

HSA Funding

Are Health Care Consumers Leaving Money on the Table?

A Vimo Research Group™ Report

Expert, independent and objective health care analysis

Compiled by the Vimo Research Group
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Consumer directed health plans are poised for rapid growth and could provide coverage to as many as fifty million Americans within four years.

Background

Millions of Americans are currently enrolled in or will soon consider a relatively new health benefit option known as a consumer directed health plan. As indicated in Figure 1 below, consumer directed health plans are poised for rapid growth and could provide coverage to as many as fifty million Americans within four years.

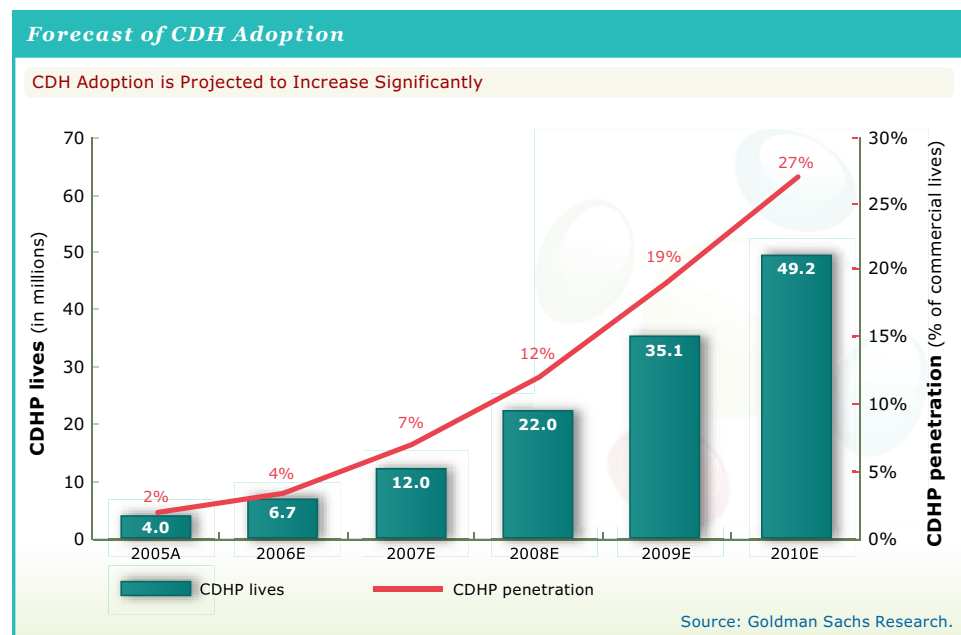


Figure 1

In general, consumer directed health plan designs include high deductibles and tax advantaged personal accounts. These financial incentives are intended to encourage a sense of ownership through more direct control over one's health resources and decision making.

There are several types of personal accounts that may accompany consumer directed plan designs. These account types include: Health Savings Accounts (HSAs); Health Reimbursement Arrangements (HRAs), and; Flexible Spending Accounts (FSAs). This particular Vimo Report™ will focus on HSAs since the accounts are a prominent component of consumer directed health plans within both the individual and employer sponsored health insurance markets. In

addition, there are emerging trends in HSA market that should be of interest to all stakeholders within the health care system.

Briefly, HSAs are highly tax advantaged personal accounts that are used to fund health spending. HSAs were created through the Medicare Modernization Act and they will have been in existence for three years at the end of December 2006. Although HSAs are private property and belong to the individual, the sources of incoming funds are varied and include: individual contributions, employer contributions, and contributions from unrelated third parties.

This Vimo Report™ will discuss funding trends that have emerged within the HSA market over the past several years. From Vimo's perspective, HSA funding levels are a key indicator of the health of the consumer directed movement. By focusing on recent enrollment statistics, it is clear that there is a significant gap between high deductible health plan enrollment and HSA adoption. Not surprisingly, it is also evident that HSA asset levels are deficient.

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Both indicators point to a troubling trend within the budding CDH industry. Inadequate HSA funding levels will be especially detrimental to the healthcare consumer if the trend continues over time. The good news is that the consumer directed movement is still very young, and there is time to set the ship on a new course. Awareness and action are required as there is much at stake for both the individual consumer and the industry as a whole.

