Abstract - Recently, the federal government began redirecting health care tax subsidies towards tax–exempt Health Savings Accounts (HSA). This tax program requires selection of high–deductible policies—shifting government tax subsidies away from the premium (pure insurance) component and towards the out-of-pocket (self-insurance) component of health insurance contracts. We analyze price sensitivity and relative risk burden effects from this policy change. Regarding risk burden allocations, we show HSA–eligible contracts can redistribute substantial health risk onto households. HSAs may reduce the moral hazard associated with traditional health insurance contracts but may increase adverse selection problems. Overall we find that HSAs are limited in their ability to effect health care spending.

INTRODUCTION

In the over 30 years since the passage of the Employee Retirement Income Security Act of 1974 (ERISA), retiree income security risk burdens have shifted steadily from employers to households. A primary avenue for this redistribution of risk burdens has been the transition in employer pension plans from a defined benefit (DB) to a defined contribution (DC) structure. As a result, households now bear most of the risks associated with retirement income security. There are a number of possible reasons for this transition. See Mitchell and Smetters (2003) for a thorough discussion.

Recently, employee and retiree health insurance programs began undergoing a similar change, with a growing number of current and future retirees expected to bear a larger burden of retirement health care risk. In this paper, we examine the effect of Health Saving Accounts (HSA) on the distribution of relative risk burdens and the price sensitivity of health care purchases. We find that HSAs shift some health care risk onto households and government but are not likely to be very effective at reducing health care demand.

Over the past ten years, health care risk burdens have progressively shifted onto households. Recently, federal tax policy began subsidizing this transition through tax–exempt Health Savings Accounts (HSAs), which require high–deduct-
ible (sometimes referred to as catastrophic) health insurance contracts. One goal of HSAs is to increase incentives for “consumer driven” health care demand. That is, the goal is to make households more price sensitive to health care purchases by increasing out–of–pocket spending. Another goal of HSAs is to facilitate an expansion of group health insurance because employers, and in particular small employers, face relatively less risk to future compensation costs when compared to more traditional group contracts with higher premiums and first dollar coverage. Both goals are facilitated through changing the emphasis on health insurance tax subsidies from the premium component to the deductible component of a health insurance contract.

We find that an HSA contract changes relative prices and increases risk burdens faced by households. Both changes have an ambiguous effect on health care demand because the change in health care tax subsidies may create incentives that substitute one set of market imperfections for another. First, we note that HSA–eligible policies redistribute risk burdens away from insurance pools and towards household self–insurance. This will tend to decrease health care demand. Second, HSAs slightly increase expected variable cost but can notably decrease the marginal cost of the deductible component of household health care spending. By placing more emphasis on self insurance (through the deductible), HSAs can reduce the moral hazard problem of overconsumption of health care related to a lack of price sensitivity. Moreover, the potential reduction in the marginal cost of health care may actually increase household health care demand. The net effect on the market from all these changes is ambiguous.

For firms with employer–sponsored insurance, HSAs may exacerbate adverse selection problems, especially if there is a range of insurance benefits offered. For firms with multiple offerings, we expect healthy types to adopt HSA–eligible contracts more readily, while less–healthy types persist in their proclivity for traditional contracts. Given that there are substantial overhead costs associated with any insurance contract, the ability of higher deductibles to reduce premiums is limited, and healthy types may opt out of the group insurance market if premiums do not fall proportionately with the increase in deductibles, leaving the potential for an adverse selection spiral. This suggests the possibility of a separating labor market equilibrium, where older workers experience job lock to compensate for unanticipated wealth losses due to loss of pooled health insurance assets, marginally disabled workers seek full disabled status to secure access to Medicare and Medicaid, and younger or healthier workers facing lower search costs experience an increase in labor mobility and self employment. When so many incentives change by the same policy, it is unclear what the total impact of the policy will be on health insurance and labor markets. The ultimate impact of HSAs will depend on the observed magnitude of future expansions of group health insurance offerings by employers, patterns of employee take–up, and increases in household price sensitivity to health care.

