



INDEPENDENT WOMEN'S FORUM  
*Position Paper*

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# Health Savings Accounts: Making the Healthcare System Work for Women

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## Executive Summary

Excluding employer-provided health benefits from taxation was supposed to make coverage more affordable. Instead it is a classic example of government failure that disproportionately harms women. Expanding Health Savings Accounts (HSAs) would make coverage more affordable and responsive to women's needs.

- **The tax code contributes to today's skyrocketing costs.** Since World War II, medical prices have risen faster than other prices in all but four years. By 1997, excess consumption caused by the tax code accounted for nearly 30 percent of health spending. One estimate puts the amount of waste at \$150 billion annually. The exclusion is a major reason why, in 2003, health insurance premiums rose an average 15 percent – the largest increase in more than a decade – and the number of uninsured Americans grew to 43.6 million.
- **Women suffer disproportionately under the tax exclusion.** Women have greater medical needs than men, and spend 68 percent more out-of-purse on medical care during their childbearing years. Their lower incomes make them more likely to forgo needed care due to cost. Further, women tend to work in jobs where health benefits are less common, and are more likely to lose coverage due to divorce, a spouse's death, or from leaving the workforce. As a result, *the number of uninsured women is growing at three times the rate of uninsured men.*
- **HSAs are improving women's coverage.** HSAs are already making coverage more affordable and portable for women, expanding their coverage options, and enabling women to save money tax-free for their greater medical needs in old age. (See page 14.)
- **Expanding HSAs would improve women's coverage further, now and in retirement.** Though a boon for women, HSAs are too restrictive at present. Expanding access to and the flexibility of HSAs would allow more women to control their health decisions and save hundreds of thousands of dollars for needed medical care in their golden years. (See page 20.)

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## Introduction

America's healthcare system is a vast network of patients, providers, and payers. While numerous factors affect this complex system, a core cause of its problems is government policies that divert control of patient care to someone other than the patient.

Every day, American women suffer under a policy that increases the cost of medical care, injects third-party bureaucrats between women and their doctors, and makes health insurance largely unaffordable for those who do not receive it as a benefit of employment. Women are particularly vulnerable because women require more medical care, have lower incomes, and have more difficulty finding and holding on to employer-provided health insurance. A classic example of government failure, this policy could hardly be more hostile to affordable healthcare for women.

The federal tax code exempts only one method of financing healthcare from payroll and income taxes—employer-provided health insurance. Though few make the connection between the tax treatment of health insurance and the problems in our healthcare system, consider what would happen if we treated car insurance the same way. Most consumers would purchase car insurance through their employer. Insurance companies would stop marketing to drivers and start marketing to employers. Car insurance would come to cover more things – routine, predictable items like oil changes – because pre-paying for these items through insurance makes them tax-free as well. Before long, we would have a feeding frenzy where workers, spending someone else's money, would drive up the cost of insurance, maintenance, and repair. Millions who aren't insured through their employers would no longer be able to afford auto insurance or a trip to the mechanic. Losing one's job would mean losing one's car insurance as well.

This is precisely the state of America's healthcare system. The tax exclusion of employer-provided health insurance has delivered ever-escalating costs, increased frustration, and reduced access to healthcare. All Americans are affected by this government failure. One survey finds that while most Americans are pleased with their own medical care, the majority are (1) dissatisfied with the overall quality of care in America, (2) worried they may lose their health coverage, and (3) willing to let the government assume control of the healthcare system.<sup>1</sup> Another survey finds more Americans worried they might lose their health insurance than that they might lose their savings in the stock market, lose their job, or be the victim of a violent crime or

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terrorist attack.<sup>2</sup> The tax exclusion is the culprit. It is a driving force behind the rising cost of healthcare and health insurance, and the growing number of Americans without health insurance.

While this government failure touches everyone, women are most affected. As a recent study observed:

Women are major consumers of healthcare services, in many cases negotiating not only their own care but also that of their family members. Their reproductive health needs, greater rate of health problems, and longer life spans compared with men make their relationships with the health system complex. Their access to care is often complicated by their disproportionately lower incomes and greater responsibilities juggling work and family. Because of their own health needs, limited financial resources, and family responsibilities, women have a vested interest in the scope and type of services offered by health plans, as well as in the mechanisms that fund healthcare services.<sup>3</sup>

Women are acutely aware of the healthcare system's ills. Amid a sluggish economy, a recent survey asked what is the most critical issue facing America today. Men were nearly twice as likely to answer "the economy" as "healthcare." Women, however, were as concerned about healthcare as the economy.<sup>4</sup> Women are less confident than men that they will be able to afford medical care in retirement.<sup>5</sup> Moreover, women are increasingly connected to the healthcare system in multiple capacities. Every year, more women come to know America's healthcare system not just as patients, but as physicians and employers. Women have the most to gain from healthcare reform done right and the most to lose if it is done wrong.

To enable women to get the most from the world's finest healthcare system, policymakers must eliminate or minimize the harm done by the tax exclusion of employer-provided health insurance. The proposal that holds the most promise is to expand tax-free health savings accounts (HSAs), which allow individuals to save money for their medical needs. HSAs return control over medical care to the patient and make health insurance more affordable. This paper will examine how the tax exclusion has harmed women, and how expanding HSAs would help.

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### **Women’s Majority Interest the Healthcare System**

Rising healthcare costs and diminished patient sovereignty impact men and women alike, but not equally. Numerous factors combine to give women a greater stake in America’s healthcare system.

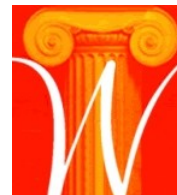
**Women as Patients.** The average woman spends 68 percent more out-of-purse on medical care than a man during her childbearing years.<sup>6</sup> A recent survey reports 50 percent of non-elderly women regularly use at least one prescription, while only 31 percent of non-elderly men do.<sup>7</sup> Part of the discrepancy may be due to higher reported rates of chronic conditions among women:

A striking one-third of [non-elderly] women (32%) reported that they had a chronic health condition that required ongoing medical treatment, compared with 26% of men. Arthritis, hypertension, and anxiety or depression are prevalent conditions affecting women—with nearly one in five experiencing at least one of these conditions.<sup>8</sup>

Women account for 60 percent of all physician office visits,<sup>9</sup> seek out health information significantly more frequently than men,<sup>10</sup> and, of course, bear 100 percent of children.

Moreover, women live longer. Girls born today in the United States have a life expectancy 5.4 years longer than their brothers (79.5 years vs. 74.1 years). American women who reach age 65 can expect to live 2.9 years longer than their male counterparts (19.2 vs. 16.3 additional years). Though American men have been closing the gap, data on life expectancies in other nations suggest women could widen it further.<sup>11</sup> Medical care takes on an even larger role in a woman’s life during these final years.

**Women as Caregivers.** Women’s roles in society bring them into more frequent contact with the healthcare system. Responsibility for the family’s healthcare decisions continues to fall on women. According to one survey, “Nearly six in 10 women (58%) made the primary decisions about choosing the health insurance plan for their families, and 22% made the decisions jointly with their partner or spouse.”<sup>12</sup> Some 80 percent of mothers report choosing a doctor for their children, taking them to appointments, and supervising follow-up care.<sup>13</sup> Women also bear the lion’s share of caring for older and disabled relatives. Nine percent of women report caring for a sick or disabled family member, compared to only 4 percent of men.<sup>14</sup>



**Women as Leaders.** Women are playing a more influential role in the healthcare system. From 1972 to 1997, the number of businesses owned by American women surged from 400,000 to nearly 8.5 million.<sup>15</sup> As more women become business owners, they confront healthcare costs and insurance decisions from the perspective of an employer as well as a patient. The share of medical degrees awarded to women grew from 9 percent in 1972 to 43 percent in 2001. By 2003, “[w]omen made up the majority of medical school applicants for the first time ever.”<sup>16</sup> Women accounted for nearly two-thirds of all pharmacy students in 1999, compared to just one-fourth in 1971.<sup>17</sup> Finally, women are playing a larger role in shaping government health policy. The 108<sup>th</sup> Congress seated 73 female members, the most in the history of the nation.<sup>18</sup>

As patients, providers, employers, and lawmakers, women have a majority and growing interest in reforming America’s healthcare system to improve quality and increase access to care.