HDHP Enrollment Trends

At the highest level, there are two pillars that support any health funding approach that employs HSAs. HSAs must be combined with "qualified high deductible health plans" (HDHPs). In other words, an individual must enroll in a HDHP before they open an HSA.

A survey conducted by AHIP or America's Health Insurance Plans (www.ahip.org) indicates that almost 3.2 million (3,168,000) HDHPs existed as of January 2006.

In the survey, AHIP's Center for Policy and Research (www.ahipresearch.org) explains that:

- Approximately 977,000 of these plans had been created in the employer-sponsored or "group" market.
- The number of HDHPs in the individual health insurance market numbered 855,000.
- The additional number of HDHPs that were not definitively categorized in either the individual or employer sponsored market totaled 878,000.

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HSA Adoption and Assets Under Management

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A separate survey conducted by the industry trade publication *Inside Consumer Directed Care* (<http://www.aishealth.com/AISConsumerDirected.html>) provides statistics on the state of the HSA market as of January 2006.

According to the *Inside Consumer-Directed Care* survey:

- 820,000 HSAs existed as of January 2006.
- The assets that existed in these 820,000 HSAs totaled \$967 million.
- Based upon the figures above, the average HSA balance was approximately \$1,180.

The simple fact is that HSA creation and asset levels are lagging HDHP enrollment by a significant margin.

An Emerging Trend?

Although both of the surveys referenced above are limited in the sense that they are based on two years of data within a brand new market, the figures do provide clear indication of a trend that is supported by anecdotal data from the employer sponsored market. As evident in Figure 2 below, the simple fact is that HSA creation and asset levels are lagging HDHP enrollment by a significant margin.

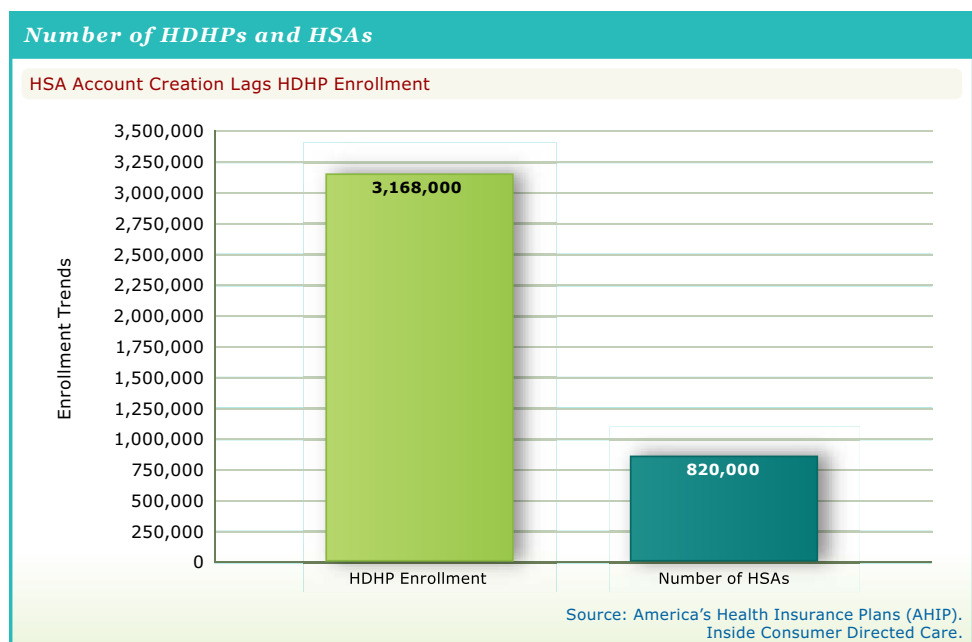


Figure 2

Figure 2 provides a couple of points to consider. First, the difference between HDHP and HSA means that there are a lot of individuals within the group and individual markets who aren't opening HSAs, even though they're entitled to them.