The remainder of the paper is structured as follows. The second section examines recent trends in health insurance pricing and health care consumption. The third section analyzes the impact of various tax subsidies of the relative distribution of health care risk burdens. The fourth section

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2 This is a feature of traditional health insurance contracts, which place most or the expected cost in the premium (fixed cost) component of the contract.

3 Premiums cover other things besides expected benefit charges—such as administrative expenses, commissions, state premium taxes, risk charges, and a return to insurer capital. These other factors receive scant attention in the current debate.
provides a discussion of potential effects on employment–based health insurance. The fifth section offers concluding thoughts.

RECENT TRENDS IN HEALTH INSURANCE

Figure 1 provides information on recent trends in the private health care market and demonstrates what many feel are unsustainable growth rates for health care spending and health insurance premiums. Panel A describes relative changes in premiums and the general consumer price index over the past decade. Panel B describes increases in per–capita medical spending and per–capita GDP.

Figure 1A. Recent Trends in Health Insurance Premiums, 1994–2004

Figure 1B. Recent Trends in Health Expenditures, 1995–2005
Both panels point to a growing share of income devoted to health care consumption. In addition, premiums have recently grown at rates in excess of ten percent per year. These increases have placed stress on the employer–provided health insurance market, and may be a factor in the observed low growth of real cash wages because employers will direct large proportions of the increase in total compensation into rapidly growing health insurance premiums.

Given that there are real substitution and income effects associated with rapidly rising premiums, households may be better off with insurance contracts that reduce the average fixed cost of health care. In this sense, HSAs might be effective in reducing the tax distortions associated with traditional health insurance by reducing incentives to purchase first dollar care.

There are several reasons to believe that HSAs will have a limited effect on premiums. First, Figure 1 suggests that changes in premium growth rates tend to lag changes in the growth of health care spending. This is mainly because actuarial methods tend to rely on prior risk experience when accessing future premiums. Even then, the impact of HSAs will have to be disentangled from other market changes—changes in health care utilization due to changes in morbidity, longevity, and medical technology, for example. Thereby, changes to the relative composition of the three–part pricing form of premiums, deductibles, and co–insurance that are associated with the introduction of HSAs may not occur for several years, and may be subsumed by more significant changes in the health care market. To the extent that HSAs do not change the final equilibrium composition of contract components, they may still be seen as a partial remedy—subsidizing household saving to meet the increased burden associated with market trends away from pooled insurance. What is not clear is how HSAs affect health care demand, since HSA tax subsidies lower the marginal cost of health care for households because HSA balances are used to finance the deductible and co–insurance components of health care. Given that health care is a normal good, HSAs may increase consumption since the government is subsidizing the marginal dollar of care. Also, unless preventative health care is covered by the pooled insurance component, the fungability of HSA tax advantaged savings provides an incentive to under–consume cost–effective health care products and increases the probability of later catastrophic claims on the pool. Thus, either preventative care must be included in pooled coverage or, in lieu of coverage, future catastrophic claims should be expected to increase demands on the pool. For all of these reasons, the opportunity for high–deductible HSA–eligible policies to stem premium growth should be seen as limited.

A focus on traditional public insurance is motivated by recent trends. Indeed, while the percentage of uninsured Americans has not changed all that significantly in recent years, in 2004 the percent of workers with employer health insurance dipped below 60 percent (DeNavas–Walt, Proctor, and Lee, 2005). Public programs are increasingly used as the primary health insurance providers for working–age adults as well as for more traditional populations of the very young (through the State Children’s Health Insurance Program—SCHIP) and the aged (Medicare). While Medicare is often held up as an example of an efficient health insurance program, as Figure 2 shows, Medicare costs and spending have risen rapidly as well.

