Health Savings Accounts and Tax Preferences for High Deductible Policies Purchased in the Non-Group Market: Potential Impacts on Employer-Based Coverage in the Small Group Market

Statement of

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Mr. Chairman, Mr. Udall, and distinguished Members of the Subcommittee: Thank you for inviting me to share my views on Health Savings Accounts (HSAs) and HR 3901, a proposal to make private non-group premiums for the high - deductible health plans associated with HSAs tax deductible. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors.

I applaud the Subcommittee taking the time to carefully consider the small business implications of the recently enacted HSA provisions and the proposed change to the tax treatment of high deductible insurance policies. Reforms of the health insurance market have potentially important implications for small businesses, which face special challenges in providing health insurance coverage to their workers.

In brief, my main points are:

- Small employers face substantial disadvantages relative to large employers when providing health insurance to their workers. These problems can largely be summarized as higher administrative costs of insurance, limited ability to spread health care risk, and a workforce with lower wages.
- While there are mechanisms available for addressing the problems facing small businesses in the purchase of insurance coverage, HSAs and the policy contained in HR 3901 are not among them.
- The Health Savings Accounts included in the Medicare prescription drug legislation signed into law in 2003 exacerbate the problems faced by small employers and their workers. They increase administrative costs, further segment individuals according to health care risk, and subsidize the highest income purchasers the most.
- The proposal contained in HR 3901 and included in the President's 2005 proposed budget would further complicate the health insurance situation for small businesses and their workers. The proposal provides additional subsidization for higher income people, increases incentives to purchase coverage individually instead of through employer groups, and is likely to decrease access to insurance coverage for high health care cost and low income workers and their dependents.

- On net, HR 3901 may actually decrease insurance coverage. The federal funds necessary to fund this legislation could more effectively be redirected toward approaches designed to address the explicit problems facing small businesses or to expansion of eligibility in existing State-Children's Health Insurance Programs (S-CHIP) or Medicaid.

I. The Scope of the Health Insurance Problems Facing Small Employers and Their Workers

Only 39 percent of establishments in firms of fewer than 10 workers offer health insurance to any of their workers, compared to 99 percent of establishments in firms of 1000 or more workers (Chart 1).[1]

Approximately 46 percent of workers employed by firms with fewer than 10 workers are offered and are eligible for enrollment in their own employer's health insurance plan, compared to 87 percent of workers employed in firms of 500 or more workers (Chart 2).[2] Workers in the smallest firms are also less likely than their large firm counterparts to take-up employer offers when they have one, although some of these workers receive coverage through a spouse employed by a larger firm (Chart 3).[3]

The lower rates of offer and take-up among small firms and their workers results in roughly 29 percent of workers in the smallest firms being uninsured, while only 9 percent of workers in the largest firms lack coverage (Chart 4).[4]

These lower rates of coverage among small employers are due, at least in part, to the fact that small employers must pay significantly more for the same health benefits than do large employers. Smaller firms face much larger administrative costs per unit of benefit.[5] Administrative economies of scale occur because the costs of administering enrollment and other activities by plans and providers are

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[1] Published tables, 2001 Medical Expenditure Panel Survey – Insurance Component, http://www.meps.ahrq.gov/MEPSDATA/ic/2001/Tables_I/TIA2.pdf

[2] Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.

[3] Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.

[4] Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.

[5] Congressional Research Service. 1988. *Costs and Effects of Extending Health Insurance Coverage*. Washington, DC: U.S. Government Printing Office.

largely fixed costs.[6] Small firms simply have fewer workers over which to spread these fixed costs. In addition, insurers charge higher risk premiums to small employers, because small employers experience greater year to year variability in medical expenses than do large firms,[7] simply because there are fewer workers over which to spread risk.

Another barrier to small employers providing health insurance is that the average worker in a small firm is paid significantly less than workers in large firms.[8] Economists believe that there is an implicit tradeoff between cash wages and health insurance benefits.[9] In other words, workers actually pay for the cost of their employers' contributions to their health insurance by receiving wages below what they would have received had no employer health insurance been offered. The lower wages of small firm workers imply that they are far less able to afford to pay for health insurance through wage reductions; consequently, their employers are less likely to offer them such benefits.

The fact that small employers must pay a higher premium for the same benefits offered by a large employer makes it difficult for them to compete with large firms for the same workers. Small firms with predominantly low wage workers will have difficulty financing insurance coverage regardless. Any reforms to the health insurance market should be focused on making it easier for small employers to provide health insurance coverage to their workers rather than undermining the efforts of those employers who do provide it.

II. Possible Approaches for Addressing the Insurance Problems of Small Employers

A number of mechanisms can be used for addressing the problems facing small employers in the provision of health insurance to their workers. Some are strategies that apply to reducing the problem of the uninsured in general, and some are of particular interest to small employers and their workers. While

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[6] Blumberg, Linda J. and Len M. Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.

