POLICY REPORT

Health Savings Accounts: Consumer-Driven Health Care for North Carolina Public Employees and Teachers

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Executive Summary

In December 2003, President Bush signed into law the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003." Title XII of the act, titled "Tax Incentives for Health and Retirement Security," amended the Internal Revenue Code to provide for tax-free "health savings accounts" ("HSAs"). HSAs are a form of medical savings account, similar to the now-familiar IRAs ("investment retirement accounts"). These accounts are the property of the employee and can accumulate interest and dividends like other savings vehicles. Funds that are not used for health care-related expenses can be used for retirement living and can also be willed to one's heirs. When combined with a high-deductible health insurance policy, an HSA replaces traditional health insurance coverage – and does so in a way that results in a more consumer-driven approach to health care.

Because of delays in the U.S. Treasury Department's announcement of regulations and guidelines pertaining to HSAs, there was a lag in corporate interest in this new health care tool. Now that this guidance has been provided, the private sector is taking a closer look at HSAs as an alternative to traditional health insurance benefits. One survey of large employers conducted in early 2005 reported that "8 percent of employers offer HSAs, another 18 percent plan to offer them in 2006 and an additional 47 percent are considering offering the accounts."

While HSA-based employee health coverage is still in its infancy, a number of studies are showing that companies using these plans are experiencing lower health coverage costs without sacrificing access to needed health care.

State governments, facing mounting pressure to get some control over skyrocketing employee benefits costs, are also looking at HSAs as a potential solution. Three states – Florida, Louisiana and Virginia – have already enacted legislation to provide for an HSA option for their public employees. Similar legislation is (or has been within the past year) under discussion in at least 15 other states. Former Speaker of the House Newt Gingrich is involved with an effort to move HSA legislation in state legislatures, with the goal of providing "every state government employee . . . the option of choosing an . . . HSA-qualified health insurance plan" by 2008. At the federal level, President Bush has pledged to make HSAs an option for federal employees before the end of 2005.

Given that the costs of providing health insurance to North Carolina's state employees has been steadily increasing for nearly a decade, with dramatic increases since 2000, the General Assembly should give serious consideration to Health Savings Accounts as an alternative to traditional health insurance coverage for state employees and public school teachers. The alternative is to wait until the current system results in a large enough budgetary train wreck to force the consideration of alternatives in an emergency atmosphere.

Health Savings Accounts: Consumer-Driven Health Care for North Carolina Public Employees and Teachers

In December 2003, President Bush signed into law the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003."[1] While the Medicare prescription drug benefit has received a great deal of attention, another, lesser-known provision of the act may well revolutionize the provision of health care in America. Title XII of the act, titled "Tax Incentives for Health and Retirement Security," amended the Internal Revenue Code to provide for tax-free "health savings accounts" ("HSAs").[2] HSAs are a form of medical savings account, similar to the now-familiar IRAs ("investment retirement accounts"). When combined with a high-deductible health insurance policy, an HSA replaces traditional health insurance coverage – and does so in a way that results in a more consumer-driven approach to health care, for reasons we will explore below.

Because of delays in the U.S. Treasury Department's announcement of regulations and guidelines pertaining to HSAs, there was a lag in corporate interest in this new health care tool. Now that this guidance has been provided, the private sector is taking a closer look at HSAs as an alternative to traditional health insurance benefits. One survey of large employers conducted in early 2005 reported that "8 percent of employers now offer [HSAs], and another 18 percent plan to offer them in 2006. Additionally, 47 percent are considering offering the accounts."[3]

While HSA-based employee health coverage is still in its infancy, as the title of an August 2005 report puts it, the "early evidence is positive," with a number of early studies "showing that companies and individuals who move to Health Savings Accounts and similar plans experience lower costs while maintaining access to needed health care."[4] Similar conclusions have been reached by the RAND Corporation[5] and the consulting firm McKinsey & Company.[6]

State governments, facing mounting pressure to get some control over skyrocketing employee benefits costs, are also looking at HSAs as a potential solution. Three states – Florida, Louisiana and Virginia – have already enacted legislation to provide for an HSA option for their public employees.[7] Similar legislation is (or has been within the past year) under discussion in at least 15 other states (See Table 1).[8] Former Speaker of the House Newt Gingrich is involved with an effort to move HSA legislation in state legislatures, with the goal of providing "every state government employee . . . the option of choosing an . . . HSA-qualified health insurance plan" by 2008.[9] At the federal level, President Bush has pledged to make HSAs an option for federal employees before the end of 2005.[10]

This paper first describes the financial difficulties faced by North Carolina's current state employee health insurance plan. It then describes the operation of HSAs and high-deductible health plans, and explains the potential for such consumer-driven plans to bring about better health care at a lower cost. It then discusses how the North Carolina General Assembly might follow the example set by Florida, Louisiana and Virginia and pass legislation giving North Carolina public employees the option of choosing high-deductible HSA coverage as their health insurance vehicle.

When combined with a high-deductible health insurance policy, an HSA replaces traditional health insurance coverage – and does so in a way that results in a more consumer-driven approach to health care.

