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Health Savings Accounts and High-Deductible Health Plans: A Data Primer

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Abstract. Individuals began establishing health savings accounts (HSAs) in 2004. These savings accounts are generally used to pay for unreimbursed medical expenses on a taxadvantaged basis. Any unspent money accrues to the individual. To open an HSA, the individual must enroll in a qualifying high-deductible health plan (HDHP). HSAs are tax-advantaged and provide some incentives for people to monitor, and perhaps reduce, their expenditures on health care. Data covering enrollment and/or cost sharing during the first few years of HDHPs and their associated HSAs are now available from at least six separate sources. Two sources provide data on HSAs, two sources provide data on HSAs and Health Reimbursement Accounts (HRAs) combined, and two sources provide data on HSAeligible HDHPs. Before analysts can evaluate the effects of HSAs, they must decide which data source(s) to use. This primer provides basic guidance in that direction. The primer also provides the most recent data available from each source on enrollment, premiums and deductibes for HSAs, HSAs and HRAs combined, and HDHPs.

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Health Savings Accounts and High-Deductible Health Plans: A Data Primer

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Summary

Individuals began establishing health savings accounts (HSAs) in 2004. These savings accounts are generally used to pay for unreimbursed medical expenses on a tax-advantaged basis. Any unspent money accrues to the individual. To open an HSA, the individual must enroll in a qualifying high-deductible health plan (HDHP). HSAs are tax-advantaged and provide some incentives for people to monitor, and perhaps reduce, their expenditures on health care.

Data covering enrollment and/or cost sharing during the first few years of HDHPs and their associated HSAs are now available from at least six separate sources. Two sources provide data on HSAs, two sources provide data on HSAs and Health Reimbursement Accounts (HRAs) combined, and two sources provide data on HSA-eligible HDHPs. Before analysts can evaluate the effects of HSAs, they must decide which data source(s) to use. This primer provides basic guidance in that direction. The primer also provides the most recent data available from each source on enrollment, premiums and deductibes for HSAs, HSAs and HRAs combined, and HDHPs.

Individuals were first able to establish health savings accounts (HSAs) in 2004. These accounts allow people to pay for out-of-pocket medical expenses on a tax-advantaged basis. Individuals must have a qualifying high-deductible health plan (HDHP) to establish an HSA. After establishing an HSA, individuals (or employers) can contribute money to the account up to an annual maximum.[1]

Although commonly discussed in combination, HSAs should not be confused with Health Reimbursement Accounts (HRAs). Although HRAs are also used to pay for unreimbursed medical expenses on a tax-advantaged basis, only employers may establish

[1] For self-only coverage, the annual deductible in 2008 for an HDHP must be at least $1,100 (with the plan's annual out-of-pocket limit not exceeding $5,600). The annual HSA contribution limit in 2008 for individuals with self-only coverage is $2,900. An explanation of the rules governing HSAs can be found in CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2008*, by Bob Lyke.

and contribute to an HRA. In addition, employees usually forfeit any remaining HRA funds at the termination of employment.[2]

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Data Sources

Table 1 identifies the six data sources with data on HSAs, HSAs and HRAs combined, and HSA-qualified HDHPs. The various data sources include a survey of large firms, a survey of individuals, data on all policies reported to an association, data from those who purchase individual policies online, and a sample of IRS tax returns. The data sources are listed in alphabetical order.

Which data source to use depends primarily on the question being asked. If the policy question truly requires information on HSAs — that is, the actual accounts rather than the associated HDHPs — then only the IRS and Kaiser/HRET sources are suitable.[3] The IRS data, which are broken down by tax reporting units, provide the total number of tax deductions taken and the aggregate value of the deductions. The Kaiser/HRET data include the number of working adults with HSAs, premiums and cost-sharing features of the insurance plans, and various characteristics of the employer. Two disadvantages of the IRS data are a total lack of information on the associated HDHPs and that the data are released well after the other data sources.

Two sources combine data on HSAs and HRAs. These data can be used if separate analyses of HSAs or HRAs are not necessary. EBRI provides enrollment estimates for privately insured individuals aged 21 to 64, while Mercer provides enrollment estimates for adults working in firms with at least 10 employees. The EBRI data are based on a survey of individuals and contain information on the workers' ages, incomes, health status, and opinions of their health plan options. The Mercer survey is of firms and contains information on firm size and whether the firm predicts it will offer an HSA or HRA in the coming year. Choosing between these two data sources comes down to a choice between an individual-level analysis (EBRI) or a firm-level analysis (Mercer).