Perhaps no group is more sensitive to changes in health care coverage than those who have both high demand for services and fixed incomes—retirees. While life expectancies have improved for this group and certain components of
coverage have expanded (e.g., the new Medicare drug benefit), current retirees are experiencing significant increases in the cost of their traditional public health insurance programs. Since 2001, the annual cost of Medicare Part B premiums have increased at a significantly faster rate than overall medical inflation. However, taking Figures 1 and 2 together, Medicare cost increases are more consistent with increases with per-capita Medicare costs than with comparable private sector increases over the same ten-year period. Also of note are increases in out-of-pocket costs for Medicare Part A. These costs, which are proportional to the deductible, have grown at a rate below overall medical inflation. Overall, these trends suggest that government policy continues to emphasize reliance on pooled insurance within Medicare, while increasing incentives for greater reliance on self-insurance for the working-age households. This may be a reasonable approach given that health is somewhat inversely related to age, suggesting the elderly benefit most from a pooled approach.4

These trends are likely to become increasingly important given recent trends in employer-provided retiree health insurance coverage. A recent Kaiser-Hewitt (2004) survey of large employers indicates that rapid increases in retiree health care costs have notably increased retiree premiums and risk burdens. Between 2003 and 2004, the average increase in premium was about 25 percent, 13 percent of employers shifted 100 percent of cost to retirees, with eight percent of employers terminating subsidized health benefits for all future retirees. This last point is most dramatic for near retirees, who have had little time to save for self-insurance or HSA purposes. Indeed, we believe one of the shortcomings of HSAs is that they do not allow for adequate front-loading of expected retiree health costs for employees with more traditional health insurance contracts.

Overall, recent trends suggest there is increasing market segmentation for

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4 For a nice look at segmented labor market impacts from employer-provided group coverage, see Gruber and Madrian (2002).
health insurance contracts. Private insurance is increasingly shifting health care costs and risk burdens onto households. This transition can be partially offset by government assumption of risk through HSA–eligible contracts. By contrast, public insurance continues to rely heavily on pooled insurance, where price insensitivity by beneficiaries frustrates attempts to contain costs for the insurance pool. This problem may be exacerbated in the near future as more workers enter retirement without an employer–sponsored retiree health insurance benefit.

TAX SUBSIDY EFFECTS ON THE STRUCTURE OF HEALTH INSURANCE COSTS

In this section, we examine the price effect of HSAs in a one–period framework. Define individual health care costs by three components, consisting of a premium \( P \), a deductible level \( D \), and a co–insurance rate \( c \).\(^5\) The premium is a known, fixed cost to the beneficiary; the actual deductible cost \( d \) is unknown, though it is capped at \( D \). Co–insurance is an unknown, variable cost that carries forward for costs greater than \( D \). For an individual, these components may be greater then, equal to, or less than actual health care expenditures.\(^6\) In the absence of any government subsidies, and defining \( M \) as total individual health care expenditures, the individual’s expected health care costs are then

\[
E(\text{Health Costs}) = P + E(d + c(\text{max}(M - D, 0))).
\]

Equation [1] is the total expected cost of health care to a household and demonstrates that health care costs can be broken into two components—a fixed–cost, pure pooled–insurance component (premium) and a variable–cost, pure self–insurance component (out–of–pocket cost). At the beginning of each year, only the fixed cost is known with certainty.

A variety of health insurance contracts can be constructed from this risk–sharing arrangement—but as is well known, care should be taken in the design of these contracts in order to prevent moral hazard or adverse selection. Contracts that rely too heavily on the premium component can result in moral hazard, since consumers have incentive to consume health services until their average fixed cost for health care approaches zero. If this type of contract is common, then health care consumption can consistently outpace overall GDP growth and premium inflation may tend to exceed general inflation.\(^7\) Conversely, too high of a deductible in a group policy can result in an adverse selection spiral. This occurs when low–risk types opt out of the insurance contract, perceiving pure self–insurance to be less costly.\(^8\) As with the previous case, this can result in rapidly rising premiums, as insurers struggle to maintain premium adequacy for an increasingly high–risk pool of insured households. However, this scenario will also tend to result in lower consumption of health care in the aggregate as the pool of self–insured households rises and marginal costs increase—inducing greater price sensitivity. These extreme market outcomes suggest that only an interior subset of contracts results in an efficient allocation of health insurance and health care for the economy.