Table 1:

Enacted HSA Legislation		
2005	Florida Acts No. 2005-97	Codified at FL Stat. 110.123(12)
2004	Louisiana Acts 890	Codified at LA Rev. Stat.. 22:228.8 and 42:802(C)
2005	Virginia Acts 572	Codified at VA Code 2.2-2818 and 38.2-5601
Proposed HSA Legislation		
2005	Alaska	S.B. 94
2005	Iowa	S.B. 314
2005	Kentucky	H.B. 2, S.B. 376, H.B. 462
2005	Maine	H.B. 1070a
2005	Michigan	H.B. 4704, H.B. 4705
2005	Minnesota	S.B. 2267, H.B. 2, S.B. 376, H.B. 872
2005	Montana	S.B. 467, L.D. 465
2005	New Hampshire	H.B. 290
2005	Oregon	S.B. 429
2005	Oklahoma	S.B. 896
2005	Rhode Island	H.B. 6097
2005	Texas	H.B. 1795, S.B. 562
2005	Washington	H.B. 1383, H.B. 1686, S.B. 6130
2005	Wisconsin	S.B. 131, H.B. 341

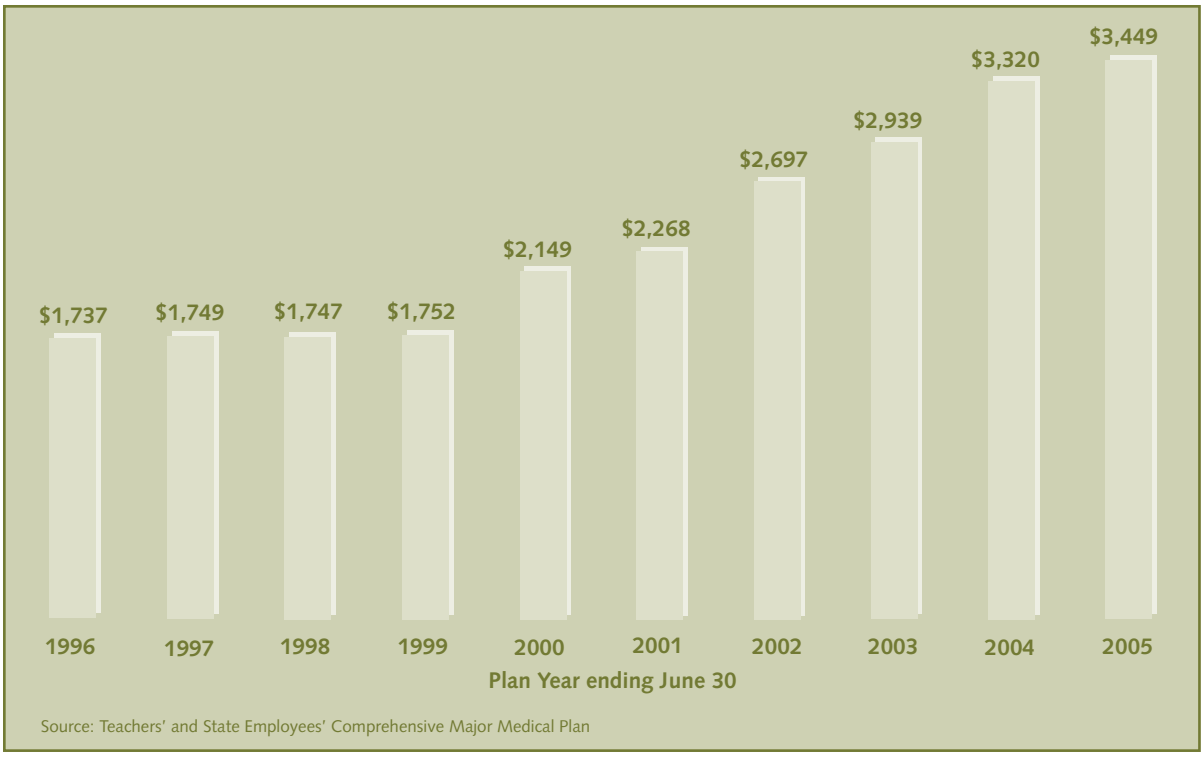
WHY SHOULD NORTH CAROLINA CONSIDER ADOPTING A CONSUMER-DRIVEN HSA FOR STATE EMPLOYEES?

North Carolina's "Teachers' and State Employees' Comprehensive Major Medical Plan" – known simply as the "State Health Plan" – covers approximately 580,000 state employees, public school teachers, and retirees, as well as some of their spouses and dependents.[11] The Plan is managed by Blue Cross and Blue Shield of North Carolina, and operates as a "preferred provider organization" (PPO). As is well known, the Plan has encountered serious financial problems over the past few years, with claims against the Plan exceeding the premiums collected by substantial amounts. Premiums have risen every year since 1998, nearly doubling since 1999 (see chart on the next page).

A recent study by the North Carolina Budget and Tax Center notes the funding shortfalls in the last three biennial budget cycles: $290 million in 1999-2001; $927.3 million in 2001-03; and $540.5 million in 2003-05. In addition, the report notes that "[t]he plan will require an additional $353 million in the upcoming 2005-07 biennium."[12] These shortfalls have been made up partially out of appropriations from state tax revenues, partly out of increases in premiums paid by employees and reductions in employee benefits, and partly out of concessions from providers.[13]

As currently configured, the Plan makes a monthly contribution of $285.92 for each covered, active employee.[14] (Contributions for and by retirees follow a similar structure, but vary according to the retiree's status vis-à-vis Medicare. This is a relatively small consideration, which we will ignore for clarity's sake.) If the employee elects "employee-only" coverage, she pays nothing more. If she elects coverage for herself and her dependent children, she will contribute $178.22 per month. If she elects "family"

Figure A: Health Care Plan Premiums 1996-2005



Source: Teachers' and State Employees' Comprehensive Major Medical Plan

coverage (herself, her spouse, and their dependent children), her monthly contribution is $427.48. As of October 1, 2005, monthly premiums have increased once again. [15] (Table 2 provides a summary of these most recent changes.)