Second, HSA asset levels are also lackluster. The same AHIP study lists the average HDHP deductibles as HDHPs \$2,378 for single coverage and \$4,760 for family coverage. The average HSA balance in the *Inside Consumer Directed Care* survey (\$1,180) is less than fifty percent of the average deductible for single coverage.

The data is also supported through anecdotal evidence. Many employers and individual policyholders seem to view CDH as some sort of cost containment panacea. Certainly there are immediate and significant savings available when companies or individuals migrate to HDHPs. This cost differential can be pocketed as a one time gain, or it can be used to fund most or all of the HDHP deductible by depositing the difference into an associated Health Savings Account. It would seem that many employers are opting for the one time gain.

The point of CDH is not to avoid spending money on health care, but rather to replace insurance with tax advantaged savings accounts that are owned and controlled by individuals.

Vimo's view is that treating consumer directed plans solely as cost containment tools misses the point almost entirely. Americans should be focused on the fact that the triple tax advantages of HSAs make them the most powerful qualified savings vehicles available. In addition, the point of CDH is not to avoid spending money on health care, but rather to replace insurance with highly tax advantaged savings accounts that are owned and controlled by individuals. Empowering the health care consumer by putting them in direct control of their own resources will lend rationality to the health care system by providing suppliers with incentives to compete on the basis of price and quality.

The Stakes are High

It is in the interest of all parties within the health care system—particularly individual consumers—to think about what is at stake as we migrate from managed care to consumer directed care. As evident in Figures 3 and 4 below, health care is the largest sector of the economy, representing almost two trillion dollars and sixteen percent of the value of all goods and services produced in the country in 2005.