### **A Healthcare System’s Presenting Symptoms**

Despite its status as a world leader, America’s healthcare system shows plenty of room for improvement.

**Rising Costs & Americans Without Coverage.** Health insurance increasingly is becoming more difficult for Americans to afford. One survey found the cost of employer-provided health insurance rose an average 13 percent in 2002 and 15 percent in 2003 – the largest increase in more than a decade.<sup>19</sup> Rising health insurance premiums have had a predictable impact on the number of Americans without insurance. By 2002 – despite years of strong economic growth – double-digit premium increases and an economic slowdown pushed the number of uninsured Americans up 13 percent from 1993’s “crisis” level, to 43.6 million.<sup>20</sup> Escalating health insurance costs have left more Americans uninsured and reduced benefits for many Americans who retain coverage.

**Loss of Patient Control.** In America, patients and doctors express increasing dissatisfaction because of the limits on their freedom to make the best medical decisions. According to a former president of the American Medical Association:

[I]n the 1990s, physicians found ourselves forced to perform so-called “drive-through deliveries” – where mothers and newborns were required to leave the hospital after 24 hours,

*Escalating costs make health insurance unaffordable for many Americans and reduce benefits for many who retain coverage.*



*The number of women who lack health insurance is growing at three times the rate of uninsured men.*

regardless of circumstances. We were subjected to gag clauses that prevented us from telling patients about treatments deemed too expensive... We were given financial incentives not to recommend care. And even when we decided to adhere to best practices, we watched as our patients were denied needed care.<sup>21</sup>

Physicians complain about not having enough time to devote to patients due to cost pressures and administrative obligations.<sup>22</sup> On the receiving end, patients feel the inattention. Insurance companies are also in an unenviable position: either try to contain costs and suffer criticism for interfering with the practice of medicine, or agree to cover more care and raise insurance premiums even higher.

**Women Bear the Brunt.** These symptoms present disproportionately in women's lives. As noted in a recent study, cost pressures take a larger toll on women: "Because women have lower incomes than men, they may be more likely to be disadvantaged when health insurance premiums increase, the costs of prescription drugs rise, or when out-of-pocket costs grow."<sup>23</sup> This helps explain why the number of American women who lack health insurance has been growing at three times the rate of uninsured men.<sup>24</sup> Women also seem to feel the impact of pressures placed on physicians more directly than men. According to one survey, "More than one in five women (22%) said they had concerns about the quality of care they were receiving, compared with 17% of men." Similarly, women change doctors due to dissatisfaction at twice the rate of men (18% vs. 9% in the past five years).<sup>25</sup>

### **"A Classic Example of Government Failure"**

For most Americans, the government's influence over healthcare is so indirect few are aware of it. It comes through the federal tax code, which grants preferential tax treatment to a narrow category of health expenditure: employer-provided health insurance.<sup>26</sup> Health benefits provided by employers are treated as a business expense for the employer, rather than income for the employee. They are thus excluded from payroll and income taxes.<sup>27</sup> In other words, employers may purchase health insurance with pre-tax dollars while everyone else must first pay taxes on the money they use to buy health insurance.

On its face, this tax break seems a laudable way to increase access to healthcare. In practice, it has proven to be a classic example of government failure. Its actual effects — rising costs, reduced access



to healthcare, loss of patient sovereignty – have been the opposite of its intended effects.

**Before-Tax Cost of \$1 of Health Insurance to Different Workers by Source of Coverage**

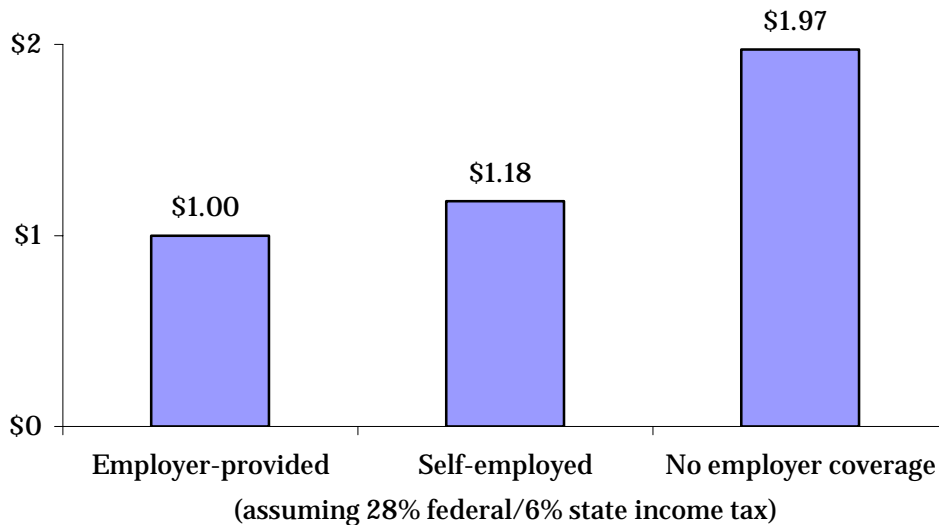


Figure 1 – Source: Author’s calculations

**Discriminatory Effects.** The exclusion encourages workers to get health insurance through their employer and lowers the cost of healthcare relative to other goods and services. Consider three women earning the same moderate income: one receives health benefits at work, the second works for herself, and the third receives no health benefits at work. The way the exclusion works, the first woman must earn \$1 to purchase \$1 of health insurance. The second woman has to earn \$1.18 to buy \$1 of health insurance. The third woman must earn \$1.97 to purchase \$1 of health insurance.<sup>28</sup> Those who purchase health insurance on their own often pay twice as much as those who receive health insurance on the job. (See Figure 1.) This creates a strong preference for employer-provided health insurance.

**Dangerous Incentives.** The exclusion also lowers the cost of medical care – including routine care – so long as it is purchased through employer-provided “insurance.” Thus it creates a nationwide dynamic where most medical care is untaxed and consumed by patients spending someone else’s money. The latter dynamic is commonly referred to as “third-party payment,” because medical

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providers are paid not by the patient but by a third party to the transaction, such as an employer or insurance company.