[7] Cutler, David. 1994. "Market Failure in Small Group Health Insurance." Working Paper No. 4879. Cambridge, MA: National Bureau of Economic Research, Inc.

[8] Nichols, Len M., Linda J. Blumberg, Gregory P. Acs, Cori E. Uccello, and Jill A. Marsteller. 1997. *Small Employers: Their Diversity and Health Insurance*. Washington, DC: The Urban Institute.

[9] Blumberg, Linda J. 1999. "Who Pays for Employer Sponsored Health Insurance? Evidence and Policy Implications," *Health Affairs*, vol. 18.

options for comprehensive expansions of coverage have been discussed extensively elsewhere,[10] I focus my comments here on incremental types of reforms that deal explicitly with the small business problems of high administrative loads, limited ability to spread health care risk, and low relative wages.

Purchasing Groups. Allowing small firms to band together for purposes of purchasing health insurance has some potential for lowering their administrative cost loads. This has been the motivation of a number of purchasing pools that have been set up in various states.[11] These purchasing pools often provide the side benefit of making it more feasible for small employers to offer their workers a choice of health insurance plans. Instead of shopping for plans independently, small employers pay premiums to the purchasing pool on behalf of their workers, and the pool performs the administrative functions of plan choice, premium negotiation, enrollment, etc. Ideally, the insurance plans interact with the pool's administrator instead of each of the member firms, with marketing and screening activities perform more centrally.

While small employer purchasing pools have met with success in some cases, realizing the efficiencies of large scale purchasing has been difficult for a number of reasons. Chief among them has been the limited ability to reduce the role and inherent expense of insurance agents in the process.[12] So while purchasing pools such as these do have potential to lower the administrative loads for small group purchasers, these savings are more difficult to capture in practice than has been presumed.

It is important to note that purchasing pools such as those described here do not include the legislatively proposed entities known as association health plans (AHPs).[13] The implications of AHPs are altogether different in that they are designed to allow particular multi-employer purchasing entities to avoid compliance with state health insurance regulations. As a consequence of the

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[10] Meyer, Jack A., Elliot Wicks. June 2001. *Covering America: Real Remedies for the Uninsured.* Economic and Social Research Institute.

[11] Directory of Consumer-Choice Health Purchasing Groups compiled by the Institute for Health Policy Solutions, http://ihps.org/.

[12] Garnick, Deborah W., Katherine Swartz, and Kathleen Skwara. March/April 1998. "Insurance Agents: Ignored Players in Health Insurance Reform," *Health Affairs*, 17(2): 137-143.

[13] Kofman, Mila and Karl Polzer. January 2004. "What Would Association Health Plans Mean for California?: Full Report." Prepared for the California HealthCare Foundation. http://www.chcf.org/documents/insurance/AHPFullReport.pdf.

AHPs' ability to limit membership to select groups and to have their premiums determined separately from the traditional commercial insurance market, they are largely a tool for segmenting health care risk rather than a tool of generating economies of scale.[14]

Subsidization of Insurance Coverage for High Risk Individuals. Insurers and others recognize that small employers are not large enough for their annual average health expenditures to reflect the average of the insured population as a whole, nor are they large enough to be stable from year to year. Even a single seriously ill worker or dependent enrolled in a small group insurance policy can have tremendous effects on the average expenses of the group in a particular year, whereas a small number of high cost cases in a large group would not substantially affect the group average. As a consequence, insurers charge small employers risk premiums to take into account such unpredictable but potentially extreme fluctuations. Unfortunately, regulatory reforms implemented thus far have been unable to sufficiently spread these risks. State insurance regulations passed throughout the past decade served only to spread the risks within the small group insured population itself. The consequences of this limited risk spreading were increased premium prices for healthy insureds simultaneous with decreased prices for the sick. This forced risk pooling within the small group market led generally to no net change in the number insured as the probability of insurance fell for the healthy and rose for the sick.[15]

Clearly, the small group market itself is too narrow a population over which to spread the costs of high risk individuals. But other risk spreading mechanisms could work much more effectively. For example, many states have established high risk pools. These pools are generally available to individuals who have been refused insurance coverage in the private market, and who do not have offers of employer-sponsored insurance. However, due to the limited public funding through state sources (frequently premium taxes on private insurance policies), these pools may have enrollment caps and usually charge premiums that are well in excess of standard policies in the private market.[16] Some high

[14] Blumberg, Linda J. and Yu-Chu Shen. January 2004. "The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis". Prepared for the California HealthCare Foundation. http://www.chcf.org/documents/insurance/AHPBlumberg.pdf.
[15] Nichols, Len M. 2000. "State Regulation: What Have We Learned So Far?" *Journal of Health Politics, Policy, and Law*. 25(1): 175-96.
[16] Chollet, Deborah. October 23, 2002. "Perspective: Expanding Individual Health Insurance Coverage: Are High Risk Pools the Answer?" *Health Affairs* Web Exclusive.

risk pools offer very limited benefit packages and maintain pre-existing condition exclusion periods. All of these limitations hamper their effectiveness in absorbing risk from the private market. However, broadening the base for financing these pools, loosening eligibility criteria for enrollment, making the insurance policies themselves more comprehensive, and offering income-related premiums have the potential to make these high risk pools powerful escape valves for the high cost in the small group insurance market.[17] Allowing small employers to buy their high risk workers into well-funded high risk pools would decrease the level and variability in the expenditures of the remaining small group workers and consequently would lower their premiums. The cost of subsidizing the medical care of the high risk could be spread across the entire population, using a broad based tax.