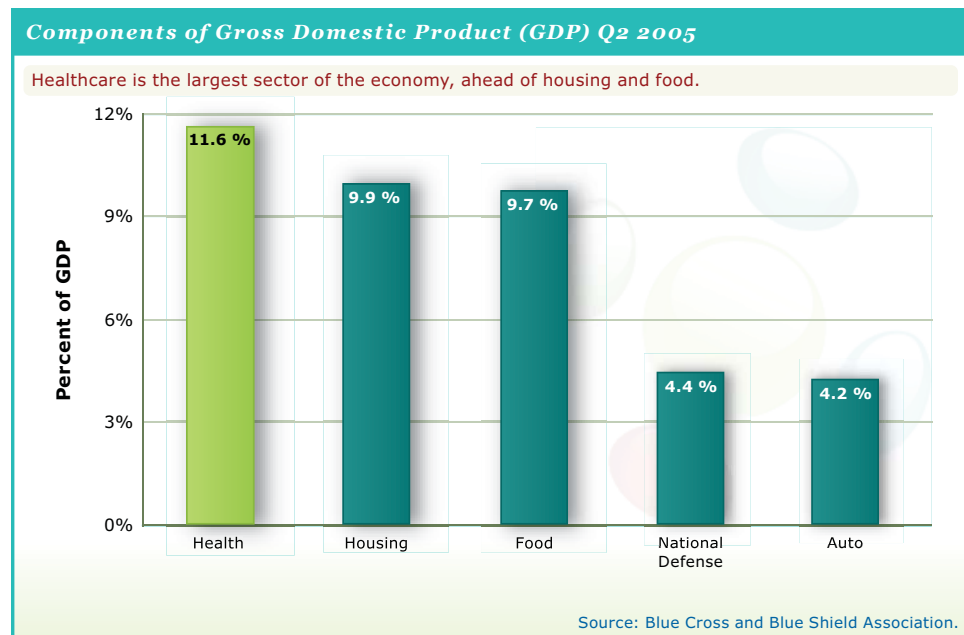


Figure 3

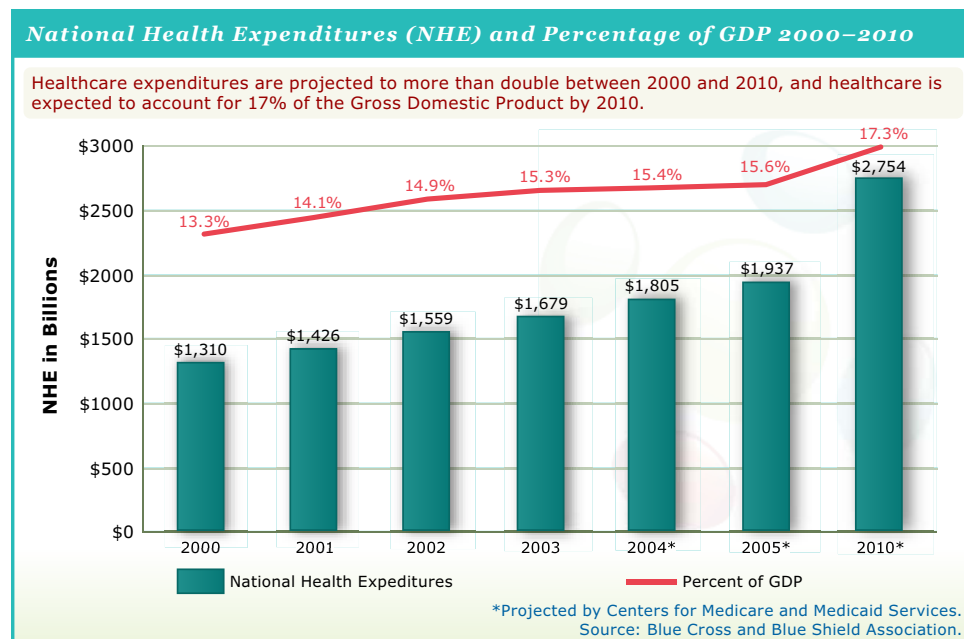


Figure 4

There are many sources of funds within the health system. Generally, funds may come from public sources such as Medicare and Medicaid, or they may originate in the private sector. Private sector funds are the focus of this report since this is where virtually all CDH adoption is taking place. Figure 5 below reveals that

private health insurance pays for approximately thirty six percent of all health spending.

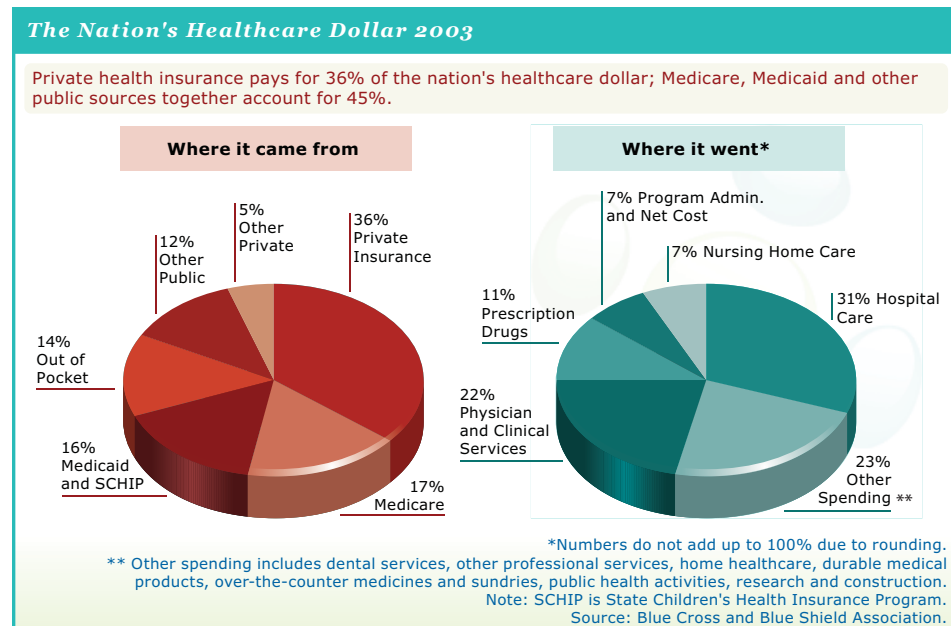


Figure 5

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It can be inferred from the figures above that approximately \$720 billion is currently spent on private health insurance in the United States. This is a massive amount of money that is not top-of-mind for many Americans—particularly those whose coverage is provided and paid for by an employer.