*The tax code creates a nationwide dynamic where most medical care is purchased with someone else's money. This has led to skyrocketing costs.*

### Shifting Sources of Healthcare Payments, 1965-2000

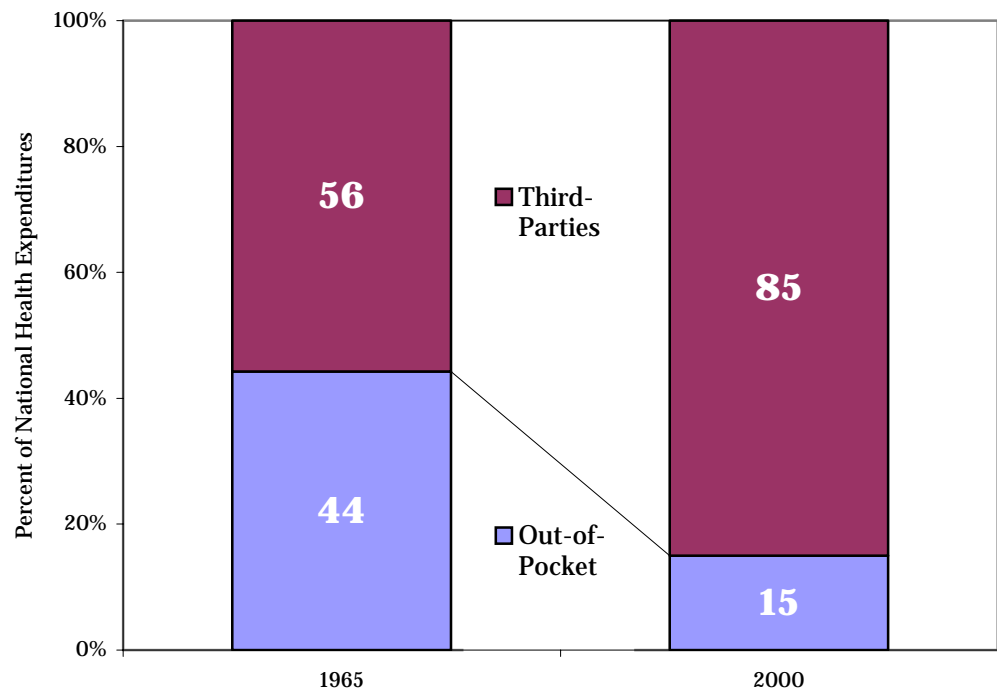


Figure 2 – Source: Center for Medicare & Medicaid Services

**Rising Costs.** The exclusion has led to dramatic growth in employer-provided health insurance, the share of medical payments made by employers and insurers, and the overall amount spent on medical care. After the tax exclusion went into effect during World War II, health insurance grew in terms of numbers of Americans enrolled, types of medical services covered, and the portion of medical expenses it covered (i.e. lower co-payments and deductibles).

In 1930, only 4 million Americans had health insurance. By 1958, 123 million Americans had health insurance, three-fourths through an employer. Even amid rising incomes during the postwar period, the share of disposable personal income spent on medical care rose 37 percent between 1946 and 1958.<sup>29</sup> Yet patients were paying less of the bill. By 2000, direct payment for medical services had eroded to



the point where only 15 cents of every healthcare dollar was spent by patients themselves (see Figure 2).<sup>30</sup> Nobel Prize-winning economist Milton Friedman tracks a 23-fold increase in real per capita spending on medical care from 1919 to 1997, and estimates the tax exemption was responsible for nearly 30 percent of Americans’ healthcare spending in 1997.<sup>31</sup>

The flood of demand in turn led to rising medical prices and diminished access to care. The tax exclusion “encourages an excessive purchase of insurance, distorts the demand for health services, and thus inflates the prices of these services.”<sup>32</sup> Before World War II, medical inflation had been measured as low as zero percent. (See Figure 3.) Since World War II, there have been only two instances (the high-inflation periods of 1973-74 and 1979-80) where prices for non-medical items rose faster than prices for medical care. In each case, medical inflation quickly caught up and overtook non-medical inflation.<sup>33</sup>

*In 1997, the tax code added nearly 30 percent to America’s healthcare bill.*

### Medical vs. Non-Medical Inflation

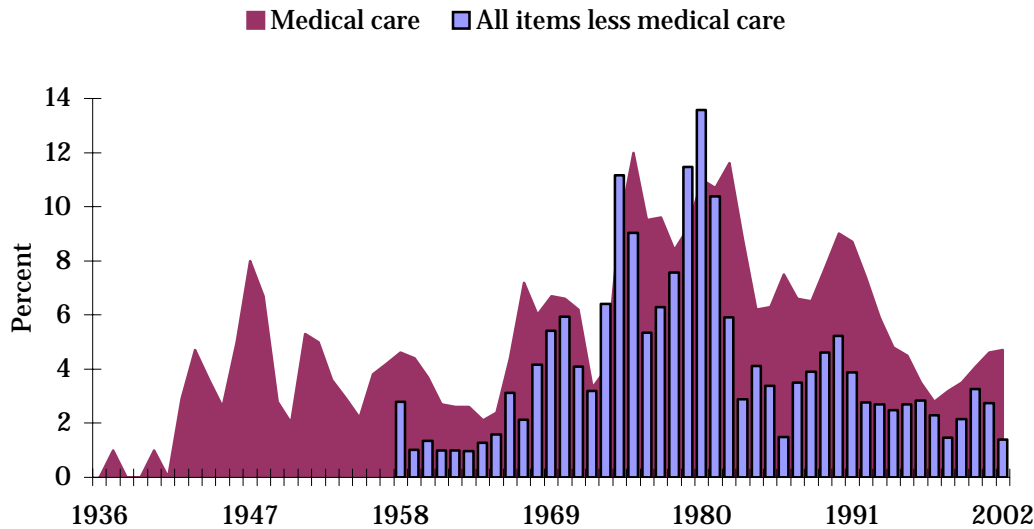


Figure 3 – Source: Bureau of Labor Statistics

Higher costs reduce access to care for all patients, particularly those without health coverage. A recent study found that:

...the sharp declines in insurance coverage among workers from 1979 to 1995 can be accounted for almost entirely by the fact that per capita healthcare spending increased much more



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rapidly than income over this period . . . More workers were uninsured in 1995 than in 1979 because rising healthcare expenditures made insurance unaffordable for a growing number of workers.<sup>34</sup>

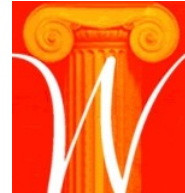
The trend toward higher spending continues today. “[H]ealthcare spending grew nearly four times faster than the U.S. economy grew in 2002.”<sup>35</sup>

**Diminished Patient Sovereignty.** The tax exclusion guarantees excessive health spending because patients perceive the cost of care to be well below its actual cost. However, employers are very aware of costs and exercise enormous control over what health insurance will and will not cover. Since workers have little reason to curb their own consumption, employers and insurers have tried to ration it.<sup>36</sup> The restrictions they impose typically clash with a “pervasive entitlement mentality”<sup>37</sup> among patients accustomed to getting the care they want while someone else foots the bill. Frustrated patients resent such restrictions, but have little recourse since they do not own or control their own health coverage; employers do. Physicians too resent the intrusion. Provider associations have been at the forefront of legislative efforts in state capitols and Washington, D.C., to ban unpopular insurance practices.<sup>38</sup>

**Billions of Dollars Wasted Annually.** The tax exclusion is primarily responsible for most of the frustration with America’s private healthcare system. As Prof. Friedman notes:

Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party—an insurance company or employer or governmental body. The second is that nobody spends somebody else’s money as wisely or as frugally as he spends his own.<sup>39</sup>

This government-induced lack of wisdom and frugality has led to overconsumption of medical care. One scholar’s rough estimate suggests the tax exemption left the American people \$149 billion worse off in 2001 alone.<sup>40</sup>



### **This Government Failure Hits Women Hardest**

The government's bias in favor of employer provided health insurance particularly penalizes women. The tax exclusion became law when a typical family included a husband who worked at the same firm most of his career and a wife who stayed at home. Much has changed since then. The tax exclusion, however, continues to force a 1940s view of women on 21<sup>st</sup> century America, and in so doing reduces women's access to quality, affordable healthcare.