Similarly, the federal government could take on the roll of public re-insurer. In this capacity, the government could agree to absorb a percentage of the costs of high cost cases, once a threshold level of health expenditures had been reached.[18] The distribution of health expenditures is highly skewed, meaning that a large share of total health expenditures is attributable to a small fraction of the population.[19] Ten percent of any insured population typically accounts for 70 percent of all spending by that group. Consequently, financing the relatively small number of very high cost cases publicly can have a substantial impact on the liability of insurers, and by extension, on the premiums charged to small employers.

Another proposal presented in the health reform literature would combine the concepts of purchasing pools for administrative efficiency with explicit subsidization of the high cost and low income.[20] This proposal allows groups wishing to purchase insurance coverage in existing markets under existing insurance rules to continue to do so. However, it would provide structured insurance purchasing pools in each state in which employers and individuals

[17] Blumberg, Linda J. and Len Nichols. Fall 1996. "First, Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs*.
[18] Swartz, Katherine. May 2003. "Reducing Risk to Increase Access to Health Insurance," *Health Affairs*.
[19] Berk, Marc L and Alan Monheit. March/April 2001. "The Concentration of Health Care Expenditures, Revisited," *Health Affairs. 20(2): 204-213.*
[20] Holahan, John, Len Nichols, and Linda Blumberg, June 2001. "Expanding Health Insurance Coverage: A New Federal/State Approach*," Covering America: Real Remedies for the Uninsured.* Jack Meyer and Elliot Wicks, eds., Economic and Social Research Institute.

could enroll in private health insurance plans at premiums that reflect the average cost of all insured persons in the state. Broad-based government funding sources would compensate insurers for the difference between the cost of actual enrollees and the statewide average cost.

Subsidization of Insurance Coverage for Low-Income Individuals. Extensive research has demonstrated that low income individuals are less likely to have health insurance than their higher income counterparts. The same holds true for workers in small firms. Chart 5 shows that rates of uninsurance among workers in small firms (fewer than 25 workers) drop precipitously with income.[21] Fifty-six percent of small firm workers with family incomes below the federal poverty line are uninsured, compared to less than 10 percent of small firm workers with family incomes of 700 percent of poverty or more. Analysis has also shown that higher income individuals are significantly more likely to take-up an employer offer of health insurance than are lower income workers.[22] In addition, there is evidence that low income workers' decisions to take-up health insurance offers from their employers are more responsive to out-of-pocket premium price than are the decisions of higher income workers.

The average wage of workers in the smallest firms (fewer than 10 workers) is roughly 48 percent of that of workers in the largest firms (500 workers or more).[23] This information taken, together with the analyses described above, suggests that affordability of health insurance is a significant barrier to coverage for many small firm workers. Consequently, income-related subsidization of insurance coverage should be strongly considered in any effort to significantly expand coverage within this population.

III. Implications of Health Savings Accounts (HSAs)

The HSA provisions in the Medicare prescription drug legislation passed last year provide a generous tax incentive for certain individuals to seek out high deductible health insurance policies. The minimum annual deductibles are $1,000 for single and $2,000 for family policies. Individuals (and families) buying

[21] Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.
[22] Blumberg, Linda J., Len Nichols, and Jessica Banthin. "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics*. vol. 1, p. 305-325, 2001.
[23] Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.

these policies either through their employers or independently in the private non-group insurance market can make tax-deductible contributions capped at the amount of the insurance plan's deductible, up to $2,600 per year in an HSA ($5,150 for a family). Annual contributions are capped at the amount of the annual deductible for the plan in which the individual or family is enrolled. Money in the account and any earnings are tax-free if used to cover medical costs.

For the small percentage of employers who were already offering high deductible policies to their workers, the HSAs allow them to provide an additional benefit to their workers. Under the new legislation, workers can contribute their own funds to the accounts on a tax preferred basis, even if their employer does not make contributions.

These accounts are most attractive to high income people, and those with low expected health expenses. The tax subsidy is greatest for those in the highest marginal tax bracket and is of little or no value at all to those who do not owe income tax. Higher income individuals are also better able to cover the costs of a high deductible, should significant medical expenses be incurred. A $5,150 HSA contribution, the maximum permitted under the law, would generate a tax reduction of $1,802 per year to a household in the top income tax bracket. The value of the tax benefit would be less than half as much for a moderate-income family. And it would be worth much less that that if the family could not afford to contribute very much into the account.