To get a sense of the magnitude of private health insurance spending, it is worthwhile to make a comparison to other sectors of the economy that have a higher profile. The U.S. stock market, which represents the corporate income flows of American businesses, provides a good basis for comparison.

The Dow Jones Wilshire 5000 Composite Index is a broad index that measures the performance of all U.S. equity securities. The total market value of this index is approximately \$16 trillion. The price to earnings or P/E ratio of this index is 19.3. As a result, it can be inferred that the cash flows that support the \$16 trillion valuation are roughly \$829 billion annually.

Private health insurance spending is also a cash flow that should rightly be viewed as a significant asset.

Private health insurance spending is also a cash flow that should rightly be viewed as a significant national asset. Applying the stock market’s multiple of 19.3 to private health insurance cash flows results in a capitalized asset that totals \$13.9 trillion, or eighty seven percent of the value of the U.S. equity market (see Figure 6 below).

Private health insurance premiums are not—at the moment at least—packaged into securities that are tradable in a financial market. The point of this exercise, however, is simply to drive home the magnitude of private health insurance premiums as a source of wealth. Stock markets loom large in the popular consciousness, but the cash flows involved in private health insurance are nearly as large. The analogy is simply intended to highlight the importance of health insurance spending.

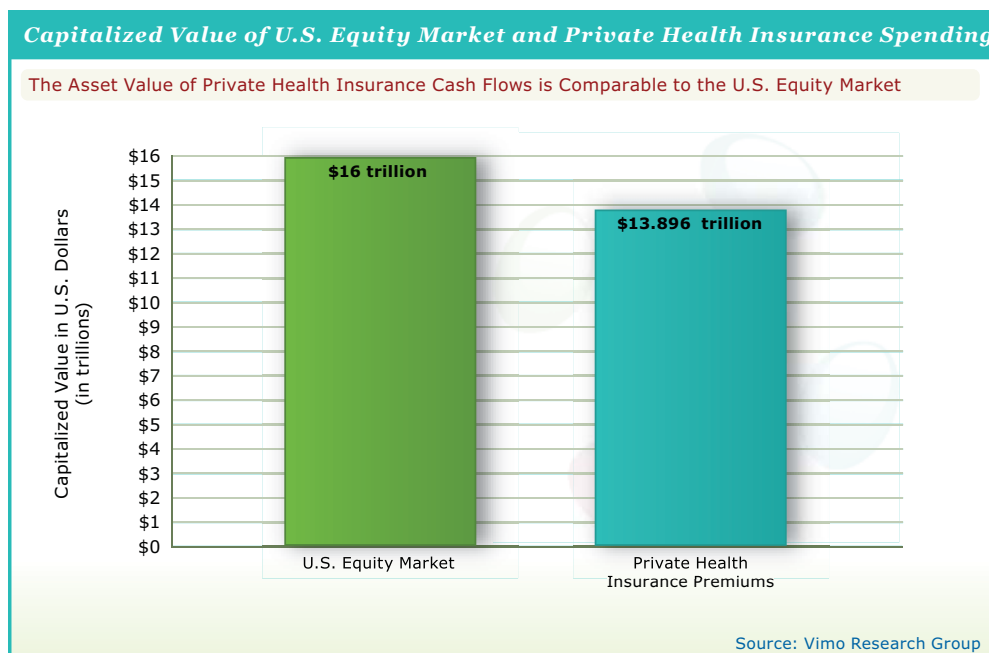


Figure 6

Health care accounted for roughly eight percent of total employee compensation from 2001 - 2003.

The Impact on Compensation

Although not widely acknowledged by employees or the press, benefits are a large portion of overall compensation. As indicated in Figure 7 below, health care accounted for roughly eight percent of total employee compensation from 2001 - 2003. This percentage has likely increased over the past couple of years due to high levels of recent health care inflation. For example, a recent study by the Kaiser Family Foundation (www.kff.org) points out that the average health insurance premium cost for family coverage is currently \$11,480 per year. This figure looms large when compared to the median household income in the United States: \$46,326.