The amounts charged employees electing dependent or family coverage have come under strong criticism, with critics noting that the percentage of the total cost for these policies paid by the employees themselves is much higher than in most other states' insurance plans. This relatively high price for additional coverage helps explain the fact that a large majority of North Carolina employees choose employee-only coverage,[16] and that a recent survey found that 44 percent of state employees said they "could not afford to purchase family coverage" under the State Health Plan.[17]

In addition to the increases in premiums for all but employee-only coverage, critics of the Plan's performance also point to repeated and substantial increases in deductible amounts and co-payments. Currently, the annual deductible is $350 per covered individual, to an aggregate maximum of $1,050 for an employee with dependent or family coverage. The maximum annual out-of-pocket payment for the deductible and co-payments per member will be $1,500 for 2004-05 and $2,000 for 2005-06, up to a family total of $4,500 for 2004-05 and $6,000 for 2005-06.

Premiums have risen every year since 1998, nearly doubling since 1999.

HOW HSAs WORK[18]

The creator of the concept of medical savings accounts, John Goodman, explains HSAs very succinctly:

> "These accounts must be combined with high-deductible health insurance, with patients typically paying expenses before the

Table 2:

	Monthly premiums as of October 1, 2005			Annual premiums as of October 1, 2005		
	State Contribution	Employee Contribution	Combined State and Employee Contribution	State Contribution	Employee Contribution	Combined State and Employee Contribution
Employee-only coverage	$321.14	$0.00	$321.14	$3,853.68	$0.00	$3,853.68
Dependent coverage	$321.14	$200.18	$521.32	$3,853.68	$2,402.16	$6,255.84
Spouse/Family coverage	$321.14	$480.14	$801.28	$3,853.68	$5,761.68	$9,615.36

deductible from their HSA and relying on third-party insurance to pay costs above the deductible. Employer contributions to these accounts are excluded from employees' taxable income and individual contributions are tax deductible. HSAs are the property of the individual, and unspent funds remain in the HSA account and grow tax free."[19]

A high-deductible health plan – sometimes referred to as "catastrophic" health insurance – doesn't pay for the first several thousand dollars of health care expenses, but provides coverage for expenses beyond this deductible. Because of the high deductible, such plans are cheaper, obviously, than coverage under a traditional, lower-deductible health insurance policy. In order to qualify to open an HSA, a person must have a high-deductible health plan with a deductible of at least $1,000 (for self-only coverage) or $2,000 (for family coverage). The annual out-of-pocket (including deductibles and co-pays) cannot exceed $5,100 (for self-only coverage) or $10,200 (for family coverage).[20]

HSA contributions are deductible on federal income tax returns; employer contributions to an HSA are not considered income.

Individuals with the requisite high-deductible coverage may sign up for an HSA at any one of dozens of institutions – including banks, credit unions, insurance companies, and other approved companies. Employers may also set up HSA plans for their employees.[21]

A person may make contributions to his HSA up to the amount of his high-deductible insurance plan each year. For example, if Tom Tarheel buys coverage for his family with a $3,000 annual deductible, he may contribute up to $3,000 annually to his HSA. (Persons age 55 or older can make additional "catch-up" contributions.) There are limits on the amount, which may be contributed annually. In 2005, the maximum for family-coverage policies is $5,250; the maximum for single coverage is $2,650. (The plan is to increase these caps in future years to take account of inflation.) Tom may contribute to his HSA on any schedule he chooses – on a monthly basis, or quarterly, or in a lump sum, for example – subject to any contractual limits he has agreed to with his HSA institution.

Now let's assume that Tom's employer decides to offer a high-deductible health plan with an HSA as an alternative to traditional health insurance, and as part of the plan offers to make a $2,000 contribution each year to each employee's HSA. Tom could make a personal contribution of up to $1,000 a year. In other words, it is treated exactly like an IRA contribution and does not require an itemized tax return. The combination of the employer and employee contributions cannot exceed the annual limits noted in the preceding paragraph.

Tom can take his HSA contribution as an "above-the-line" deduction on his federal income tax return. This allows him to reduce his taxable income by the amount he contributed to his HSA. (It is not necessary to itemize deductions in order to claim this benefit.) His employer's contribution to Tom's HSA is not considered income to Tom; therefore, he does not pay federal income taxes on that amount. Further, contributions can also be made to Tom's HSA by others (e.g., relatives). However, Tom, not the benefactor, would receive the benefit of the tax deduction.

If Tom or any of his covered family members incur health care expenses, Tom will pay the first $3,000 in any given year out of his own funds – either from his HSA or otherwise out of his own pocket. If Tom uses HSA funds to pay "qualified medical expenses," these funds are not counted as income to him, or subject to federal income taxation. If Tom uses HSA funds for non-medical expenses, it is counted as income to him and subject to normal federal income taxes and a 10 percent surcharge. At age 65, Tom may use these funds as he wishes without the surcharge, but, like an IRA, regular income taxes would be paid on withdrawn funds not used for qualified medical expenses.

Unused funds in Tom's HSA "roll over" each year for use in subsequent years. Thus, there is no "use-it-or-lose-it" incentive here. HSA funds can be invested in the same types of investments permitted for IRAs – including stocks, bonds, mutual funds and certificates of deposit. Ideally, the HSA grows year-in and year-out, free from federal income tax, and remains Tom's personal property until its proceeds are used for health care expenses.

Significantly, Tom's HSA money is "portable" in the sense that the account remains his property even if he switches jobs. On his death, Tom's HSA will pass to his wife, if she survives him; otherwise, it becomes part of Tom's (taxable) estate. In other words, HSA funds are fully the property of the account holder and can be left to his or her heirs.