Finally, two additional data sources provide information on HSA-qualified HDHPs. The AHIP data are obtained from insurance plans and measure all covered lives in the

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[2] For additional information on the differences between HRAs and HSAs, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.

[3] Approximately one-third of the insurers that provided HDHP information to AHIP also reported information on enrollees' HSA accounts. However, because this information was provided on a voluntary basis, the sample is non-random and not necessarily representative.

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plans. Both individual and group plans are analyzed. The data form virtually a census of such policies among AHIP member companies. Thus, the AHIP data are based on a large number of enrollees in high-deductible health plans. Along with the average premiums and deductibles, information on enrollees' age and state of residence is also available. Compared with the AHIP data, the eHealthInsurance data are less comprehensive because only individual policies purchased through the company's website are included. However, like the AHIP data, information on premiums and deductibles is available. Of course, individuals who purchase insurance online through eHealthInsurance may differ greatly from individuals who purchase insurance from agents.

Enrollment

Table 2 presents the most recent available data on enrollment, premiums, and deductibles for the six sources. Four of the sources contain data on enrollment. As shown in **Table 2**, the enrollment estimates differ greatly. These differences occur because each source measures a unique concept. Kaiser/HRET estimates that 1,900,000 working adults (in firms with at least three employees) were enrolled in an HSA in 2007. The IRS data do not measure enrollment but report that 215,781 returns claimed an HSA deduction in 2005. These populations, enrollment definitions, and years are too dissimilar to provide meaningful comparisons. EBRI reports that 2,300,000 individuals between 21 and 64 were enrolled in either an HSA or HRA in 2006. Mercer reports that 5% of all covered employees (in firms with at least 10 employees) have either an HSA or HRA, also in 2006.

Although none of these numbers is directly comparable, it is reassuring that the number of HSAs from Kaiser/HRET is smaller than the number of HSAs plus HRAs from EBRI. The number of individuals who claim deductions for HSA contributions in 2005 is the smallest of all, as would be expected for two reasons: (1) the number of HSAs has been growing over the 2005 to 2007 period, and (2) not all individuals contribute money to the HSA — and of those who do, not all claim an HSA deduction. The AHIP enrollment numbers are the largest because they show enrollment in an HSA-qualified HDHP (regardless of whether an HSA account was actually established) from group coverage as well as individual coverage.

Premiums and Deductibles

AHIP provides the most complete information on premiums and deductibles; the average values are available for the small group and large group markets, and for three age groups in the individual market. No other data source provides breakdowns for more than one of these markets. In all cases, values for individual (and not family) insurance plans are reported.

In general, individuals in small group markets are more costly to insure because the risk of major illness is spread across fewer individuals and because there are fewer economies of scale. Small group market deductibles should therefore be higher than large group market deductibles, assuming benefits and other policy characteristics are comparable across group size. The AHIP data display the expected pattern for HSA-eligible HDHPs: The average deductible for small group policies is $2,244, and the

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average deducible for a large group policy is $2,046. On the other hand, the premium values are virtually identical between groups.

The data from eHealthInsurance provides information only from individual policies sold through its website. The eHealthInsurance results show higher average deductibles and lower premiums than the comparable AHIP data. However, this may reflect the characteristics of individuals enrolling in health insurance through a website like eHealthInsurance. In addition, the AHIP premium and deductible information were based on reports of each insurer's best-selling HDHP products, which may not equate to the average of all HDHP premiums and deductibles.

Conclusion

HSAs have been available since 2004, and at least six data sources can be used to uncover some basic facts about the recent experience. Nevertheless, the data sources differ in the insurance markets analyzed; whether the information covers HSAs, HSAs and HRAs combined, or HSA-eligible HDHPs; and whether the information is provided by employers, insurance companies, or individuals. Information from different sources therefore should be combined with extreme care. A more fruitful strategy would be to decide on a specific question and use only the source which best answers that question.

