plan.⁴¹ The Fowles study found that those who opted for an HSA plan were less likely to be African American and less likely to have chronic disease or to have visited a physician recently.⁴² While these studies were too small to support conclusive judgments about HSAs generally, their consistency with the economic theory provides significant evidence that adverse selection is a serious concern.

Interestingly, instead of denying that adverse selection is likely to occur, advocates of HSAs seem either to downplay its seriousness or even applaud it as fair and rational. For example, Hertzlinger responds to the complaint by characterizing it as *irrelevant to employers* who self-insure and pay all their enrollees' cost anyway.⁴³ Her point seems to be that even if traditional plans are priced out of existence, chronically ill and high utilizer employees will still be covered under an HSA plan, and their expenses will still fall to self-insured employers anyway. She avoids addressing the impact on those patients who, because of recurring higher utilization, will have to pay their way through the gap between the HSA deposit and the high deductible every year.

HSA advocate Greg Scandlen emphasizes that both adverse selection and moral hazard are insurance induced distortions of market forces and are good examples of why health "insurance" should only cover true risks, rather than more-or-less expected costs.⁴⁴ He then defines "risks" as only those services that would be "unaffordable" to the patient, which he presumably means would be those in excess of the annual deductible of \$1,500 to \$2,000.⁴⁵ He characterizes costs short of those levels as "known consumption"⁴⁶ which should be paid through non-insurance mechanisms such as HSA deposits and out-of-pocket, after-service installment plans. Rather than arguing that adverse selection will not happen, or that it does not threaten an end to traditional plans, advocates seem to argue that the end of traditional plans would be a benefit to the public.

On the other hand, Gail Shearer, a critic of consumer driven health care, sees *cost sharing* as a primary goal of health insurance, regardless of how high or expected one's costs may be.⁴⁷ HSAs are a threat, then, in large part because chronically ill and higher utilizers would face increased out-of-pocket expenditures as they spend through the gap every year, while low util-

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ers would "take back" some of their overpayments through account deposits and lower premiums. The disagreement really comes down to a choice between competing ideals. Presumably both sides would acknowledge that the third party payment system distorts market incentives, drives up prices, and reduces efficiency and convenience. To overcome this, advocates of HSAs are willing to have higher utilizers pay more for their own health care consumption and even see such an arrangement as a fairer alternative to shifting their costs to others. Out-of-pocket expenses of up to \$800 per year for ongoing chronic illness care are not that much, they would argue. Furthermore, the government could subsidize such payments for low-income workers without destroying the market forces that consumer driven health care seeks to preserve.⁴⁸ And since HSA plans are typically cheaper than traditional plans, they would provide lower cost options for people who otherwise could not afford insurance at all.

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Critics view putting individuals at risk of having to pay higher costs—in particular if those costs continue year after year for chronically ill patients—as unacceptable, even if out-of-pocket costs are within the gap ranges contemplated under HSAs. They also fear that over time, employers and plans will reduce HSA deposit amounts as they see many employees accumulating large balances, will increase coinsurance requirements in the high deductible insurance component, and ultimately will seek to drive employees into the individual insurance market by discontinuing group coverage. In such a scenario, as insurers try to price individual plans to risk, the scheme would reduce cost sharing entirely and causing each individual to bear his own health care cost.⁴⁹

Conclusion

This article has explored the theory and limited available data related to experience with HSAs and has attempted to reconcile opposing ideologies in order to predict likely outcomes if HSAs become widespread. The health care industry continues to exhibit rising costs, rigidity, and inconvenience in an age when other industries are reducing costs and meeting the demands of 24-hour customers. And there are strong reasons to believe that the third-party payer system so prevalent in the United States is the root cause for such inefficiencies, since patients have little incentive to demand cost effectiveness and little leverage to demand improved quality or convenience.

Two key policy issues, then, are whether forcing the chronically ill and other persistently high utilizers into HSA plans is morally and politically acceptable, and whether government would somehow subsidize those with low incomes.

At the same time, it is not clear that HSAs will be able to deliver on all their promises. Limited data on overall cost containment under HSAs shows relatively modest savings. Given how skewed health care spending is across the population, there is reason to doubt that HSAs would have much effect on health

care spending nationwide. At the same time, there are strong reasons to believe that HSAs would significantly increase competition—and would therefore drive down prices while improving quality and convenience—in delivery of certain health care goods and services, as has already occurred in the vision care industry.