Additionally, those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free that they can use for a broad array of health related expenses that are not reimbursable by insurance (e.g., non-prescription medications, eyeglasses, cosmetic surgery). Those without substantial health care needs may also be attracted to HSAs because they can be effectively used as an additional IRA, with no penalty applied if the funds are spent for non-health related purposes after age 65. Young, healthy individuals may even choose to use employer contributions to their HSAs for current non-health related expenses, after paying a 10 percent penalty and income taxes on the funds; a perk unavailable to those enrolled in traditional comprehensive insurance plans.

Moving individuals into higher deductible policies actually increases the share of premiums attributable to administrative costs. The administrative "load" charged

by insurers is simply the total administrative costs divided by the total benefits paid. So a 15 percent administrative load implies that administrative costs are equal to 15 percent of benefits paid out. Because many administrative costs are fixed, lowering the actuarial value of the benefits requires the insurers to increase the administrative load. Consequently, a larger share of premiums paid for high deductible policies will be attributable to administrative charges than when comprehensive coverage is purchased.

The idea of lower premiums under high deductible policies also make these recent reforms attractive to some employer purchasers. However, the savings can only be modest for a fixed group of enrollees. The limited ability of high deductibles to reduce premiums is rooted in the skewed distribution of health expenses. Because the majority of spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles even to $1,000 or $2,000 from currently typical levels will not decrease premiums dollar for dollar. The vast majority of medical spending still will occur above even those higher deductibles. And because premium savings can only be modest, the price effect of moving to higher deductible plans cannot go far in encouraging more employers to offer insurance or more individuals to take it up.

The real premium savings from HSAs can occur by altering the mix of individuals who purchase coverage. By providing incentives for healthy individuals and groups to purchase HSAs with high deductible policies, insurance risk pools can be further segmented by health status. The average medical costs of those purchasing the new plans will be substantially lower if the high risk population is left in more traditional comprehensive plans. The practical effect, however, is that the most vulnerable populations (the sick and the low income) are left bearing a greater burden of their health expenses. The extent to which this is a preferred societal outcome should be explicitly debated.

HSAs will exacerbate all of the existing problems facing small employers. They will lead to higher administrative loads, both for small firms and individuals, further degrade risk pools, and provide the largest subsidies to high income people.

IV. Implications of Tax-Deductibility for Individually Purchased High-Deductible Policies (HR 3901)

HR 3901, consistent with the proposal included in the President's fiscal year 2005 budget,[24] would make the premiums associated with individually purchased high deductible health insurance plans deductible from income taxation. The definition of "high deductible" is the same as that used in the legislation describing HSAs, a minimum of $1,000 for a single and $2,000 for a family policy. The deduction would be allowed regardless of whether other itemized deductions are taken.

This proposal to allow individuals to deduct premiums for policies purchased with HSAs would further complicate matters for small businesses. The tax subsidy would be worth most to those who least need assistance. More importantly, it would undermine the small employer market in key ways. This new proposal increases the incentive for individuals to purchase health insurance in the private non-group insurance market, as opposed to acquiring it through employers. Making the private non-group market more attractive may lead to a decline in the availability of coverage available through small firms.

The proposal would provide a non-group insurance product whose tax advantage is almost as great as that available in the group market and which is most attractive to those with high incomes and low health care risk. Low cost/high-income purchasers, armed with yet another subsidy, would be likely to find price advantages in the non-group insurance market, since most states allow non-group insurers to charge lower premiums for those in good health and to completely exclude from coverage those with current or past health problems. But as low cost purchasers leave the group market, the average cost of those staying in the group market will rise, making group insurance more difficult to afford for higher risk and low income populations. In addition, since employers and key employees will be able to get tax breaks for their high-deductible health insurance even if they do not provide it to their other employees, there will be even less incentive for them to take on the hassle, expense, and risk of offering

[24] "General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals." Department of the Treasury, February 2004. http://www.treas.gov/offices/tax-policy/library/bluebk04.pdf.

insurance to their workers. The net result could be *less* insurance coverage among small businesses.

While the risk pooling available to small firms is low compared to large firms, they are still afforded a greater degree of pooling than is the case in most states' non-group markets. Administrative costs in the non-group market are also even higher than for small firm purchasers. Consequently, those with high costs and low incomes have the most to lose if coverage shifts from the small group to the non-group market.