HSAs AND LOWER COSTS

Thus far, the lower cost and greater flexibility associated with HSAs, compared to traditional health insurance, have proved particularly attractive to individuals and to small businesses. According to a survey[22] by the insurance industry group American Health Insurance Plans, by March 2005, its member companies had enrolled more than one million people in HSAs. Approximately 37 percent of the individuals who bought HSA coverage personally had had no previous health insurance coverage, and 27 percent of the small businesses that bought group coverage had previously not offered health insurance as a benefit. For those concerned about the number of uninsured workers in America, this should come as welcome news.

Given the dramatic, year-in, year-out increases in public employees' health care costs, any improvement in performance should be pursued.

Moreover, anecdotal evidence indicates that small businesses can lower their health care costs by using HSAs.[23] For example, one firm with 14 employees reduced its annual health care costs by $35,500 by switching from traditional health insurance to HSAs. Another small business in California offered its 12 employees an HSA alternative, and all 12 chose it. The firm pays for both the high-deductible policy and the HSA – $322 a month per employee for individuals and $360 for families – compared with PPO premiums of $380 for individuals and $460 for a family. The firm's controller says all employees will be ahead financially with the HSA. "It reduces our costs and gives a tax-free bonus to the employee, and it's their choice to spend it or roll it over to a (retirement) account," she said. "It puts some responsibility on the individual consumer for health care choices."[24]

Most of the early evidence shows HSAs to be a boon to small businesses and individuals, and particularly to previously uninsured workers.

What about larger businesses and their employees? To date, HSAs have not been widely adopted by larger employers. To recap the survey of large employers noted above:[25] only 8 percent offered HSA coverage as of early 2005, while another 18 percent planned to begin offering them in 2006, and another 47 percent are studying HSAs as an option. Another indication of how slow larger companies have been to experiment with HSAs is that as of January 2005, Aetna had enrolled only 70 companies with 51 or more employees in its HSA products, and Cigna had only around 30.[26]

This situation looks like it's about to change, perhaps rapidly and radically. Indeed, one estimate is that as many as 25 percent of all commercially insured people will be enrolled in consumer-driven health plans by 2009.[27]

The more dramatic effects of a move to HSAs will come in the longer term, as HSAs teach public employees to be better informed – and thriftier – consumers of health care services.

The first academic study of the effects of the adoption of an HSA-based, consumer-driven plan on utilization and cost are fairly encouraging. The study looked at the experience of one employer with over 3,000 employees, comparing the cost of the HSA plan with the costs of their previous Preferred Provider Organization (PPO) and Health Maintenance (HMO) options. It found, among other things, that enrollees in HSA contracts had lower total expenditures than enrollees in PPO contracts, as well as lower out-of-pocket expenditures.[28] It should be noted that the current North Carolina state employees health plan is a PPO.

The fact remains, however, that right now, state governments cannot look at cost savings data from large employers for evidence of the kinds of cost savings they might achieve in moving to HSAs. Based only on the experience of small businesses and individual purchasers of HSAs, there seems to be some prospect of immediate cost savings for state governments in moving to HSAs, but the short-term potential savings appear to be modest.

Given the dramatic year-in, year-out increases in public employees' health care costs, any improvement in performance should be pursued. But the kind of changes necessary to get some control over North Carolina's burgeoning public employee health care costs – which have doubled since 2000, to the current annual level of $1.8 billion[29] – would seem much more dramatic than the immediate cost savings likely to be generated by a move toward HSAs.

Is this the end of the story for HSAs, then? No. There may be another, larger benefit to be derived from their adoption.

BENEFITS FROM HSAs: CONSUMER-DRIVEN HEALTH CARE

The more dramatic effects of a move to HSAs will come in the longer term, as HSAs teach public employees to be better informed – and thriftier – consumers of health care services. The long-term effects that HSAs will have on the consumption of health care services – and thus its cost – have been the key public policy improvement cited by the proponents of HSAs.

To cite John Goodman once again: Employees with HSAs will "be able to profit from being wise consumers of medical care by having account balances grow tax free and eventually be available for non-medical purchases."[30]

The dramatic break with the past offered by HSAs is highlighted in a recent paper by two McKinsey & Company consultants:

> "For the first time since the introduction of employer-funded health premiums during the Second World War, the government is authorizing health insurance plans that are consistent with efficient markets. These plans at least partially end the third-party-payer system and force people to make economic trade-offs between consuming more health care and other goods and services. With the ability to accumulate unspent funds and invest them tax free,

> consumers have a strong incentive to avoid unnecessary care and to become more cost conscious when they do seek treatment. Medical providers, in turn, will be increasingly pressured to improve the quality of care and service they offer to consumers while maintaining competitive prices."[31]

This is the essence of the idea of "consumer-driven health care," of which HSAs are the most important reform thus far. Consumer-driven plans address head-on the three problems facing American health care identified by the McKinsey authors: "third-party payers that insulate consumers from the financial implications of their health care choices, a lack of transparency in the quality of care and in the prices providers charge, and a reimbursement system that rewards activity over outcomes."[32]

The McKinsey authors explain that HSAs will give employees the incentive to "avoid what they perceive to be unnecessary services and become more cost conscious when they do seek treatment – choosing cheaper generic drugs rather than branded ones, avoiding expensive facilities such as emergency rooms, and showing more discipline about visiting doctors in the payer's medical network." More fundamentally, the impact of HSA incentives will extend to lifestyle decisions, as the possibility of asset appreciation in the form of money left in the HSA, rather than spent on health care, will give employees more of an incentive to stay healthy, as noted by one benefits consultant: "There is going to be an increasing awareness that if I'm healthy, I'm going to be better off financially . . . That's good. It will cause people to change their behavior. And that's not a bad thing."[33]

The benefits from such a change in our way of providing employee health coverage could be immense. But they will take time to materialize and, in any event, will be extremely difficult – or even impossible – to calculate with any degree of accuracy. It would not be accurate to characterize the adoption of HSAs on the basis of these potential gains as a leap of faith, because the logic supporting the long-term claims of HSA is very strong. But, at this point in time, we lack real-world evidence of system-wide improvements due to increased employee and competitor discipline.