**Job-Based Tax Breaks Fail to Reach Many Women.** Men are still the primary breadwinners in most families, but higher divorce rates make women more vulnerable to losing coverage. As one study observes:

Women were less likely than men to have coverage through their own job and more likely to be covered as a dependent (also known as family coverage). Compared with men, women are more likely to work part-time and work in industries that are less likely to offer health insurance. Having dependent coverage leaves women vulnerable to losing insurance if they become widowed or divorced. It also places them at high risk for losing insurance if their spouses' employer opts to drop dependent coverage or raise the level of cost-sharing due to rising healthcare costs. . . One-third of women were covered through their own employer, compared with 53% of men, and 27% had dependent coverage, compared with 13% of men.<sup>41</sup>

Even when working full-time, women work in jobs where health insurance is less available. Women represent 64 percent of minimum wage workers age 20 and over,<sup>42</sup> and hold 62 percent of jobs in the service sector, where health benefits are less prevalent.<sup>43</sup> Women also leave the labor force more often than men, making women more likely to lose job-based coverage. According to the Department of Labor, between the ages of 18 and 36, women spend 27 percent of their time out of the labor force (mainly to care for children<sup>44</sup>) compared to 11 percent for men.<sup>45</sup>

Many women find affordable, continuous coverage elusive, as well as the ability to form a lasting relationship with a physician. According to one study that examined how often and why women change health plans,

For many women, long-term stability with a plan does not exist. Rising costs for employers, higher employee cost-sharing, volatility in the job market, and dissatisfaction with the plans

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*The tax code makes it harder for women to find and keep health coverage, with potentially harmful health consequences.*

themselves are all factors that contribute to plan switching. In fact, nearly half of nonelderly women (46%) switched from one insurance plan to another in the past five years. The leading reasons women gave for switching plans were that the employer providing coverage changed plans (34%) and that the women or their spouses changed jobs (30%). Only a fraction of women reported that they changed plans because they needed better or different options (6%) or needed a less expensive plan (6%). Among women who switched plans, 13% left their old provider and changed to a different doctor affiliated with their new plan. This can disrupt continuity of care because many women cannot afford to continue with providers who are not in their new networks.<sup>46</sup>

A system that ties health insurance to employment is certain to make healthcare less accessible to women.

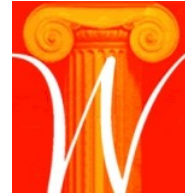
**Women Suffer More from Higher Costs, Bureaucracy.**

With lower incomes and greater healthcare needs, women are more sensitive to cost increases and more frequently forgo needed care.<sup>47</sup> Women's greater use of the healthcare system also ensures greater frustration with the bureaucracy that comes with increased reliance on third-party payment:

Fifteen percent of insured women reported that within the past two years, their health plan refused to approve or pay for medical treatment or tests they thought should have been covered. . . . The lack of plan approval or payment for treatment or tests resulted in nearly one-half of women (45%) either delaying or never receiving these services. For women in fair or poor health, lack of plan approval resulted in nearly six in 10 either delaying treatment or not getting treatment.

Over one-half of women who are refused coverage for a test or treatment are dissatisfied enough with their coverage to contest their health plan's decision.<sup>48</sup>

Given their societal roles and greater healthcare needs, the exclusion makes it harder for women to buy and keep insurance, with potentially harmful consequences for their health. The total harm suffered by women is difficult to estimate. However, it is safe to say that a policy is clearly not designed to help women if it (1) increases the cost of medical care, (2) disproportionately penalizes those who most need medical care, (3) diverts control from patients to bureaucrats, (4) burdens those who most often care for sick or disabled relatives, and



(5) puts low-income workers, stay-at home parents, longer-living spouses, and workers who move in and out of the labor force at added risk of losing access to care.

**The Solution: Let Women's Choices Guide the Market**

Making America's healthcare system work for women means eliminating or minimizing the harmful incentives created by the tax exclusion of employer-provided health insurance. Such a reform holds the promise of delivering high-quality, affordable medical care to the greatest possible number of Americans.

**The Ideal: Government Neutrality.** Ideally, government would not influence consumers' decisions to purchase medical care versus non-medical items, or to purchase health insurance through their employer versus some other arrangement. Consumers would enter the medical marketplace spending their own dollars, not their employer's. They would purchase health insurance that pays for fewer procedures than today, because there would be no tax benefit to pre-paying for care. Patients would be more satisfied with their healthcare, because they would choose the plan that best meets their needs instead of surrendering control to a third party.

In such an environment, suppliers of health insurance and medical care would compete to give consumers the highest value for their dollar. With insurers forced to cater to consumers, the diversity of health insurance products would increase. The same would be true of physician services. Moreover, doctors would have more time to spend with patients since receiving payment directly from the patient involves less administrative work than third-party payments. Consumers, rather than employers or other third parties, would drive the market through the decisions they make between competing products.

The idea that consumers should pay directly for a larger share of their medical expenses causes concern to some. Researchers, however, have found that requiring families to pay the first few thousand dollars of medical bills "reduced expenditure about 25 to 30 percent relative to a plan in which care was free to the family" yet "had little to no net adverse effect on health for the average person. Indeed, restricted activity days fell[.]"<sup>49</sup> As noted before, the tax exclusion wastes somewhere on the order of \$150 billion annually, which could be eliminated by restoring the incentives for patients to be wise consumers.

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Achieving this ideal would mean repealing the tax exclusion for employer-provided health insurance, taxing health insurance and medical care like any other item, and lowering tax rates.<sup>50</sup> However, such a solution is not politically feasible.

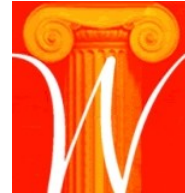
**The Attainable: Expand Tax-Free Health Savings Accounts.** The next best option is to remove the bias toward employer-provided insurance over other ways of financing medical care as much as possible. The most promising reform available is tax-free Health Savings Accounts, or HSAs.

HSAs, which became available to the public in January 2004, extend the favorable tax treatment of employer-provided health insurance to savings by individuals for future medical expenses. Consumers save pre-tax dollars in an account (the HSA) dedicated for medical expenses, which they own and control just like any other savings account. HSA funds pay for out-of-purse medical expenses. The account holder keeps what she does not spend, and interest on deposits is tax-free. HSAs enable consumers to accumulate significant savings for future healthcare needs, both before and during their retirement years.

HSAs level the playing field between third-party payment and self-insurance. While they do not eliminate the tax-preferred status of medical expenditures, they make the preference neutral between payments made by patients versus payments made by employers or insurance companies. This enables patients to make decisions based on what meets their needs, rather than what provides the greatest tax benefit. Since the HSA is cash the patient owns, she need ask no one for permission to spend it. Moreover, she has an incentive to spend it wisely because she gets to keep whatever she does not spend. The layers of rules, bureaucracy, and paperwork that employers and insurers use to discourage unnecessary care themselves become unnecessary.

**How HSAs Work.** As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which the President signed into law on December 8, 2003, the federal government allowed millions of Americans to open HSAs starting in January 2004. The following is a brief outline of how HSAs currently operate.

- **Eligibility.** Any American who is covered by a qualified high-deductible health plan (see Health Insurance Requirement below), who is under the age of 65, and who cannot be claimed



as another's dependent for tax purposes, is eligible to open a tax-deferred HSA.