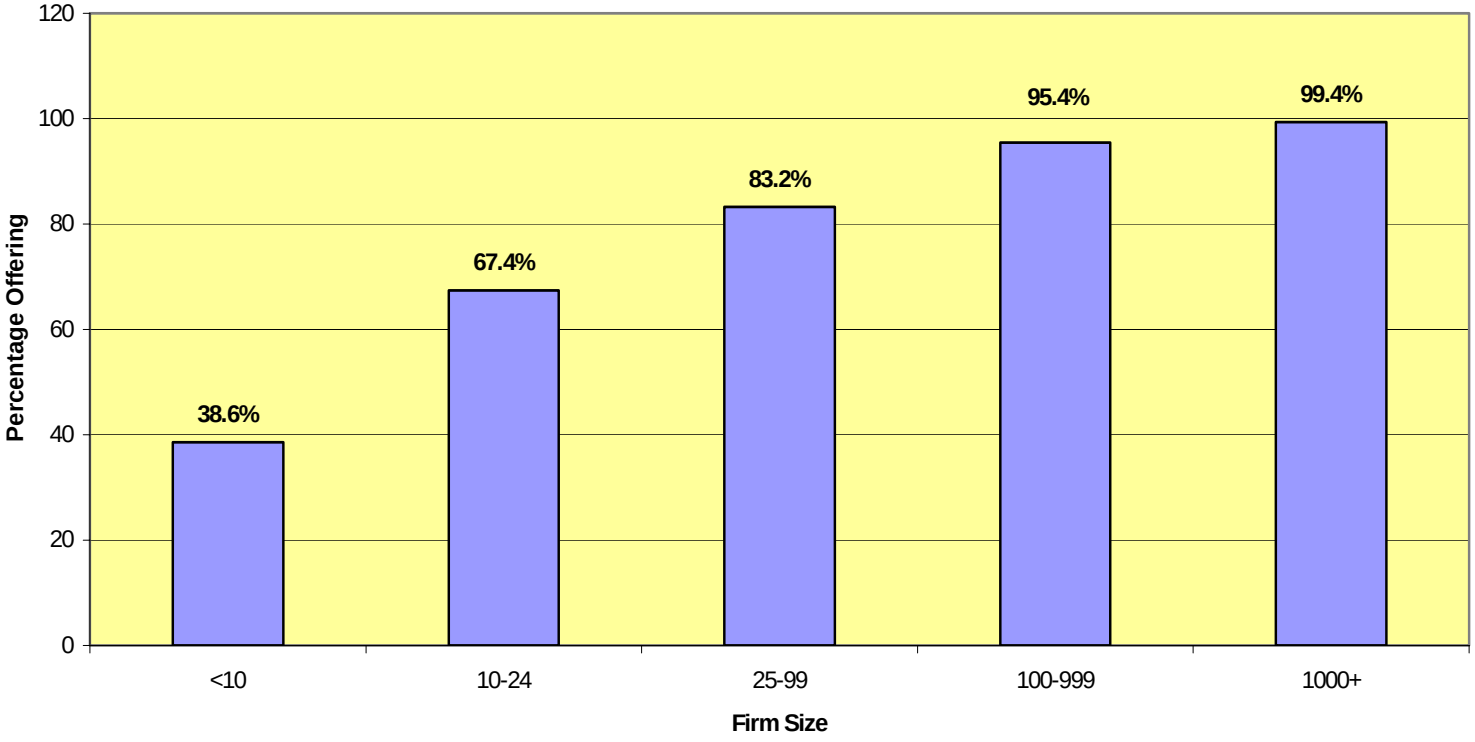
Some will support making these high deductible policies tax deductible from the standpoint of increasing tax equity relative to current law. However, while the bill would put individually purchased high deductible plans on more equal footing with employer purchased plans, it would create new inequities in the private non-group insurance market. The bill would bias incentives for individuals to purchase high deductible policies relative to more comprehensive policies in the non-group market. This new distortion would have the practical effect of further segmenting the non-group insurance market, with high income purchasers even more likely to be drawn out of comprehensive policies. And because health status is highly correlated with income, this would also likely have the effect of segmenting the market further by health status. When creating policy affecting health insurance markets, a single-minded pursuit of tax equity risks ignoring what should be of paramount concern: the impacts on insurance risk pools.

V. Conclusion

While small businesses face formidable difficulties in providing affordable health insurance to their workers, tools are available for increasing coverage in this sector. The focus of such efforts should be on lowering administrative burdens, developing mechanisms for spreading the risk of high cost cases more broadly, and subsidizing low income workers. Reforms intended to expand coverage to small firm workers and their dependents should be evaluated in terms of these goals.