CRITICISM AND EVIDENCE

There are certainly doubters and detractors of HSA-based reforms. Some of the more dramatic critics of HSAs tend to focus on a comparison of current, low-deductible health insurance policies with HSAs and then pronounce the latter a "raw deal"[34] or a "cheap trick."[35] But this kind of comparison misses the point. While it is understandable that the beneficiaries of the current system, and their champions, would like to maintain the status quo,[36] the fact is that the current system is increasingly unsustainable over the long run. Its cost has doubled in this decade, and there is no reason to believe that high yearly growth rates in its cost will abate any time soon. Thus, the "raw deal" criticism completely misses the point that state and local governments will change the status quo at some point in the near-term future. While the employee and retiree groups, again understandably, want to put off the date of this change, it will never get any easier to consider changes to the system than it is right now. Delay will increase the costs borne unnecessarily in clinging to the current system, such as foregone appreciation in HSA accounts.

The impact of HSA incentives will extend to lifestyle decisions, as the possibility of asset appreciation in the form of money left in the HSA...will give employees more of an incentive to stay healthy.

A variation on the "raw deal" critique doubts that employees are interested in trying to make decisions about their consumption of health care services, or are capable of doing so. While one might prefer the appearance of a paternalistic system taking care of its

members, this aspect of the status quo is also unsustainable at present (and future) costs. People make decisions about other large questions of life – choice of education, mate, career, home purchase, etc. – and there seems to be no reason why people could not make health care decisions with at least as high a degree of success. Advocates of HSAs recognize the need for additional information and education in order to equip people to make these decisions, and have developed plans to make this happen as HSA usage spreads. While an HSA regime does not promise to be nirvana, neither is the current, unsustainable status quo.

Yet another critique of HSAs involves the phenomenon known as "adverse selection." The worry is that younger, healthier people will be disproportionately attracted to the HSA option, and their departure from traditional insurance pools will cause rates for traditional insurance to rise even faster.[37] This criticism is summed up in the put-down phrase that HSA purchasers are limited to the "young and healthy" or, alternatively, the "healthy and wealthy." While this makes an effective sound bite, it finds very little support in the survey evidence to date. One study found that in 2004, the average age of purchasers of HSA-eligible coverage was 40, while the average age of purchasers of non-HSA-eligible insurance plans was 35. In that same year, 40 percent of all HSA-eligible policies were purchased by people with incomes of $50,000 or below, and 89 percent of purchasers paid a monthly premium of $200 or less per person.[38] Other evaluations of our experience to date are consistent with these findings. For example, a full-dress academic study of the consumer-driven health plan offered to the employees of the University of Minnesota found that it "was not chosen disproportionately by young and healthy, but it did attract the wealthy and those who found the availability of providers more appealing."[39]

The fact is that the current system is increasingly unsustainable over the long run. Its cost has doubled in this decade, and there is no reason to believe that high yearly growth rates in its cost will abate any time soon.

One might worry that this evidence, drawn from such an early stage of this market experiment, will not hold up over time. Yet the point remains that the sky has not fallen, and, to the extent that traditional, low-deductible insurance becomes unaffordable for state and local governments to purchase, the adverse selection point becomes irrelevant.

In sum, much of the criticism of HSAs comes from people who see themselves with a vested interest in the continuation of the status quo – even for a little while longer – and who tend to under-appreciate the power of the marketplace to improve quality and lower price. While taking the HSA route will not be risk- or pain-free, the skyrocketing cost of the status quo virtually guarantees its replacement with another system or systems. Given the attractive features of HSAs – their tax treatment, portability, lack of a use-it-or-lose-it feature, and investment growth potential for their owners – they rank as the most attractive alternative for public employees at this point in time.

HOW NORTH CAROLINA MIGHT PROCEED

The North Carolina General Assembly should seize the initiative on HSAs and pass legislation that requires the offering of a high-deductible/HSA option to state and local employees, by a date certain. This suggestion is modeled on Virginia's recently passed law, which envisions a two-year study and phase-in period in order to reach this goal. North Carolina officials should pursue cooperative opportunities with their counterparts in Florida, Louisiana and Virginia, to take advantage of information-sharing possibilities as those states implement their new HSA statutes. In this way, North Carolina may be able to make the transition to a consumer-driven plan expeditiously.

How could the state redirect the $3,853.68 per employee it currently spends on health insurance into an HSA option? Let's use BlueCross/BlueShield's BlueOptions HSA[40] as an example. The deductible

Table 3:

Comparison of Current State Employee Health Plan with Representative High-Deductible/HSA Plan

	Current Plan Individual	HDHP/HSA Individual	Current Plan Dependent	Current Plan Family	HDHP/HSA Family
Employee Contribution	$0	$550	$2,402	$5,761	$1,100
Plan Deductible	$350	$1,100*	$1,050	$1,050	$2,200*
Plan Maximum Out-of-Pocket	$2,000	$5,000	$6,000	$6,000	$10,000
Maximum Net Cost	$2,000	$4,450	$8,402	$11,761	$8,900