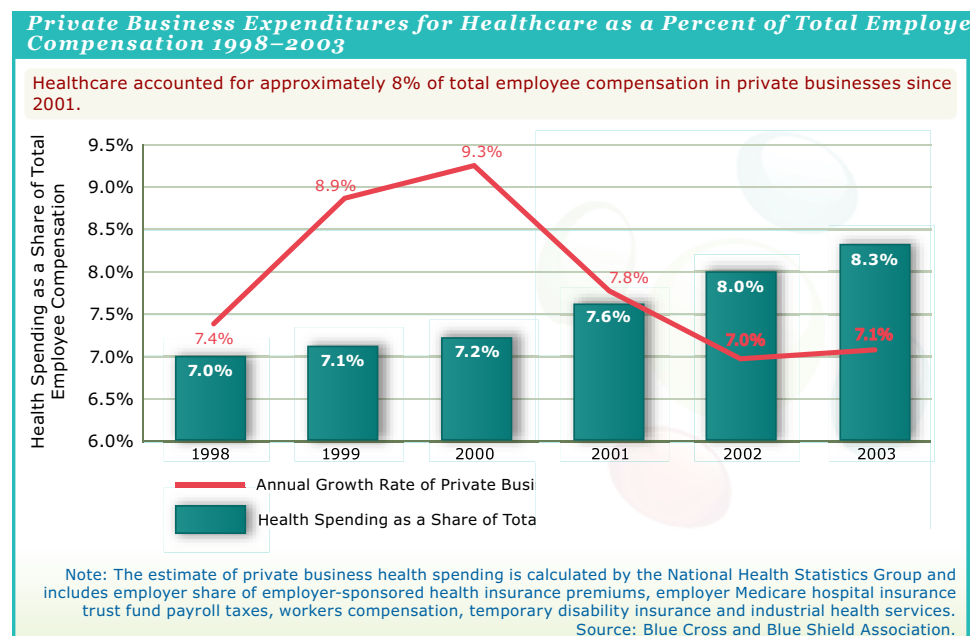
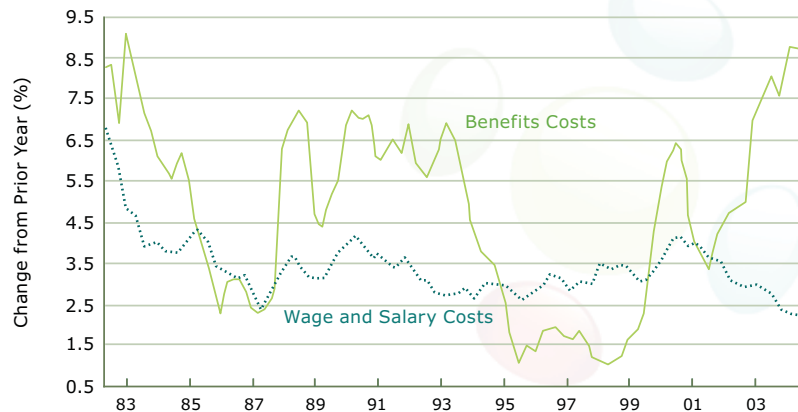


Figure 7

The impact of health spending on overall compensation is especially clear when comparing growth trends within the two areas. When adjusted for inflation, wages and salaries have grown very little over the past three decades (see Figure 8 below). In contrast, the costs of health care and employee benefits have increased at a pace well above the rate of inflation.

Benefits Costs vs. Wage and Salary Costs, 1982–2004

Benefit Costs are Growing at a Much More Rapid Pace than Wage and Salary Costs



Note: Data from second quarter 1982 through third quarter 2004.
Source: Financial Analysts Journal, Jul 2005, Vol. 61, No. 4: 29-41

Figure 8

Anything that affects the value of health insurance will have an especially large impact on compensation since the wage and salary components of compensation are relatively stagnant.

The moral of this story has two fundamental points:

- 1) Health insurance is a large and growing part of compensation, and therefore;
- 2) Anything that affects the value of health insurance benefits offered to employees will have an especially large impact on compensation since the wage and salary components of compensation are relatively stagnant.