- **Health Insurance Requirement.** Consumers must be covered by a qualified high-deductible health plan in order to be eligible to open an HSA. For individuals, this means a health plan must have a deductible of at least \$1,000 and a limit on out-of-pocket expenses (including deductibles and co-payments) of \$5,000. For families, it means a deductible of at least \$2,000 and an out-of-pocket limit of \$10,000. The only type of coverage allowed below the deductible of a qualified high-deductible health plan is for preventive care. Coverage for accidents, disability, dental, vision, and long-term care is also permitted in addition to the high-deductible health plan.
- **Contributions.** Individuals may make tax-free contributions to their HSA up to the age of 65. HSAs established by an employer may be funded tax-free by the employee, the employer, or both. Family members may contribute to another family member's HSA.

Each year, individuals may contribute an amount equal to their health insurance deductible, with an upper limit of \$2,600. Families also may contribute the amount of their health insurance deductible, with an upper limit of \$5,150. Individuals aged 55-64 may make additional "catch-up" contributions. As of 2004, they may contribute up to \$500 above what would otherwise be their limit. The "catch-up" contribution limit will rise annually until it reaches \$1,000 in 2009.

HSA funds may be invested in a variety of vehicles, including checking accounts, money market accounts, mutual funds, and certificates of deposit. Whatever funds the holder does not spend remain in the HSA and grow tax-free.

- **Distributions.** Money withdrawn from an HSA for medical expenses of the account holder, her spouse, or dependents is not taxed. Medical expenses include premiums for long-term care insurance, COBRA coverage, health coverage while receiving unemployment compensation, Medicare, and the employee share of premiums for employer-sponsored health insurance for those over age 65.

HSA funds spent on non-medical items are subject to income taxes and an additional 10 percent tax.

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Upon the account holder's death, HSA funds are transferred tax-free to the spouse or taxed as income if someone other than a spouse is the beneficiary.

**How HSAs Empower Women.** HSAs undo much of the damage wrought upon women's healthcare by government.

**HSAs Make Coverage More Affordable.** With lower incomes and more tenuous links to health insurance, women are particularly sensitive to healthcare costs. Anecdotal<sup>51</sup> and empirical<sup>52</sup> evidence confirm that when patients manage their own medical spending, they keep costs under control, which makes coverage and care more affordable for everyone. Perhaps the best evidence is that, in the Archer Medical Savings Account (MSA) demonstration program – a precursor to HSAs that was severely hampered by unnecessary restrictions – nearly three-fourths of enrollees were previously uninsured.<sup>53</sup> (See Figure 4.)

### Archer MSA Enrollment, 2001

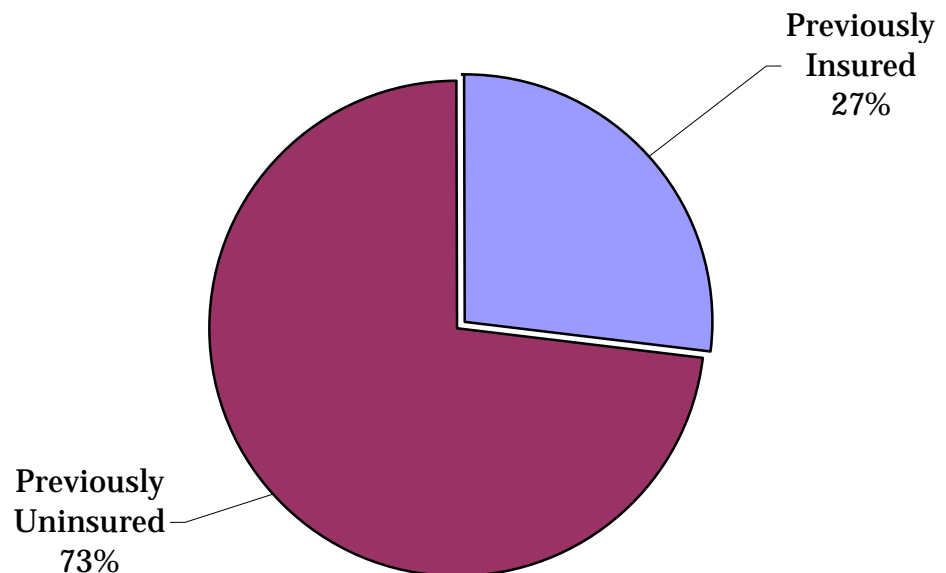
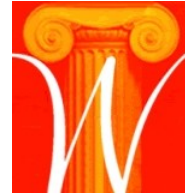


Figure 4 – Source: Internal Revenue Service

**HSAs Expand Women's Coverage Options.** Thanks to the new HSA law, women have greater freedom to choose the health plan



that best meets their needs. For example, a 35-year-old single woman living in San Francisco who switches from a \$500 deductible plan to a \$1,700-deductible plan would save \$1,500 on her premiums in the first year. She would save even more in subsequent years because inflation would have less of an impact on her new, lower premiums.<sup>54</sup> If she deposits her first-year savings in a health account, she might face a \$200 gap in coverage after that money runs out and before her insurance kicks in. However, because her new premiums would rise more slowly than under her previous plan, the premium savings could completely cover her \$1,700 deductible by the third year.<sup>55</sup> (This is without counting any health account funds she may save.)

By the same token, HSAs enable women to save enough to switch from their employer's plan to a policy they choose themselves. The savings women accumulate in their HSAs (see below) will be able to provide coverage between jobs or when they leave the workforce. HSAs liberate women to find a health plan that meets their needs and stay with it through changes in employment or other changes.

**HSAs Give Women Greater Control Over Coverage Decisions.** Having her healthcare dollars in an account she controls – rather than with her employer or an insurance company – gives a woman much greater control over how her healthcare dollars can be used. A common source of frustration for women is that many health plans lack contraceptive coverage. “One study found, for example, that two-thirds of plans that cover prescription drugs in general do not routinely cover oral contraceptives in their typical policy.”<sup>56</sup> HSAs can be used to purchase oral contraceptives, or any other medical item, even if they are not covered by a woman's health plan.

HSAs also allow women to escape useless and frustrating bureaucracy. According to one study:

Three of four women ages 18 to 64 in managed care (75%) reported that they needed a primary care physician referral prior to seeing a specialist. Although referral requirements for OB-GYN care are less restrictive than those for other specialist services, one of four women (23%) said they needed such referrals.<sup>57</sup>

With an HSA, a woman can see whatever doctor she chooses, whenever she chooses. If she knows she needs to see her OB-GYN, a mandatory referral meant to eliminate waste is itself wasteful. HSAs free women from the burden of having to get permission from a bureaucrat in order to take care of themselves.

*Health savings accounts can be used to purchase oral contraceptives, or any other medical item, even if they are not covered by a woman's health plan.*



*HSAs greatly enhance a woman's ability to save for retirement.*

**HSAs Deliver More Responsive Care.** HSAs also make healthcare more responsive to women, particularly women with special needs. One study found Latinas are more likely than white or African-American women not to have their questions answered by a doctor, not to understand or remember a doctor's instructions, and to have concerns about the quality of their care. This may help explain why Latinas were twice as likely as white women not to have seen a doctor in the past year, and suggests that cultural and language barriers could be preventing Latinas from getting optimal care.<sup>58</sup>

Given the chance to accumulate savings in HSAs, Latinas will find medical professionals marketing directly to them. Simply put, when more doctors are answering directly to Latinas rather than insurance companies, more doctors will speak Spanish.