Finally, both proponents and critics seem to acknowledge that HSAs represent something other than just another option in the insurance marketplace, should they become widespread. Instead, there is a strong likelihood that traditional plans will cease to exist as low utilizers abandon them in an effort to stop subsidizing high utilizers with their premiums. Two key policy issues, then, are whether forcing the chronically ill and other persistently high utilizers into HSA plans is morally and politically acceptable, and whether government would somehow subsidize those with low incomes. **BLB**

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ENDNOTES: Daniel C. Brown

- 1 See Julia Appleby, *Workers Bear Brunt of Rising Health Care in '03*, USA Today, Dec. 8, 2003, available at http://www.usatoday.com/money/industries/health/2003-12-07-healthcosts_x.htm (last visited Sept. 1, 2006) (reporting that employer health care costs increased by only 10.5%, instead of 15% in the previous year, only because employers shifted more of the costs onto employees).
- 2 See *Study OKs Drive-Through Deliveries*, CBSNews.com, Dec. 19, 2002, available at <http://www.cbsnews.com/stories/2002/12/19/health/main533629.shtml> (last visited Sept. 1, 2006) (revealing that a Harvard Medical School study years later found there was no scientific basis for requiring plans to cover longer stays, since the extensions resulted in no decrease in complications).
- 3 See David M. Tuomala, *The Case for Consumer-Driven Health Care*, CONTINGENCIES, May/June 2003, available at <http://www.contingencies.org/mayjun03/commentary.pdf> at 10 (reproducing a graph from the Office of Actuary, Center for Medicare and Medicaid Services to illustrate a dramatic shift in who makes most payments for health care services).
- 4 See Greg Scandlen, *Rethinking the Uninsured*, HEALTH ISSUES at 6 (Sept. 2004) available at <http://www.galen.org/fileuploads/Uninsured.pdf> (last visited Sept. 1, 2006) (accusing the triangular relationship among patients, providers, and health plans of creating inefficiency and administrative waste).
- 5 One commentator suspects that “advances in medical science have reached a point where we can probably spend the entire [gross national product] on health care in useful ways!” Scandlen, *supra* note 4, at 4 (quoting National Center for Policy Analysis president John Goodman).
- 6 See, e.g., Tuomala, *supra* note 3, at 10 (arguing that the vision care industry is highly competitive even though vision care services are provided by skilled professionals and are just as “necessary” as other types of health care). Vision care services have become more affordable and convenient even as technology has advanced precisely because insurers often do not cover elective procedures such as lasik. *Id.* Patients demand convenience and efficiency because they must spend their own funds. *Id.*
- 7 To counteract the incentive to forego routine services such as annual physicals just to save money, many plans fully cover preventive care whether or not the annual deductible is met.
- 8 Meredith Rosenthal & Arnold Milstein, *Awakening Consumer Stewardship of Health Benefits: Prevalence and Differentiation of New Health Plan Models*, 39 HEALTH SERVICES RES. 1055, 1062 (2004).
- 9 *Id.*
- 10 I.R.C. § 223(d)(2) (2003). Participants who withdraw the funds for non-medical expenses must income tax and a withdrawal penalty. I.R.C. § 223(f).
- 11 For example, a 2003 nationwide survey found that only twenty-four out of 680 health plans had participants in a product featuring a health savings account, with a total of 466,039 participants. Rosenthal & Milstein, *supra* note 8, at 1061.
- 12 See Anthony T. Lo Sasso et al, *Tales from the New Frontier: Pioneers' Experiences with Consumer-Driven Health Care*, 39 HEALTH SERVICES RES. 1071, 1088 (2004) (noting that the HSA plans had managed to contain the rate of cost increases overall).
- 13 *Id.* at 1082.
- 14 *Id.* at 1079. Smaller studies routinely present the difficulty of determining to what extent lower expenditures in HSA plans are due to reduced spending by participants compared to before their enrollment in the HSA plan or instead because lower spenders tend to gravitate toward HSA plans generally. *Id.*