Historically, the U.S. government has encouraged employer take–up of group

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\(^5\) The third component can also be measured as a fixed dollar co–payment.

\(^6\) By contrast, the aggregated sum of these three components is ideally set to approximately cover the total expected medical cost for the health care industry.

\(^7\) As noted in the second section, the Economic Report of the President (Dow, 2006) discusses this scenario.

\(^8\) Specifically, when this occurs over some significant period of time \( t \), \( E(M, \text{no insurance}) < E(M, \text{insurance}) \).
health insurance contracts through tax subsidies geared at the premium (pure insurance) component of the cost structure. These tax subsidies include an employer deduction of health insurance premiums and administrative costs as a general business expense, an employer exemption from payroll tax on employer contributed premiums, and an employee income and payroll tax exemption on the employer–contributed premiums. In addition, employees may be able to take advantage of premium conversion, a tax code provision that allows workers to receive tax exemptions for their wage contributions to premiums. Introducing traditional tax incentives to the contract yields

\[ E(\text{Health Costs}) = \alpha P(1 - \tau_1 - \tau_{ss}) \]
\[ + (1 - \alpha)P \]
\[ + E(d + c(\max(M - D, 0)))) \]

where \(\alpha\) represents the proportion of the premium paid for by employer contributions and employee–paid premium conversions, with \(\tau_1\) and \(\tau_{ss}\) representing the marginal tax rates on income and payroll taxable earnings, respectively. Note that with traditional contracts, the tax subsidy is completely on the fixed cost component of the price. This creates an incentive for employers to bundle expected health care costs inside the premium—thereby encouraging over consumption. Also, the total tax subsidy includes a payroll tax component. While providing a more egalitarian distribution of subsidies, it comes at the price of potentially reducing future Social Security benefits for workers whose employer opts to pay most of the premium as a fringe benefit.9

By contrast, the structure of HAS–eligible contracts places more weight on the deductible portion of the price, in return for expected declines in the premium. In the case of individual direct purchase health insurance, the tax subsidy applies only to income taxable earnings. Assuming the co–insurance rate does not change, equation [3] shows the price of HSA eligible health care as

\[ E(\text{Health Costs}) = \hat{P} + E(\hat{d}(1 - \tau_1) \]
\[ + c(M - \hat{D}, 0))). \]

where \(\hat{P}\) and \(\hat{D}\) are the new HSA eligible premiums and deductibles, respectively. Since by definition \(\hat{D} > D\) and \(\hat{P} < P\), the HSA induces a transfer of risk away from the pure insurance component and towards the self–insurance component of the health insurance contract. In this context, the HSA tax subsidy can be viewed as government risk sharing of the household self–insurance component. Importantly, given a set of relatively fixed premium components (covering administration, profit, and other possible factors like enhanced preventative care), one should expect that \(E(|\hat{D} - D| > |\hat{P} - P|).\) When the change to government tax subsidy is greater than the differential, households should respond by shifting to an HSA. This in turn depends on household income and health characteristics as we discuss below.

In the case of employer–sponsored insurance, the impact on risk burdens depends on the nature of the risk–sharing arrangement, both ex–ante and ex–post. The relative distribution of risks in the new contract will depend on relative contributions to health insurance premiums, the amount of employer HSA contributions, the marginal tax rate of the beneficiary, and whether the beneficiary has earnings above the Social Security maximum taxable wage. In the simplest cases with premium conversion and where the

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9 It also places stress on the Medicare system since it reduces contributions to a fixed benefit. See Richardson (2005) for a detailed discussion of these “opt out” effects.
HSA is funded completely by either the employee or the employer we have,

\[ E(\text{Health Costs}) = \hat{P}(1 - \tau_c - \tau_{ss}) + E(\hat{d}(1 - \tau_c) + c(\max(M - \hat{D}, 0))), \]

and

\[ E(\text{Health Costs}) = [\hat{P} + E(\hat{d})](1 - \tau_c - \tau_{ss}) + E(c(\max(M - \hat{D}), 0)), \]

where formulae [4] and [5] represent the tax treatment of premium and deductibles through employee or employer HSA contributions, respectively.