**HSAs Give Women Greater Retirement Security.** HSAs are particularly valuable to women as they age. The proportion of women age 44 to 65 who report their health as "fair" or "poor," and who report suffering from a disability, handicap, or chronic condition, is nearly twice that of women age 18 to 44.<sup>59</sup> These trends continue later in life,<sup>60</sup> when health needs place a greater burden on women:

Given women's longer life spans ... women on Medicare are more likely than men to have multiple health problems and functional limitations. They rely more on long-term care services and constitute the majority of users of home healthcare and nursing home services. Exacerbating their poorer health status is their worse financial situation.<sup>61</sup>

For example, women's Social Security benefits are typically lower than men's.<sup>62</sup> As a result, out-of-purse medical expenses consume 22 percent of elderly women's income, compared to 17 percent for elderly men.<sup>63</sup> "More than one of five [women] (22%) have no supplemental coverage to pick up their share of Medicare premiums or to help pay for services that Medicare does not cover."<sup>64</sup> Encouraging greater retirement savings becomes even more important as employers continue to curtail retiree health benefits,<sup>65</sup> and Medicare's financial picture worsens.

HSAs greatly enhance women's ability to save for their retirement. Experience with Archer MSAs shows even low-income individuals are able to accumulate savings. Forty-seven percent of MSAs and over one-third of MSA deposits were owned by Americans making less than \$50,000 annually. Over one-fifth of MSAs were held by those earning less than \$25,000 per year.<sup>66</sup> (See Figure 5.)



**Distribution of MSA Holders and Deposits, 2000**

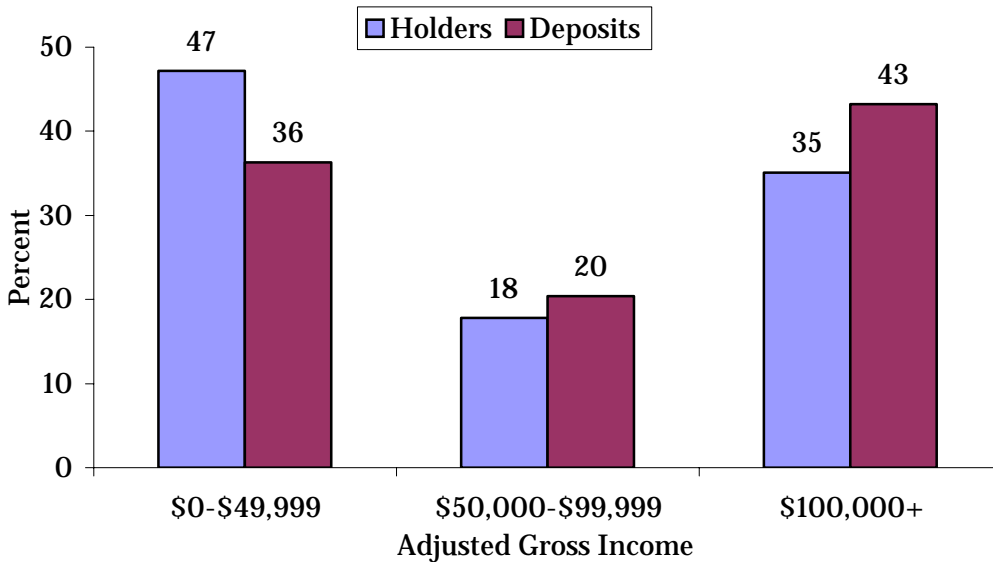


Figure 5 – Source: Internal Revenue Service

A study examining women’s lifetime medical consumption estimated how much women would save by age 60 by contributing \$2,000 annually to an HSA-like account. Investing in stocks, 90 percent of women would reach age 60 with \$100,000 or more in their HSAs, and half of women would have saved \$250,000 or more. At the low end, just 10 percent of women who invested in bonds (stocks) would reach age 60 with less than 50 percent (125 percent) of their lifetime contributions. “Only a small fraction would approach retirement with small balances.”<sup>67</sup>

**HSAs Aid Women with Severe Illnesses.** HSAs help the sick and healthy alike. According to one Archer MSA holder:

“I had breast cancer and so we haven’t saved anything,” said [Julie] Seguin, 40. But “I had been paying on a PPO before and felt like I was throwing money away. With MSAs, you still pay the premium, but can get part of it back.”<sup>68</sup>

HSAs even benefit the very small percentage of women with high medical costs. First, HSAs lower the cost of care by curbing medical inflation. Second, severely ill women can pay their out-of-purse

*Investing HSA funds in stocks, 90 percent of women would reach age 60 with over \$100,000 saved and half would have saved \$250,000 or more.*



*Health savings accounts give women affordable coverage, more choices, more control, more retirement savings, and greater satisfaction.*

expenses with pre-tax dollars, and would at least have a chance to save some funds tax-free. Third, women with high medical expenses benefit the most from the increased control HSAs offer. Fourth, a woman's family members and employer can contribute to her HSA, as can her husband's employer if she is unemployed. Making HSAs more flexible and raising the contribution limits (see below) would deliver even greater value to women with high medical expenses. Finally, HSAs can eliminate waste and improve quality in government safety net programs such as Medicaid.<sup>69</sup>

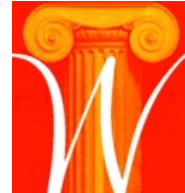
**How to Make HSAs Even More Valuable to Women.** As important to women as HSAs are in themselves, HSAs can be improved to better meet women's needs. To aid as many women as possible to the maximum extent possible, HSAs should be enhanced in a number of ways.

- **Expand Eligibility.** HSAs should be open to all Americans, regardless of age or health insurance status.
- **Eliminate Health Insurance Requirements.** HSAs are currently allowed only with high-deductible insurance and with specified limits on consumers' out-of-pocket exposure. There is no reason to limit consumers' choices in these areas. Individuals should be permitted to open an HSA on its own or in combination with any health insurance plan.

One reason to allow greater flexibility is to encourage more Americans to save for their health needs as opposed to handing their healthcare dollars over to a third party. For example, with their greater health needs, many women may be reluctant to switch to a high-deductible health plan. Those who are more comfortable with low-deductible coverage should be allowed to begin saving in an HSA that would cover their deductibles and co-payments. As these women accumulate savings, many would gravitate toward higher-deductible plans.

More fundamentally, women who do not want or cannot obtain health insurance deserve the same access to HSAs as others. Likewise, an employer who cannot provide health insurance but can contribute to her workers' HSAs should also have that option.

Experience in other countries demonstrates how highly consumers value greater flexibility. For example, in South Africa, HSAs may be coupled with any type of health insurance. This has enabled insurers to innovate plans of varying



deductibles. South African consumers have responded by giving HSAs over half of the private health insurance market.<sup>70</sup>

In 2003, the House of Representatives moved in this direction by approving a bill (H.R. 2596) sponsored by House Ways and Means Committee Chairman Bill Thomas (R.- Calif.) that would have allowed HSAs to be combined with more types of health insurance, or to be opened by those without health insurance. This added flexibility was dropped from the bill before it was rolled into the Medicare Prescription Drug, Improvement, and Modernization Act.

HSAs are designed to restore consumer sovereignty by removing government interference. To prescribe what type of health insurance (if any) consumers must buy conflicts with the underlying philosophy of HSAs, which is to free consumers from government restrictions.

- **Allow deductibility of insurance premiums.** While both individuals and employers can make tax-free HSA contributions, only employers may deduct the cost of health insurance premiums from taxes. This is discriminatory and unfair to women, many of whom do not have access to employment-based coverage. Individuals should be allowed to deduct the cost of their health insurance premiums from income taxes. This can be accomplished either by raising HSA contribution limits (see below) and allowing HSA funds to be used for all health premiums (see farther below), or by granting a deduction specifically for health insurance premiums. President Bush has endorsed the latter approach for high-deductible premiums.<sup>71</sup>
- **Increase contribution limits.** In the absence of any health insurance requirements, HSA contributions would have to be subject to some other limit. In general, annual limits should be set high enough for consumers to couple a health account with a true high-deductible health insurance policy and have no gaps in coverage. For example, individuals could be allowed to contribute \$3,000 per year and purchase a health insurance policy with a \$3,000 deductible, while families could contribute \$6,000 per year and have a \$6,000 deductible. "Catch-up" contributions for those nearing retirement should also be increased, such as by raising the maximum amount and lowering the age at which such contributions may start.