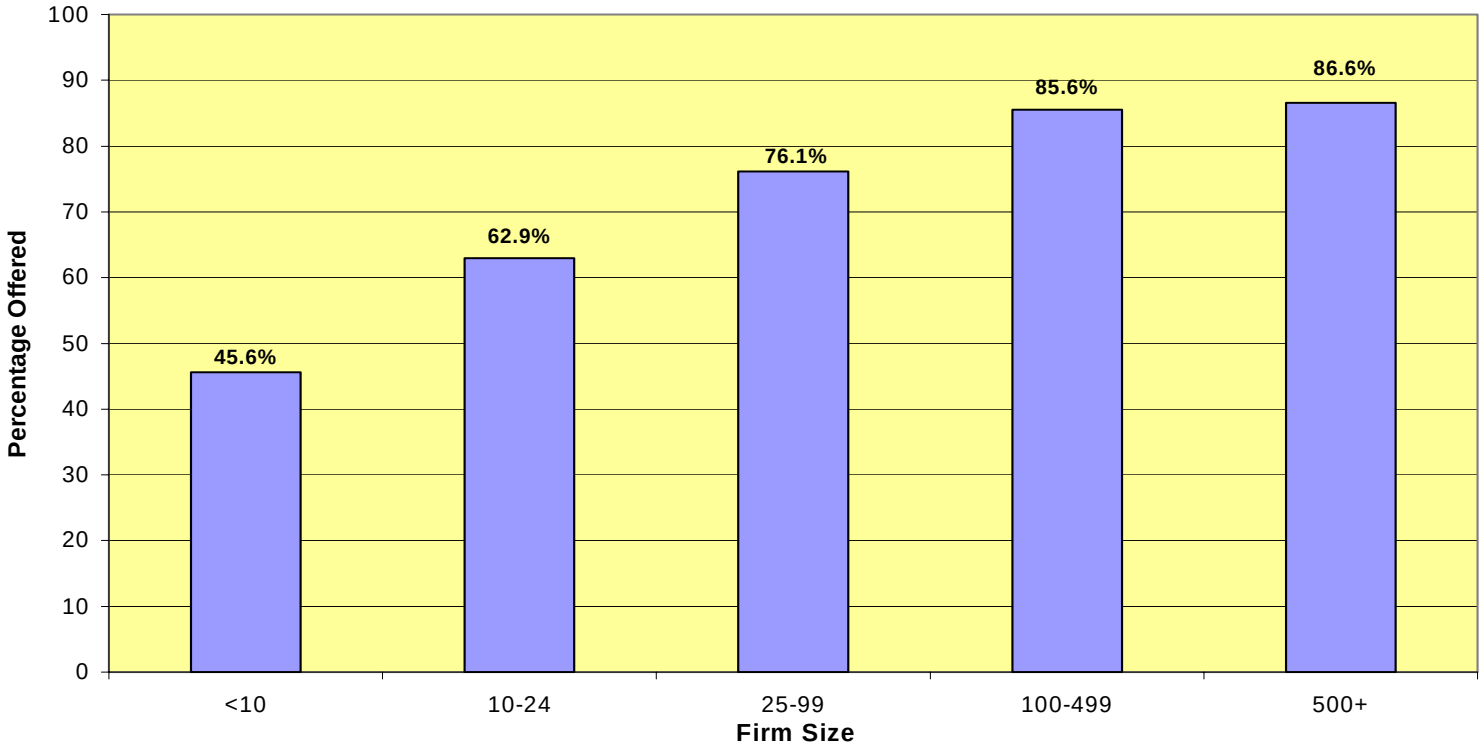
The Treasury Department estimates that allowing deductibility for individually purchased high deductible health insurance would reduce federal revenues by $25 billion over the next ten years, even though the net result could be a reduction in coverage. Funding approaches designed to explicitly address the problems faced by small employers would be federal money better spent.

Chart 1: Share of Establishments Offering Health Insurance, by Firm Size



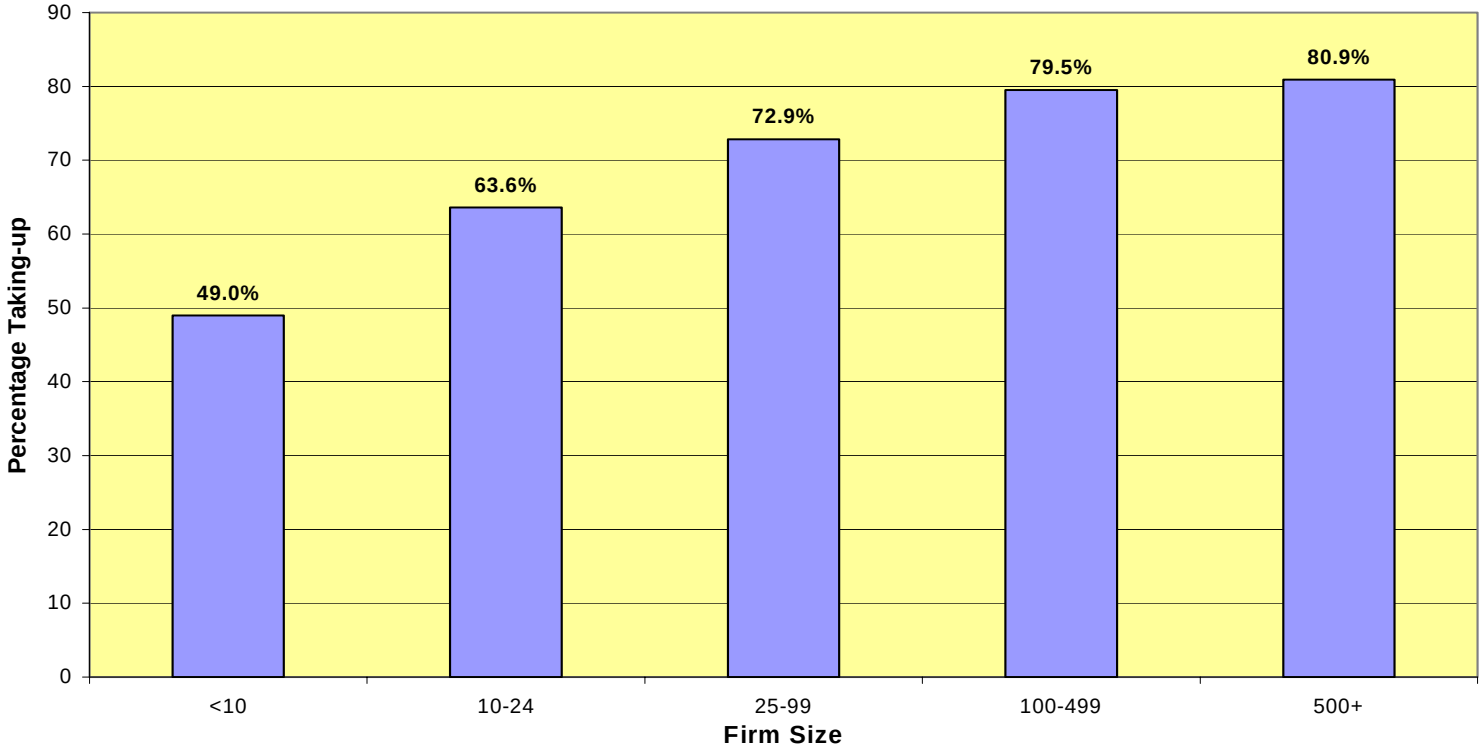
Source: 2001 Medical Expenditure Panel Survey-Insurance Component