* This is all paid from the HSA, half of which is contributed by the state

- **Employee Contribution:** Under the current plan, this is the annual premium the employee pays over and above the state's payment. Under the HDHP/HSA, it is the employee's contribution to the HSA, matched by the state. This amount is before taxes in both cases.
- **Plan Deductible:** Under the current plan, this amount is paid out of pocket by the employee, after taxes. Under the HDHP/HSA, the HSA is funded to this level and all payments from the account are tax-free. If the individual does not spend up to her deductible, the money in her HSA continues to gain interest and rolls over.
- **Plan Maximum Out-of-Pocket:** In addition to premiums, this is the maximum total of deductible and co-payments the employee is responsible for in a plan year.
- **Maximum Net Cost:** Under the current plan, this is the amount the employee pays in premiums plus the plan maximum. Under the HDHP/HSA, this is the plan maximum minus the state's HSA contribution.

for individuals is $1,100. The state puts $550 into the HSA and the employee can contribute up to $550 before taxes as well. This translates into monthly payments of $45.83 from the state and the employee. The deductible for family coverage is $2,200, meaning monthly contributions of $91.67 from the state and the employee. The state or individual employees could choose higher deductibles, but current State Employee Health Plan deductibles are not far from these.

Most state employees currently choose individual coverage. Dependent coverage costs a state employee about $200 a month. Adding a spouse raises the monthly premium to $480 a month, or $5,761 a year. This creates a significant incentive for state employees' spouses to work and provide coverage for the family. Switching to an HDHP/HSA could eliminate this incentive while also allowing many families to save for future medical bills (Table 3).

Pre-tax contributions into an HSA ($1,100) are much lower than the premium payments to cover a spouse ($5,761) or children ($2,402), and are about equal to the maximum deductible for a family of three under the current plan ($1,050). In case of something catastrophic, the maximum out-of-pocket cost for deductibles and co-payments under the current plan is $6,000, in addition to the $5,761 in premiums. The maximum for a plan that includes coverage for a spouse and children under the high-deductible/HSA is $10,000, but $1,100 of that is provided by the state, making the individual contribution just $8,900.

An HSA also has benefits for individuals. Using the example above, an individual puts $550 into her HSA and the state contributes another $550. The effective deductible for the employee is not $1,100, but $550. This is close to the $350 deductible under the current state employee health plan and becomes closer when one remembers that neither the $550 nor any of the interest that it earns is taxed. If a person has little need for medical care, the extra money continues to earn and can be used for future medical expenses. Again, this money is the employee's, it is

completely portable, and it can be used tax-free for medical expenses or after retirement without penalty for any expense.

At contributions of $550 per individual or $1,100 per family, the state would have between $2,803.68 ($233.64/month) and $3,253.68 ($271.14/month) left for annual insurance premiums per employee. At this point, only anecdotal evidence is available, but it is quite encouraging for the state's ability to purchase a suitable high-deductible health plan. The American Health Insurance Plans survey reported that average monthly premiums for high-deductible plans "ranged from about $100 a month for a twenty-something single to $460 for a family policy in the 55-64 age group."[41] The demographics of state employees will, therefore, affect total savings.

The case of Whole Foods Markets, Inc., is instructive.[42] The company is a grocery retailer, with more than 160 stores and more than 30,000 employees. In 2002 it was facing a $7 million funding shortfall in its traditional self-insurance health plan. To keep the plan solvent, the company considered a premium increase in the range of 30 percent to 35 percent. Instead, in January 2003, it implemented a new consumer-driven plan, using high deductibles and "personal wellness accounts" – the precursor of HSAs. In the new plan, the company paid 100 percent of the premiums for full-time employees, and paid from $300 to $1,800 into each employee's private account, based on seniority. The HDHP deductibles were $1,000 for medical services and $500 for prescription drugs; maximum out-of-pocket for deductibles and co-payments was $3,500.

Whole Foods' first-year results were spectacular. The company's combined policy premiums and contributions to the employees' personal accounts averaged $2,082 per employee – a 25.5 percent decrease over the previous year. In the second year of the plan's operation, the cost per employee increased to $2,988 – due, according to the company's CEO, to greater employee understanding of the plan's features. Even this higher level was just 7 percent higher than its premiums in 2002, when the company was looking at 30 percent higher costs in one year, and was 51 percent lower than the relevant industry average of $5,804. The fact that Whole Foods is able to buy high-deductible coverage and make contributions to the employees' individual accounts for less than $3,000 further suggests that the state of North Carolina might be able to do so as well.

Would state employees now covered by the State Health Plan find our hypothetical HSA alternative attractive? In exchange for the somewhat higher deductibles and co-pays, the employee would receive the investment feature of the HSA, its favorable tax treatment, its rollover and portability features, the ability to use it for retirement income, and the ability to will the account to heirs.

In addition to any cost savings, of course, the North Carolina budget would benefit because future growth in health care expenses would be curbed by the employees' increased attention to their own health care decision-making and the incentive an HSA gives them not to over-utilize the covered health care services. Moreover, HSAs offer the prospect of substantial long-term improvements in health care outcomes and the performance of health care providers. While likely not a "magic bullet" budget fix, the adoption of an HSA plan in North Carolina promises substantial benefits both to state taxpayers and to state employees over the intermediate and long term.

Accordingly, the North Carolina General Assembly should begin to give serious consideration to Health Savings Accounts as an alternative to traditional health insurance coverage for state employees and public school teachers. The alternative is to wait until the current system results in a large enough budgetary train wreck to force the consideration of alternatives in an emergency atmosphere. Even under those circumstances, HSAs will be the most attractive alternative from the point of view of most public employees. However, waiting for a train wreck wastes time that could be used by HSA investors to grow their account balances.