Breaking it Down – An Individual Scenario

Consider, for example, the hypothetical “average employee.” This employee and her family are currently covered by a health insurance plan that costs \$11,480 per year—the average annual premium from the Kaiser Family Foundation study.

Next, let’s assume that this person’s employer transitions to a high deductible health plan coupled with an HSA. The annual premium for this HDHP is \$3,951.

From Vimo's standpoint, the health care consumer must remain aware of their interests and of what is at stake during this period of change.

\$3,951 happens to be the average annual premium (for a person age 30-54) for the best selling family HDHP in the AHIP study. The cost difference between these two health insurance plans is \$7,529.

This employer now has a choice, and the decision will have a profound impact on the hypothetical employee's compensation. One option for the employer would involve using a large part of the \$7,529 cost difference to fully fund the employee's HSA. An alternative scenario would have the employer providing a more meager level of HSA funding—say \$1,000—while pocketing a very large, one time gain.

If the employer chooses the latter option, then the gain is clearly at the employee's expense because the financial value of the consumer directed health plan is \$4,951 (HDHP premium + \$1,000 HSA contribution) while the financial value of the current program is \$11,480. This fifty seven percent decrease in health plan value is a direct blow to the employee's compensation, and this is exactly the type of effect that could spell disaster for the consumer directed care movement.

Transitioning from conventional health insurance programs to CDH should simply involve converting a portion of this existing asset from insurance to savings.

Conclusion

Health care is in a period of transition. The consumer directed health care field is young, and the participants—both individuals and institutions—still have much ability to shape the course of the industry. From Vimo's standpoint, the health care consumer must remain aware of their interests and of what is at stake during this period of change.

Consider, for example, the larger implications if HSA funding levels continue to be anemic over the next several years. As indicated in the individual scenario above, deficient levels of HSA funding can have a profound impact on a person's compensation and wealth. Inadequate HSA funding can decrease the value of a person's benefit program by as much as sixty percent.

Hundreds of millions of dollars are being left on the table by virtue of the fact that many individuals are enrolled in HDHPs but have not taken the opportunity to open an HSA.

In addition, hundreds of millions of dollars are being left on the table by virtue of the fact that many individuals are enrolled in HDHPs but have not taken the opportunity to open an HSA. In January 2006, there were 2,348,000 more HDHPs than HSAs. Assuming an average HSA contribution of \$1,000 and a 28% marginal tax rate, the American health care consumer left behind \$657,400,000 in tax benefits. Further, this figure does not include the additional tax benefits that would accrue to individuals through the tax advantages on capital gains and distributions.

Summing less than positive individual experiences over the larger private health insurance market drives home the magnitude of the potential problem. Say, for instance, that growth projections prove accurate and that twenty seven percent of the private health insurance market consists of CDH plans by 2010. The possibility of a significant wealth reduction on such a scale should be grabbing major headlines. How, for example, might people react to a twenty or thirty percent decrease in their equity holdings or home values? What might the headlines and media coverage look like? What might the “wealth effects” be?

On the other hand, though, the transition to consumer directed health care can be viewed as a once in a lifetime opportunity. The reality is that we have a “fully funded” private health insurance system at the moment. In other words, the assets or cash flows that support private health insurance system are real and robust. Transitioning from conventional health insurance programs to CDH should simply involve converting a portion of this existing asset from insurance to savings.

We have a choice. We can engage in a zero sum take away that is largely at the expense of employees and individual policyholders, or we can embrace a once in a lifetime, golden opportunity to put real wealth and decision making power into the hands of the health care consumer.

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About Vimo

Vimo is the nation's first integrated comparison-shopping portal for healthcare products and services. On January 24, 2006 we launched a website that allows businesses and consumers to research, rate and purchase health insurance plans and Health Savings Accounts (HSAs), and choose doctors from across the country. Vimo brings together a variety of private and public data sources so that shoppers can find a physician and compare hospital prices for medical procedures. Vimo users can read and post reviews about any of the services or products available.

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