MEMORANDUM
For: Joseph Grogan, Office of Management and Budget (OMB)
From: Dean Clancy, Adams Auld LLC
Subject: HSA Effect Evidence

Thank you for today’s meeting. As promised, below is a list of studies that document the HSA effect, the observed change in the behavior of health care consumers that arises from having a consumer-driven health plan (CDHP) as compared to a traditional health plan. We find this body of evidence to be compelling and hope you will too.¹

I. Background

A CDHP is generally defined in the literature as a high-deductible health plan (HDHP) plus a health savings account (HSA) or medical savings account (MSA). Presumably, the HSA effect results from both parts of the CDHP: 1) the high deductible, which induces the consumer to face most health care costs directly, and 2) the savings account, which induces the consumer to think of the account balance as his or her own money. The consumer with a CDHP faces tradeoff choices regarding how and whether to spend his or her own money that the consumer with a traditional health plan does not. The latter typically behaves as if he or she is spending other people’s money. While two demographic factors, health and wealth, are also discussed in some of the studies as possible contributing factors to the HSA effect, no study, to our knowledge, attributes the entire HSA effect to them.

II. Studies of the HSA Effect²

1. A 2009 literature review by the American Academy of Actuaries cites several industry-led studies, all of which find a measurable HSA effect when estimating the year-over-year spending reduction due to switching from a traditional health plan to a CDHP:

   ● CIGNA Choice Fund 2008 (4 percent spending reduction)

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¹ EEOB meeting, February 28, 2018. In this meeting, OMB indicated that, to its knowledge, CMS actuaries, in their scoring of the president’s Medicare HSA/MSA proposal, did not incorporate any behavioral-change assumptions. That proposal, included in the FY 2019 President’s Budget, includes a sentence that appears to describe a policy earlier proposed by the ABA HSA Council regarding Medicare HSAs for working seniors. The HSA Council proposal is intentionally limited to working seniors because it is a relatively simple step that can pave the way to the establishment of true Medicare HSAs and cannot fail to be a budgetary saver, thanks to its reliance on employer-provided coverage as primary and Medicare as secondary coverage in almost all cases, with no medigap involved. If structured as proposed by the HSA Council, the working-seniors portion of the president’s proposal would have significant fiscally positive behavioral effects.

² Some of the studies cited in this memorandum were done by health insurers and thus may be self-interested. On the other hand, it is safe to assume that health insurers have an honest interest in discerning whether switching to CDHPs can generate greater profit margins for health insurers. Insurers also have access to proprietary data, not just simulation models.
- Aetna HealthFund 2008 (10 percent spending reduction)
- Uniprise 2008 (15 percent spending reduction)

Interestingly, all three of these studies found higher rates of preventative care use.

2. A literature review by RAND Corp. cites, among other studies:

- Nichols Moon and Wall 1996 (if all workers switched to a CDHP, national health expenditures could be reduced by 4 to 6 percent)
- Keeler et al 1996 (if all non-elderly insured were to enroll in a CDHP, health care spending would decline by 0 to 13 percent)
- Hahn 2005 [Humana 2005] (after switch from a PPO plan, CDHP spending was lower than expected by 25 to 35 percent).
- Baicker Dow and Wolfson 2006 (a hypothetical switch from a PPO to a CDHP would reduce individual health spending by 5 percent in short run).
- Burke and Pipich (Milliman) 2008 (CDHP plans produce 1.5 percent in savings beyond non-CDHPs).

3. A case study by Trumbower and West (Health Equity) 2016 finds that two Pennsylvania school districts that switched to a CDHP reduced their health spending by an adjusted net of 17.46 percent in total claims, compared to districts that continued with the previous, traditional health plan.

The only studies we’ve encountered that show CDHPs leading to higher costs in some (but not all) provider settings are by Parente, Feldman, and Christiansen, circa 2004-2007. Of these, the RAND literature review cautions: “Some of the variation in results of these studies may stem from the heterogeneous benefit designs of both the HDHPs and the conventional plans studied.”

The above list is non-exhaustive, but the cumulative weight is clear. Even the least favorable study, Burke and Pipich (Milliman) 2008, shows a 1.5 percent savings from switching to a CDHP. The other studies show even higher savings.

III. Conclusion

1. The HSA effect is real. While the quantity of the HSA effect is uncertain, its existence and its direction (positive reduction in expenditure) would seem from the foregoing evidence to be undeniable.

2. Working-seniors proposal generates significant savings. The HSA Council’s proposal for Medicare HSAs for working seniors is structured to be a net saver in any scenario. It assumes that Medicare-eligible workers, a significant percentage of whom today default into full Medicare out of fear or ignorance, would instead opt into an arrangement in which the participant has or obtains a CDHP, Medicare remains or becomes the secondary payer, and medigap is prohibited. (Medigap is purchasable by working seniors under current law.) In view of all of these elements, Adams Auld LLC assumed a 10 percent savings due specifically to the HSA effect, separate and apart from other behavioral effects. That particular assumption is open to debate and discussion,
but the direction of savings is not. The working-seniors proposal is a net saver for taxpayers.

**Addendum: HSA Effect Studies (Select List)**


Uniprise. “CDHP Results Discussion.” March 2008. [Referenced in AAA, above.]