*In South Africa, HSAs may be coupled with any type of health insurance. This has enabled insurers to innovate with plans of varying deductibles.*



*The more flexible the rules for contributing to HSAs, the better women (and men) will be able to save for their retirement health expenses.*

It is desirable – indeed necessary – that HSA contribution limits be higher than currently allowed. Given employers' continuing curtailment of retiree health benefits and the extreme fiscal pressures that will be exerted on Medicare in the coming decades, the federal government should encourage all Americans to save as much as possible for their health needs. The more flexible the rules for contributing to HSAs, the better women (and men) will be able to save for their retirement health expenses.

- **Disbursements.** Consumers should be able to use untaxed health account funds to pay for any medical expense. This should encompass all currently allowed expenses, plus all health insurance premiums, including individually purchased insurance, COBRA, and Medicare supplemental insurance.

Disbursements for non-medical expenses should be subject to income taxes with no additional penalty.

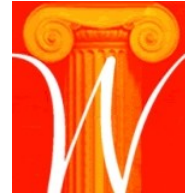
Upon the death of the account holder, health account funds should be transferred untaxed first to the spouse, then to any dependents covered under the account holder's health insurance policy. Only absent such relationships should HSA funds be subject to tax as part of the decedent's estate.

Improving HSAs with the above changes would make health insurance even more affordable for women, give women more coverage choices, provide more flexible coverage, guarantee women more control over their medical decisions, allow women to accumulate significant savings for their current and future health expenses, and make the healthcare system more responsive to women's needs.

### **Conclusion**

Women have an even greater stake than men in ensuring that healthcare reform is done right – that it control costs, empower patients, and increase access to medical care – because any healthcare reform will affect women more than men. Women live longer, bear the children, arrange medical care for the family, and consume more care than men.

The tax treatment of employer-provided health insurance unfairly discriminates against women. It increases healthcare costs, robs women of control over their medical care, and raises additional barriers to care for those who do not have a steady connection to



employer-provided health benefits. Because women have lower incomes than men, consume more healthcare, and have less access to employer-provided coverage, they are penalized by this government failure several times over.

A more compassionate approach would allow women's choices – rather than government's choices – to guide providers, insurers, and women's destinies. Tax-free Health Savings Accounts provide the best opportunity for making America's healthcare system work for women. Congress should build on this important reform by making HSAs more flexible and widely available. If fully realized, HSAs would provide more options for comprehensive coverage, restore power to patients, make health insurance more affordable, and improve retiree healthcare – particularly for women.

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### **Acknowledgements**

The author would like to thank Scott Moody of the Tax Foundation and Terry Holman of Direct to the Source, Inc., for their assistance in collecting data.

### **About the Author**

Michael F. Cannon is Director of Health Policy Studies at the Cato Institute in Washington, D.C.. He is also a Senior Fellow with the National Center for Policy Analysis in Dallas, Texas, and a Lincoln Fellow with the Claremont Institute in Claremont, California. Cannon previously served as a domestic policy analyst at the U.S. Senate Republican Policy Committee, where he advised the Senate leadership apply classical liberal principles to health, education, labor, welfare, and Second Amendment policy. Cannon has appeared in media nationwide to discuss free-market ideas, including CNN, CNBC, C-SPAN, Fox News Channel, National Public Radio, *National Review Online*, the *Washington Times*, *Investor's Business Daily*, *Regulation*, and the *San Diego Union-Tribune*. Cannon holds a B.A. in American government from the University of Virginia in Charlottesville, Virginia.

*Health savings accounts restore power to patients, make coverage affordable, and improve retiree healthcare – particularly for women.*



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### Endnotes

<sup>1</sup> Will Lester, "Poll: Public Supports Healthcare for All," *Washington Post*, October 20, 2003, <http://www.washingtonpost.com/wp-dyn/articles/A52611-2003Oct20.html>. Support for a government-run system was nearly 2-1 (62 percent vs. 32 percent), though support diminished when limiting choice of doctors and waiting lists were linked to government control. Other surveys have shown increased support for government-provided health insurance. See "2003 Health Confidence Survey Summary of Findings," Employee Benefit Research Institute, September 2003, p. 9, <http://www.ebri.org/hcs/2003/03hcssof.pdf>.

<sup>2</sup> "Healthcare Worries in Context with Other Worries," Kaiser Family Foundation *Health Poll Report*, July/August 2003, <http://www.kff.org/healthpollreport/templates/detail.php?page=2&feature=hsw>.

<sup>3</sup> Alina Salganicoff and J. Zoë Beckerman, "Women's Health in the United States: Health Coverage and Access to Care," Kaiser Family Foundation, May 2002, p.1, <http://www.kff.org/content/2002/6027/6027final.pdf>.

<sup>4</sup> Employee Benefit Research Institute, p. 3. The difference between women rating the economy (25 percent) vs. healthcare (23 percent) as their highest concern was within the survey's overall margin of error (plus or minus 3 percent).

<sup>5</sup> Employee Benefit Research Institute, p. 5.

<sup>6</sup> National Women's Law Center, "Contraceptive Coverage: An Essential Component of Health Benefits Plans," <http://www.nwlc.org/pdf/ContraceptiveCoverageFactSheet2003.pdf>.

<sup>7</sup> Salganicoff and Beckerman, p. 7.

<sup>8</sup> Ibid.

<sup>9</sup> Misra, D, ed., *Women's Health Data Book: A Profile of Women's Health in the United States*, Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation. 2001, p. 177, <http://www.kff.org/content/2001/6004/Final%20Data%20Book.pdf>.

<sup>10</sup> Ha T. Tu and J. Lee Hargraves, "Seeking Healthcare Information: Most Consumers Still on the Sidelines," Center for Studying Health System Change *Issue Brief*, No. 61, March 2003, <http://www.hschange.com/CONTENT/537/537.pdf>.

<sup>11</sup> *Health, United States 2003*, National Center for Health Statistics, pp. 46, 131, 133, <http://www.cdc.gov/nchs/data/hs/hs03.pdf>.

<sup>12</sup> Salganicoff and Beckerman, p. 19.

<sup>13</sup> Roberta Wyn, Ph.D. and Victoria Ojeda, "Women, Work, and Family Health: A Balancing Act," Henry Kaiser Family Foundation *Issue Brief*, April 2003, p. 1, [http://www.kff.org/content/2003/3336/Balancing\\_Act\\_Issue\\_Brief.pdf](http://www.kff.org/content/2003/3336/Balancing_Act_Issue_Brief.pdf).

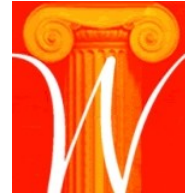
<sup>14</sup> Karen Scott Collins et. al., "Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health," The Commonwealth Fund, May 1999, p. 11, [http://www.cmwf.org/programs/women/ksc\\_whsurvey\\_332.pdf](http://www.cmwf.org/programs/women/ksc_whsurvey_332.pdf).

<sup>15</sup> U.S. Census Bureau and Small Business Administration data, in Diana Furchtgott-Roth and Christine Stolba, *Women's Figures: An Illustrated Guide to the Economic Progress of Women in America* (AEI Press: 1999), p. 94, <http://iwf.org/pubs/figures.shtml>.