- 15 Stephen T. Parente et al, *Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization*, 39 HEALTH SERVICES RES. 1139, 1200 tbl.3 (2004).
- 16 Laura du Preez, *Medical Savings Plans 'Not Just for the Healthy, Personal Fin.*, Jul. 26, 2003, available at <http://www.persfin.co.za/index.php?fSectionId=707&fArticleId=196531> (last visited Sept. 1, 2006).
- 17 *Shifting Health Care Decisions From Employers to Consumers*, House/Senate Joint Economic Committee, 108th Cong. (2004) 2004 WL 354016 (statement of Gail Shearer) [hereinafter *Shearer Testimony*] available at http://jec.senate.gov/_files/Shearer02252004.pdf, at 2.
- 18 See *New Remedies: There Must Be a Better Way*, The Econ., Jul. 17, 2004, at 78 (reporting that having gained new access to health information on the internet, Americans are becoming distinctly unhappy about the value for money they get from the health care industry).
- 19 du Preez, *supra* note 16. The same company said it experienced similar results in the United States through its Destiny HSA plan.
- 20 Lo Sasso, *supra* note 12 at 1076-77.
- 21 *Id.*
- 22 Parente, *supra* note 15, at 1204.
- 23 *Id.*
- 24 *Shearer Testimony*, *supra* note 17, at 5.
- 25 Karen Davis, *Consumer-Driven Health Care: Will It Improve Health System Performance*, 39 Health Services Res. 1219, 1223 (2004).
- 26 *Shearer Testimony*, *supra* note 17, at 5 (including a graph showing that average spending for the top 10% reaches \$16,710 per year, which is 71% of the total of all groups' averages).
- 27 Davis, *supra* note 25, at 1223.
- 28 See Rosenthal & Milstein, *supra* note 8, at 1062 (noting the average HSA plan has an annual deductible of only \$1,654).
- 29 *Shearer Testimony*, *supra* note 17, at 5 (supporting the estimation that the top 80% of spenders are responsible for 88% of spending, based on calculations of stated averages).
- 30 See George C. Halvorson, *Commentary—Current MSA Theory: Well-Meaning but Futile*, 39 HEALTH SERVICES RES. 1119, 1121 (2004) (arguing that the average current benefits package is irrelevant to both high spenders and low spenders but is potentially painful for chronic care patients).
- 31 Regina Herzlinger, *Consumer-Driven Health Care: Taming the Health Care Monster*, J. OF FIN. SERVICES PROF., Mar. 2004, available at http://www.manhattan-institute.org/html/_jfsp-consumer.htm (last visited Sept. 1, 2006).
- 32 Halvorson, *supra* note 30, at 1120.
- 33 *Id.*
- 34 That is, the price of consuming the amount of the service or good normally consumed within one year.
- 35 See *Shearer Testimony*, *supra* note 17, at 5.
- 36 See Gail Shearer, *Commentary—Defined Contribution Health Plans: Attracting the Healthy and Well-off*, 39 Health Services Res. 1159, 1159 (2004).
- 37 I.R.C. § 223.
- 38 See *Shearer Testimony*, *supra* note 17, at 6 (predicting that HSAs would send traditional plans into a “premium spiral,” driving out comprehensive coverage all together).
- 39 Davis, *supra* note 25, at 1225.
- 40 Laura A. Tollen et al, *Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.*, 39 Health Services Res. 1167, 1182-84 (2004).
- 41 Lo Sasso, *supra* note 12, at 1087.
- 42 Davis, *supra* note 25, at 1225; see Jinnat Briggs Fowles et al, *Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment*, 39 HEALTH SERVICES RES. 1141, 1154 (2004) (noting that the emergence of race as an independent predictor of choice was unexpected, and so far unexplored in the literature).
- 43 Herzlinger, *supra* note 31.
- 44 Scandlen, *supra* note 4, at 5.
- 45 *Id.*
- 46 *Id.* at 7.
- 47 *Shearer Testimony*, *supra* note 17, at 6 (criticizing approaches that sacrifice the notion of sharing one's neighbor's burden in favor of marketplace efficiency).
- 48 See Scandlen, *supra* note 4, at 7 (suggesting there is no reason to use government subsidies to offset premium costs rather than instead using them to soften the blow of high out-of-pocket expenditures on low-income earners).
- 49 *Shearer Testimony*, *supra* note 17, at 5-7 (insinuating that the ultimate goal of consumer driven health care advocates is to eventually remove employers from the role of negotiating group coverage for their employees, instead sending them into the marketplace to fend for themselves individually).