Note that since the tax subsidies are applied in a contingent claims market with contracts containing a mixture of full insurance and self-insurance, changes in the application of tax subsidies will tend to induce equal size changes in the allocation of fixed (premium) and variable (deductibles and co-insurance) costs, assuming there is no change in demand for health care. This approach is informative since it traces the induced changes in relative risk burdens of households, employers, and the government given the transition from traditional health insurance contracts to HSA-eligible contracts.

In general, the increase in price sensitivity will depend on the expected contingent claims of the household. To gain insight into potential changes in price sensitivity, we consider the impact of the subsidies as outlined in [2] through [5] via a simple example. We assume the "traditional" insurance contract has a $250 deductible and a 20 percent co-insurance rate, while an HSA-eligible contract has a $1,000 deductible and a 20 percent co-insurance rate. In addition, we add a fixed $200 charge to the premium that represents the influence of other factors discussed in the second section. We consider three marginal income tax rates, and examine two scenarios: an individual with earnings below the maximum taxable social security wage, and an individual with earnings above the maximum taxable social security wage. We assume a binomial distribution of outcomes, with expected claims of $5,000 and $50,000, and allow the probabilities associated with these states of nature to vary, allowing us to gain insight into the changes in price sensitivity for households with various expected contingent claims. We assume 80 percent of the population to be of the low contingent claims type.

Figure 3 provides information on the transfer of risk burdens associated with transitioning from a traditional to an HSA-eligible health insurance policy for a household with a 75 percent probability of having $5,000 in costs (our low expected contingent claims case). For traditional contracts (Trad), in the absence of tax subsidies the expected cost is allocated about 83 percent to pure insurance, and 17 percent to self-insurance. Tax subsidies vary with tax rates and, thus, government risk burdens (through subsidization of premiums) range from 23 percent to 30 percent of the total expected cost. By comparison, the HSA-eligible contracts (HSA) change the net distribution of pure insurance and self-insurance across income groups by about three percentage points. For each income group, the amount of self-insurance increases, and the amount pure insurance decreases. Also, the tax subsidy for each group increases slightly. While Figure 3 presents a static change in shares before behavioral responses are factored in, generally, we expect changes in risk burdens to change demand for health care services. We will return to this point in order to formally price behavioral changes after considering the high contingent claims case below.

Figure 4 provides similar analytics for households with high expected contingent claims (approximately a 75 percent
Figure 3. HSA Cost-Sharing Impacts—Low Contingent Claims Case

Figure 4. HSA Cost-Sharing Impacts—High Contingent Claims Case
probability of $50,000). For these types of households, we do not expect any significant increases in price sensitivity since the value of the tax subsidized deductible is low relative to the size of their expected self–insured contingent claim. Because self–insurance plays a greater role in financing high contingent claim health care, the impacts are proportionally smaller. Thereby, HSAs are less effective in controlling costs for this type of household.