Chart 2: Share of Workers Offered Employer-Sponsored Health Insurance, by Firm Size



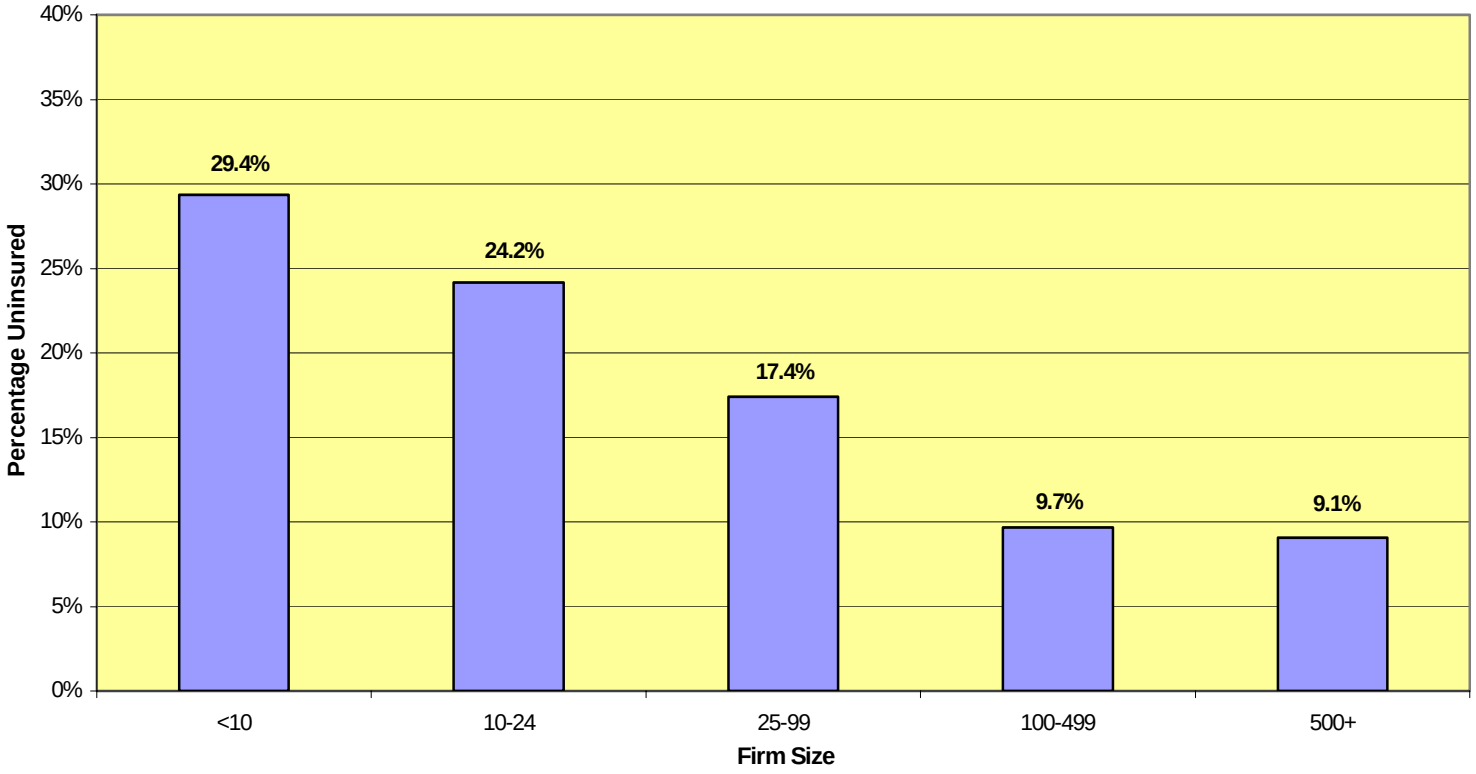
Source: Urban Institute tabulations of a merged file of the 2001 February and March Current Population