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Table 1. Characteristics of Data Covering HSAs, HSAs and HRAs Combined, and HSA-Eligible HDHPs

	America's Health Insurance Plans (AHIP)	eHealthInsurance	Employee Benefit Research Institute (EBRI)/ Commonwealth Fund	Internal Revenue Service	Kaiser Family Foundation/Health Research and Education Trust (Kaiser/HRET)	Mercer
Description of organization	association of health insurance firms	seller of individual insurance policies online	nonprofit research organization/ private foundation	federal agency	nonprofit foundation/ nonprofit organization	human-resource consulting firm
Source of data	information reported by 97 AHIP member insurance companies	sample of 12,000 policies sold through company website	online annual survey of 4,217 privately insured individuals	sample of nearly 300,000 individual federal income tax returns	annual survey of nearly 2,000 employers	annual survey of nearly 3,000 employers
Level of data	insurance firms	individual HDHP policies sold	privately insured individuals	tax reporting units	employers (firm size of 3 or more)	employers (firm size of 10 or more)
Insurance markets covered	individual and group	individual	not distinguished	not distinguished	group	group
Most detailed plan/account information available	HDHP (HSA eligible)	HDHP (HSA eligible)	HSA and HRA combined	HSA	HSA	HSA and HRA combined
Data available						
Total enrollment	covered lives reported by AHIP member plans	no	privately insured individuals ages 21 to 64	no	employees in firms with at least 3 workers	employees in firms with at least 10 workers
Average premium	yes	yes	for families	no	yes	yes
Average deductible	yes	yes	yes	no	yes	yes
Tax deductions taken	no	no	no	yes	no	no
Average value of deduction	no	no	no	yes	no	no

Sources: [http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf], [http://www.ehealthinsurance.com/content/ReportNew/2005HSAFullYearReport-05-10-06F.pdf], [http://www.ebri.org/pdf/briefspdf/EBRI_IB_03-2008.pdf], [http://www.irs.gov/pub/irs-soi/05inalcr.pdf], [http://www.kff.org/insurance/7672/upload/76723.pdf], and [http://www.mercer.com/referencecontent.jhtml?idContent=1287790].

http://wikileaks.org/wiki/CRS-RL32237

Table 2. Comparisons of Enrollment, Premiums, and Deductibles Across HSA/HDHP Data Sources

	America's Health Insurance Plans (AHIP)	eHealthInsurance	Employee Benefit Research Institute (EBRI)/ Commonwealth Fund	Internal Revenue Service	Kaiser Family Foundation/Healht Research and Education Trust (Kaiser/HRET)	Mercer
Type of plan	HDHP (HSA eligible)	HDHP (HSA eligible)	HSA and HRA combined	HSA	HSA	HSA and HRA combined
Total enrollment	6,118,000[a]		2,300,000		1,900,000	5% of all covered employees
Enrollment measure	covered lives reported by AHIP member plans		privately insured individuals ages 21 to 64		employees in firms with at least 3 workers	employees in firms with at least 10 workers
Period of most recent data	January 2008	2005	2007	2005 tax returns	2007	2007
Premiums						
Average individual market	$1,319 to 3,724 depending on age	$1,368				
Average small group	$3,189					
Average large group	$3,185					
Average large and small groups					$3,894	[b]
Deductibles						
Average individual market	$2,600[c]	$3,190				
Average small group	$2,244[c]					
Average large group	$2,046[c]					$1,769 in network
Average large and small groups			46% under $2,000		$1,556	
HSA tax deductions						
Number of HSA tax deductions taken				215,781		
Average value of deduction				$2,367		

Sources: [http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf], [http://www.ehealthinsurance.com/content/ReportNew/2005HSAFullYearReport-05-10-06F.pdf], [http://www.ebri.org/pdf/briefspdf/EBRI_IB_03-2008.pdf], [http://www.irs.gov/pub/irs-soi/05inalcr.pdf], [http://www.kff.org/insurance/7672/upload/76723.pdf], and Figure 8 at [http://www.mercer.com/referencecontent.jhtml?idContent=1287790].

a. Consists of 1.5 million from the individual market, 1.8 million from the small group market (as defined by each insurer), and 2.8 million from the large group market.

b. Mercer provides the "average cost per employee," for individual as well as family coverage, of $5,479, which is not comparable to the premium for individuals.

c. Based on each insurer's best-selling product.

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