An important question is whether HSAs can be effective in helping contain the growth of health care spending. Analyzing the health care demand response is difficult since variable costs will rise while both the total cost and marginal costs may rise or fall under an HSA–eligible contract. To see this, we continue our previous example. Under a traditional contract, the expected out–of–pocket expenses are $3,450 for a low–risk household and $7,950 for a high–risk household. As discussed above, total out–of–pocket expenses under HSAs will depend on effective marginal income and payroll tax rates. Consider a case where the deductible goes to $1,000—a $750 increase in the deductible, but only a $600 increase in the pretax expense as 20 percent of the $750 would have been paid as co–insurance in either the low– or high–contingent claim case. In after–tax terms, the effective increase again depends on marginal tax rates. Indeed, the marginal cost increase in the HSA contract falls as the tax rate increases. Applying the standard behavioral elasticity of –0.2 (Manning, Newhouse, Duan, Keller, Leibowitz, and Marquis, 1987), the change in medical consumption behavior ranges from about $72 to $102. To estimate the total macroeconomic size of this impact, we can take that maximum impact per capita of $102 times the number of privately insured, and compare that to the overall size of the economy. This yields an upper bound estimate of approximately one percent.

Based on these results, we contend that in the short run it is unlikely that HSAs will impact the underlying risk and cost parameters in the health care market because HSAs place too much behavioral weight on an increased deductible. Because of this, there is little incentive for insured households and health service providers to bargain over prices. Rather it is insurance companies and health service administrators that will continue to determine prices. In fact, the redistribution of risk burdens may actually create a lack of incentive for insurers to continue to negotiate prices. If, by any channel, there is an overall increase in price sensitivity, we would still expect these changes to take several years to flow through to insurance pool experience ratings. Further, by Figure 4 we show that households with high expected contingent claims have relatively smaller incentives to become more price sensitive. This is an important point because these households are primary catalysts in health care cost inflation.

Another important issue is whether HSAs can provide incentives to reverse recent reductions in employer–provided health insurance. Relative to increasing price sensitivity, we believe a better short–run objective of HSAs is to facilitate the expansion of health insurance, thereby reducing potential cost shifting onto the insured pool. That is, if cost shifting of the uncollectible charges of non–insured households to the insured pool is a main driver in rapidly rising health insurance premiums, then expansion of the insured pool should reduce this pressure, as more

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10 In our examples, expected deductible and co–insurance payments are always below average out–of–pocket maximums typical to health insurance contracts.

Health Savings Accounts: Will They Impact Markets?

individuals pay at least a portion of their health care costs. Clearly, the debate would benefit from more empirical research into the impact of various combinations of premiums, deductibles, and co–insurance on the demand for health care.

In the longer run, it may be possible for HSAs to impact the underlying risk and cost parameters in the health care market, either by expanding coverage pools or through increases in price sensitivity. Expanding coverage works in favor of a positive impact if the net benefit of expanded provision outweighs the adverse selection considerations mentioned earlier. Increases in price sensitivity occur if households’ health care consumption behavior innovates to the point where they begin to bargain over health care prices. In general, how HSAs impact both health insurance and health care spending will depend on how households price health care. When making decisions on health care purchases, do households consider total expected cost, total variable cost, or simply marginal cost? If households focus on marginal cost, then HSAs may actually make households less price sensitive because tax subsidies will lower the effective marginal cost. If households focus on the composition of fixed and variable costs, then HSAs will likely make households more price sensitive, reducing overall demand for health care.

Adding to this uncertainty, not all health care purchases are equivalent. There are important differences in attributes such as quality of services, elasticity of demand or supply depending on need and geographic location, and household morbidity. For example, if households respond to HSAs by reducing investment in preventative and maintenance care, then long–term health care costs and premium financed costs may again rise. As noted above, perhaps HSAs promise lies in the potential to expand health insurance coverage, thereby reducing the ability (necessity) of health service administrators to shift uncollectible uninsured costs onto the insured pool.