End Notes

1 Pub. L. No. 108-173 (2003).

2 Pub. L. No. 108-173, § 1201 et seq., codified at 26 U.S.C. § 223, and scattered other sections.

3 Press Release, "More Employers Adopting Health Management, Consumer-Directed Programs to Control Costs," Watson Wyatt Worldwide, March 17, 2005, www.watsonwyatt.com/news/press.asp?ID=14366

4 Grace-Marie Turner, "Consumerism in Health Care: Early Evidence is Positive," *Health Issues*, Galen Institute, August 11, 2005, www.galen.org/fileuploads/Consumerism.pdf

5 "'Consumer-Directed Health Plans': Implications for Health Care Quality and Cost," RAND Corporation, June 2005, www.chcf.org/documents/insurance/ConsumerDirHealthPlansQualityCost.pdf (for the California Health Care Foundation).

6 "Consumer-Directed Health Plan Report – Early Evidence Is Promising," McKinsey & Company, June 2005, mckinsey.com/clientservice/payorprovider/Health_Plan_Report.pdf

7 Louisiana provides HSA coverage for local, as well as state, government employees.

8 The website of the Council for Affordable Health Insurance lists 14 state legislatures that considered HSA legislation in 2005. See "HSA State Implementation Report," www.cahi.org/cahi_contents/consumerinfo/implementationguide.asp In addition, the Texas and Washington legislatures appropriated funds for feasibility studies of HSA coverage for state employees. See Texas H.B. 2772 (2005) and Washington S.B. 6090 (2005). In Kansas, senate Republicans proposed a pilot HSA program for state employees. Press release, "Senate GOP Health Care Proposals An Important Step," Flint Hills Center for Public Policy, Jan. 20, 2005, http://www.flinthills.org/Non%20master%20articles/Senate%20GOP%20health%20care%20proposal%20news%20release.htm For more information on state legislative developments, see the website of the National Conference of State Legislatures, www.ncsl.org/programs/health/hsa.htm

9 "HSA Project Goals," Center for Health Transformation, www.healthtransformation.net/projects/health_savings_accounts/657.cfm

10 Julie Miller, "HSAs catching on, but surveys disagree about how well," *Managed Healthcare Executive*, Mar. 1, 2005, www.managedhealthcareexecutive.com/mhe/article/articleDetail.jsp?id=150886

11 This number is from April 2005. "A breakdown of that total includes: more than 340,000 active employees; 144,000 dependents and non-Medicare retirees; and nearly 93,000 retirees and their nearly 4,000 dependents with one or more members covered primarily by Medicare. Dependents include spouses and unmarried children under age 19 (or under age 26 if full-time students)." Found at http://statehealthplan.state.nc.us/aboutus.html

12 Amna Cameron, "The State Employee Health Plan: Costly for the State and Plan Members," *BTC Reports*, Vol. 11, No. 7 (June 2005), at p. 2. www.ncjustice.org/media/library/375_btcrpthlth682005.pdf

13 Ibid. at pp. 2-3.

14 According to the Plan's website, these rates went into effect on October 1, 2003. See http://statehealthplan.state.nc.us/benefits/benefits_monthlyrates.html.

15 See http://statehealthplan.state.nc.us/benefits/benefits_monthlyrates_new.html.

16 Out of a total of 295,634 active employees enrolled in the State Plan, 228,125 have employee-only coverage, or a bit more than 77%. See Cameron, supra note 12, at p. 2, Figure 1.

17 Ibid., at p. 1.

18 This section relies heavily on the explanations provided by the U.S. Department of the Treasury, www.treas.gov/offices/public-affairs/hsa/

19 John C. Goodman, "Bush Health Plan: Consumer-Driven Health Care," National Center for Policy Analysis, Brief Analysis No. 486, Sept. 20, 2004, www.ncpa.org/pub/ba/ba486/

20 As of April 1, 2005, the North Carolina Department of Insurance reported that there were eleven life insurance companies doing business in the state that write HDHP policies. See www.hsainsider.com/find_insurer.asp

21 Of the eleven life insurance companies noted in footnote 20, eight offer HSA accounts as well as high-deductible coverage. Of these eight, four market to large groups only (CIGNA, Mutual of Omaha, UNICARE, and UnitedHealthCare) and one (Great-West) markets to small as well as large groups.

22 The survey is described in "Number of HSA Plans Exceeded One Million in March 2005," www.ahipresearch.org/pdfs/HSAExceedMillion050405_summary.pdf

23 Joe Gardyasz, "Health Savings Accounts can save big money," *Des Moines Business Record*, Mar. 27, 2005, www.businessrecord.com/Main.asp?SectionID=8&SubSectionID=9&ArticleID=1767 .

24 Jan Norman, "HSAs gaining favor as health insurance option," *The State* (Columbia, S.C.), Mar. 21, 2005 (appeared originally in the *Orange County Register*).

25 See footnote 3 and accompanying text.

26 Tracy Byrnes, "Health Savings Accounts Worth the Investment," *TheStreet.com*, Jan. 13, 2005, www.thestreet.com/pf/funds/investorforum/10203081.html

27 Paul D. Mango & Vivian E. Riefberg, "Health savings accounts: Making patients better consumers," *The McKinsey Quarterly*, Jan. 2005, www.mckinseyquarterly.com/article_page.aspx?ar=1567&L2=12&L3=63 (registration required). See also Kent Hoover, "HSA's to dominate small business marketplace," *East Bay Business Journal*, Mar. 18, 2005, www.bizjournals.com/eastbay/stories/2005/03/21/focus2.html?page=1

28 Stephen T. Parente, Roger Feldman & Jon B. Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization," *Health Services Research*, vol. 39 (2004), pp. 1189-1209 (2004). It should be noted that not all their results were favorable to the CDHP. They found, but could not explain, higher hospital usage by CDHP enrollees, as well as a higher "illness burden" among them. In addition, the employer studied experienced higher costs in the second year of the program. Not surprisingly, the authors called for further research on these questions.