Chart 3: Share of Workers Taking-up Own Employer Offer, by Firm Size



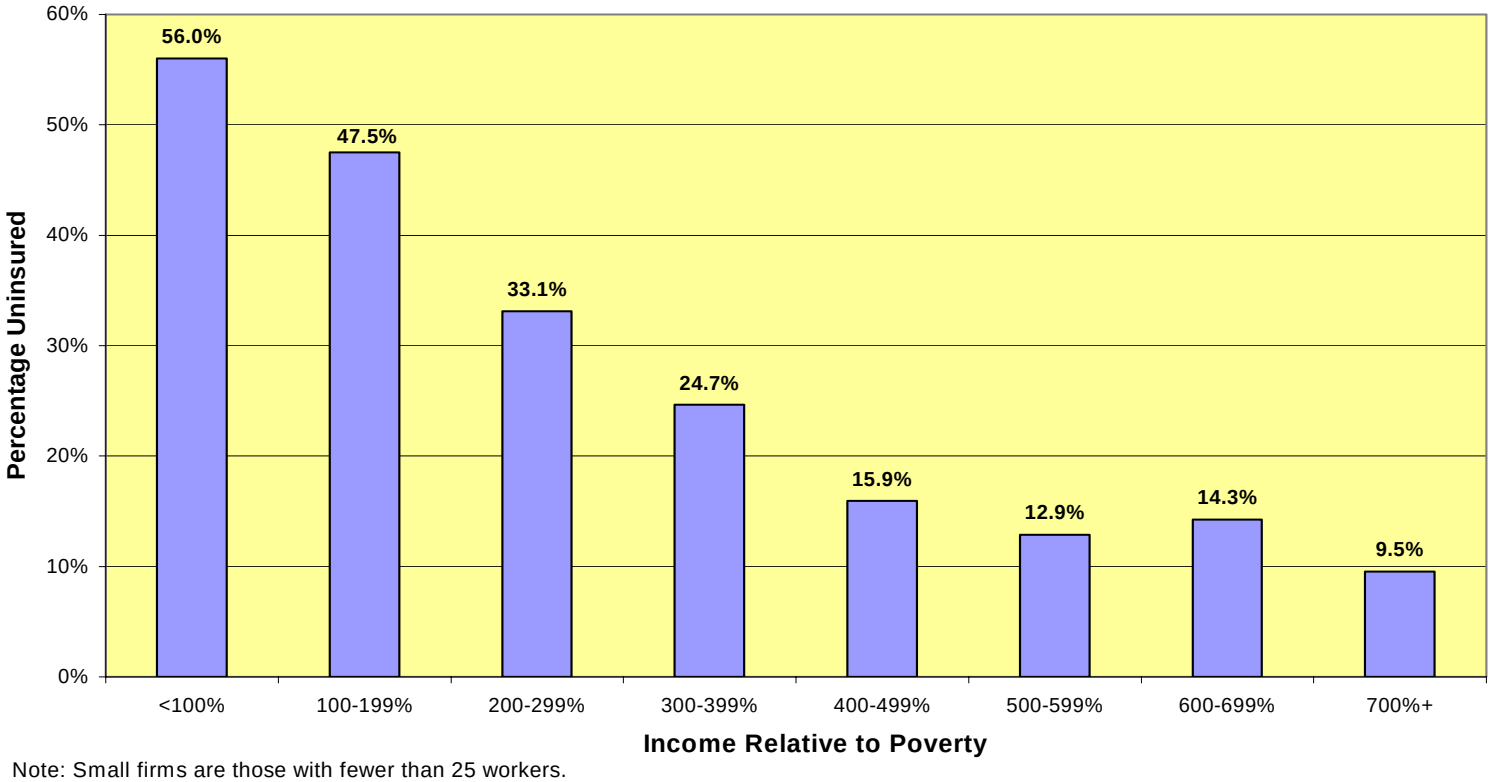
Source: Urban Institute tabulations of a merged file of the 2001 February and March Current Population

Chart 4: Share of Workers Uninsured, by Firm Size



Source: Urban Institute tabulations of a merged file of the 2001 February and March Current Population Surveys.

Chart 5: Uninsurance Rates of Workers in Small Firms, by Income Relative to Poverty



Note: Small firms are those with fewer than 25 workers.

Source: Urban Institute tabulations of a merged file of the 2001 February ad March Current Population