POTENTIAL IMPACTS OF HSAS ON EMPLOYMENT BASED HEALTH INSURANCE

In this section, we expand on the price effects outlined in the previous section and discuss potential labor–market effects and issues. For employers without a current health insurance benefit, HSAs provide a mechanism for minimizing the risk exposures associated with traditional contracts and, thus, may expand employer–provided health insurance coverage. For employers with an existing health insurance benefit, the incentive to adopt an HSA–eligible contract will depend on the employer’s risk tolerance and the composition of labor–force skills. HSAs should be less attractive to employers that devote significant resources to developing job–specific human capital for their employees because HSA–eligible contracts increase the portability of coverage and, thus, increase the employer’s risk of losing high–skilled employees. Previous research considering the impact of health care coverage on transitions to self employment suggests that HSAs may have this impact. Madrian and Lefgen (1998) find evidence that mandatory insurance continuation programs like COBRA and spousal health insurance have positive impacts on the transition to self–employment. Likewise, HSAs lower the cost of self–insurance through government tax subsidies, thereby lowering transition costs to self–employment.

As demonstrated above, HSAs are more attractive to workers with higher combined tax rates. These workers also tend to be healthier and more productive. Less–healthy and less–productive workers will tend to favor traditional contracts. This suggests a separation of risk types, which may result in an adverse selection
spiral under which traditional contracts become less viable. As with the adoption of 401(k) plans, HSA-eligible contracts may quickly develop as the dominant form of contract offered to employees. This is of no concern if the HSA provides for a superior insurance product, and especially if HSAs induce net new private savings that are at least adequate to finance both the public’s tax subsidy and the health care provision costs they are designed to offset.

In short then, this policy change may help enhance labor productivity for industries characterized by healthier, mobile workers, but may hurt labor productivity in industries with aging workforces that have less healthy workers. Finally, HSAs may facilitate an expansion of health insurance coverage, even while, in dynamic settings, they perhaps lead to the disappearance of defined benefit employer pooled insurance structures.

CONCLUSIONS

Over the past ten years, health care risk burdens have progressively shifted onto households. Recently, federal tax policy began subsidizing this transition through tax-exempt Health Savings Accounts, which require high-deductible (catastrophic) health insurance contracts. These contracts shift tax subsidies away from a pooled risk-sharing (premium) component and towards the self-insurance (deductible and co-insurance) component of the health insurance contract. In this paper, we have illustrated how HSA-eligible policies can result in a large redistribution of relative risk burdens away from pooled insurance and towards self-insurance. This can reduce the moral hazard associated with traditional health insurance contracts, but may exacerbate adverse selection problems for firms that offer multiple insurance contracts. However, any reduction in firm offerings of pooled insurance reduces the costs associated with job search, and would be expected to lead to a more efficient distribution of productive labor.

In general, we suggest that HSAs’ impact on the health care market is, for now, largely unknown—while we estimate that the direct impact of HSAs is at most one percent of health care spending, total impacts rely on indirect effects as well. In general, the total impact is a function of demands by an extremely heterogeneous group of consumers facing widely differing incentives for health care purchases. In addition, any impact requires a large-scale change in bargaining behavior by consumers who are not experienced in negotiating over health care prices. On net, we believe that how HSAs impact the health insurance market and health care spending will depend on how households view the price of health care. If households focus on the marginal cost, then HSAs may actually make households less price sensitive. If households focus on the composition of fixed and variable costs, then HSAs will likely make households more price sensitive, reducing overall demand for health care. Perhaps the best hope is that HSAs have

12 Recently, many policymakers have pointed out that one does not need to hold a high deductible health policy to hold or consume HSA balances, but only to make contributions. Young workers can, thus, attempt a hybrid insurance strategy whereby they take high deductible coverage and make HSA contributions when young, and plan on transferring to traditional plans later in their working careers. However, this behavior may accelerate the reduction in traditional health insurance offerings. As long as the private benefit from entering the traditional pool is lower than the social benefit, these pools should be expected to exhibit some rate of evaporation. This point is most concerning given the recent literature on quasi hyperbolic discounting (Laibson, 1997; Diamond and Koszegi, 2003). Additionally worthy of note, without proper employer insurance default design, it is possible for young workers to announce a plan to save in an HSA while forestalling actual savings through this instrument—as Madrian and Shay (2001) have pointed out in the context of defined contribution pension plans.
the potential to expand health insurance coverage, thereby reducing incentives to shift costs onto the insured pool.

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