29 Jean P. Fisher, "Prophet in his time," Raleigh *News and Observer*, March 31, 2005, www.newsobserver.com/business/v-printer/story/2266704p-8645983c.html

30 John C. Goodman, "Health Savings Accounts Will Revolutionize American Health Care," National Center for Policy Analysis, Brief Analysis No. 464, Jan. 15, 2004, www.ncpa.org/pub/ba/ba464/

31 Mango & Riefberg, cited in footnote 27 (emphasis added).

32 Ibid. More information on consumer-drive health care can be obtained on the websites of the National Center for Policy Analysis, cdhc.ncpa.org, the Flint Hills Center for Public Policy, www.flinthills.org, and the Galen Institute, www.galen.org

33 Quoted in Hoover, cited in footnote 27.

34 Linda Stern, "Pumped-Up Savings or Just a Raw Deal?" *AARP Bulletin Online*, July-August 2004, www.aarp.org/bulletin/yourmoney/Articles/a2004-08-11-rawdeal.html

35 Barbara T. Dreyfuss, "Cheap Trick," *The American Prospect Online*, Aug. 13, 2004, www.prospect.org/web/printfriendly-view.ww?id=8345

36 An attempt to prohibit funding or otherwise restrict HSAs being offered to federal employees, led by U.S. Reps. Jim Moran (D.-Va.) and Eleanor Holmes Norton (D.-D.C.), failed by a 42-vote margin in the House in October 2004. The legislation was vigorously supported by the National Association of Retired Federal Employees (NARFE). "Two Amendments to Restrict or Defund Health Savings Accounts for Federal Employees Fail on the Floor of the U.S. House of Representatives," *The HSA Insider*, Oct. 22, 2004, www.hsainsider.com/hsainsider_v1_n19.pdf. A quick check of the public sections of the NARFE website (most of which is restricted to NARFE members) doesn't turn up any evidence of current lobbying activity against President Bush's efforts to extend an HSA option to federal employees, but this does not prove that the organization – and others like it – have dropped their opposition to HSA-based reform.

37 Adverse selection was the key worry in two reviews of HSA bills from the legislative research bureaus in Montana and Wisconsin. The Montana report, data.opi.state.mt.us/bills/2005/FNPDF/SB0467.pdf, concluded that "it is not possible to predict whether or not developing a HSA and its assorted HDHPs in conjunction with the other health plans offered by the state, would have a net fiscal impact." The Wisconsin report, www.legis.state.wi.us/2005/data/fe/SB-131fe.pdf, reached a darker conclusion: "[T]here would be a continued and growing disparity between the cost of the current state plans and the cost of the HDP (because of adverse selection) resulting in ever increasing contribution amounts to the HSAs of people enrolled in the [consumer-driven health plan]." This degree of pessimism seems to be based on a static view of the situation, with no expectation of any improvement in employee health decisions or provider performance.

38 See "Health Savings Accounts: The First Year in Review," eHealthInsurance.com, Feb. 15, 2005, image.ehealthinsurance.com/ehealthinsurance/ReportNew/0215052004HSA1stYrRev.pdf

39 Stephen T. Parente, Roger Feldman & Jon B. Christianson, "Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting," *Health Services Research*, vol. 39 (2004), pp. 1091-1111 (2004).

40 http://www.bcbsnc.com/plans/cdhp/hsa/eligible.cfm

41 As described in Turner, supra note 4, at pp. 3-4.

42 This paragraph is based on the keynote address given by John Mackey, the Chairman and CEO of Whole Foods, at the annual meeting of the State Policy Network, in October 2004. For the power point slides from this presentation, go to www.spn.org/newsite/main/past_event_details.php?past_event_id=20

Appendix

Employer-Paid Premiums under the State Health Plan by Plan Year*

	Active Employees		Retired Employees	
Plan Year (4)	Annual Premiums Collected ($Millions)	Average Annual Enrollment	Annual Premiums Collected ($Millions)	Average Annual Enrollment
1995-1996	$341.011	196,300	$117.259	81,500
1996-1997	$328.462	187,786	$121.477	84,491
1997-1998	$321.901	184,263	$125.550	87,242
1998-1999	$334.388	190,854	$131.759	91,475
1999-2000	$432.624	201,326	$170.560	96,086
2000-2001	$540.449	238,330	$195.661	103,301
2001-2002	$734.636	272,349	$259.853	111,338
2002-2003	$822.006	279,677	$291.633	117,531
2003-2004	$951.262	286,511	$342.183	122,643
2004-2005	$1,013.687	293,918	$371.370	127,811

Data Source: Teachers' and State Employees' Comprehensive Major Medical Plan

***Notes:**

(1) Data excludes enrollment counts and premium contributions made on behalf of eligible employees and retired employees who participated in an optional HMO offering, or effective January 1, 2005, employees or retired employees who are TRICARE eligible who opted to forego employer-paid coverage under the Plan and instead elect to receive an employer-paid contribution of $63.50 per month for a TRICARE supplemental insurance program.

(2) HMO options ended September 30, 2001.

(3) Premium amounts may include some amount of employee-paid premiums paid by employees who do not qualify for fully contributory health benefit coverage.

(4) Plan year runs from July 1 through June 30.

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"To prejudge other men's notions before we have looked into them is not to show their darkness but to put out our own eyes."

JOHN LOCKE (1632–1704)

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