<sup>16</sup> "Applicants to U.S. Medical Schools Increase; Women the Majority for the First Time," Association of American Medical Colleges press release, November 4, 2003, <http://www.aamc.org/newsroom/pressrel/2003/031104.htm>.

<sup>17</sup> *Health, United States 2003*, p. 298.

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<sup>18</sup> "Women in the U.S. Congress 2003," Center for American Women and Politics *Fact Sheet*, January 2003, p. 2, <http://www.rci.rutgers.edu/~cawp/Facts/Officeholders/cong.pdf>.

<sup>19</sup> To contain rising premium costs, employers have tended to reduce health benefits. If not for these changes, premiums could have risen as much as 3 percent more. Bradley C. Strunk and Paul B. Ginsburg, "Tracking Healthcare Costs: Trends Stabilize but Remain High in 2002," *Health Affairs Web Exclusive*, June 11, 2003, pp. W3-272, <http://www.healthaffairs.org/WebExclusives/2204Strunk.pdf>.

<sup>20</sup> "Table A-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1987 to 2002 – Continued," U.S. Census Bureau, <http://www.census.gov/hhes/hlthins/historic/hihist1.html>. This government estimate is the most commonly used measure of the number of Americans without health insurance. However, this measure tends to portray uninsurance as a constant for the entire group, when in fact many are without health insurance only for brief periods. For an examination of uninsurance that accounts for the dynamic nature of health insurance markets, see "How Many People Lack Health Insurance and for How Long?" U.S. Congressional Budget Office, May 2003, <ftp://ftp.cbo.gov/42xx/doc4210/05-12-Uninsured.pdf>.

<sup>21</sup> Richard F. Corlin, M.D., "Managed Care and its Impact on American Medicine: A View from the AMA," American Medical Association press release, November 15, 2002, <http://www.ama-assn.org/ama/pub/article/1752-7136.html>.

<sup>22</sup> Marc Siegel, M.D., "I'm Sorry, Your Illness Is Coded for Only 15 Minutes," *The Washington Post*, September 14, 2003, p. B03, <http://www.washingtonpost.com/wp-dyn/articles/A3664-2003Sep12.html>.

<sup>23</sup> Salganicoff and Beckerman, p. 1.

<sup>24</sup> "If the trend continues, the number of uninsured women will surpass that of men for the first time in 2005," Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey, "Health Insurance Tax Credits: Will They Work For Women?" The Commonwealth Fund, December 2002, p. vi, [http://www.cmwf.org/programs/insurance/collins\\_creditswomen\\_589.pdf](http://www.cmwf.org/programs/insurance/collins_creditswomen_589.pdf).

<sup>25</sup> Salganicoff and Beckerman, p. 31.

<sup>26</sup> Certain other health expenditures are given preferential tax treatment, including a deduction for medical expenses above 7.5 percent of adjusted gross income. However, the excludability of employer-provided health benefits has the largest impact on the healthcare system.

<sup>27</sup> Interestingly, the practice began because of another government failure. Employer-provided health benefits had been excluded from taxation since the imposition of a federal income tax in 1913. However, employer-provided health benefits became more widespread during and after World War II as employers used non-wage compensation to skirt government wage controls and attract workers. See Robert B. Helms, "The Tax Treatment of Health Insurance: Early History and Evidence, 1940-1970," in Grace-Marie Arnett, ed., *Empowering Healthcare Consumers Through Tax Reform*, (University of Michigan: 1999), pp. 1-25, <http://www.galen.org/book.asp>.

<sup>28</sup> Assuming a 15.3 percent payroll tax and a marginal income tax rate of 34 percent (28 percent federal and 6 percent state). Self-employed workers may deduct the cost of health insurance from their income taxes only.

<sup>29</sup> Helms, pp. 6-8.

<sup>30</sup> The drop in out-of-pocket spending since 1965 is due to greater third-party payments through Medicare and Medicaid as well as the tax exclusion of employer-provided health benefits. "National Healthcare Source of Funds; Selected Calendar Years," U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, September 2002, <http://www.cms.gov/researchers/pubs/datacompendium/2002/02pg15.pdf>.



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- <sup>32</sup> Martin Feldstein and Elisabeth Allison, in Helms, p. 12.
- <sup>33</sup> U.S. Department of Labor, Bureau of Labor Statistics, <http://www.bls.gov/data/>. Consumer Price Index – All Urban Consumers custom data files (not seasonally adjusted).
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- <sup>35</sup> Strunk and Ginsburg, p. W3-266.
- <sup>36</sup> See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Healthcare Crisis* (Cato Institute: 1992), pp. 200-208, <http://www.catostore.org/>.
- <sup>37</sup> Clark Havighurst in Helms, p. 6.
- <sup>38</sup> See Corlin, Siegel.
- <sup>39</sup> Friedman, p. 6.
- <sup>40</sup> Estimate derived from \$496.1 billion National Health Expenditure on private health insurance for 2001 ("National Healthcare Expenditures Projections: 2002-2012," U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, Table I, p. 3, <http://www.cms.gov/statistics/nhe/projections-2002/proj2002.pdf>) and Martin Feldstein's estimate of a net welfare loss due to the exclusion equal to 30 percent of total private health insurance premiums (Helms, p. 16). Helms makes a similar "crude" estimate for 1993.
- <sup>41</sup> Salganicoff and Beckerman, p. 13.
- <sup>42</sup> Author's calculations based on Bureau of Labor Statistics, "Characteristics of Minimum Wage Workers: 2002," Table 1, p. 3, <http://www.bls.gov/cps/minwage2002pdf.pdf>.
- <sup>43</sup> Celeste Colgan and Michael F. Cannon, "Tax-Free Health Savings Accounts: Portable, Flexible Health Coverage for Working Women," National Center for Policy Analysis *Brief Analysis*, No. 455, September 15, 2003, <http://www.ncpa.org/pub/ba/ba455/ba455.pdf>.
- <sup>44</sup> U.S. Census Bureau, "Reasons People Do Not Work, 1996," Table 3, p. 5, <http://www.census.gov/prod/2001pubs/p70-76.pdf>.
- <sup>45</sup> "National Longitudinal Survey," Bureau of Labor Statistics, USDL 02-497, p. 1, <http://www.bls.gov/nls>.
- <sup>46</sup> Salganicoff and Beckerman, p. 23.
- <sup>47</sup> Out-of-pocket costs consume a greater share of income in families headed by women than families headed by men. Mark Merlis, "Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity," The Commonwealth Fund, June 2002, p. 30, [http://www.cmwf.org/programs/insurance/merlis\\_oopspending\\_509.pdf](http://www.cmwf.org/programs/insurance/merlis_oopspending_509.pdf).
- "[O]ne in five women reported they did not fill prescriptions due to costs, a rate that was significantly higher than men (13%)." Salganicoff and Beckerman, p. 41.
- In 1998, one-fifth of women age 45-64 reported not getting care when needed, not seeing a specialist when needed, or not getting a prescription filled due to cost. Karen Scott Collins and Erin Strumpf, "Living Longer, Staying Well: Promoting Good Health for Older Women," The Commonwealth Fund Issue Brief, September 2000, p.1, [http://www.cmwf.org/programs/women/collins\\_olderwomen\\_ib\\_412.pdf](http://www.cmwf.org/programs/women/collins_olderwomen_ib_412.pdf).



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"Overall, approximately one-quarter of women reported they delayed or did not get healthcare in the past year because they could not afford it, a significantly higher rate than men (16%)." Salganicoff and Beckerman, p. 38.

<sup>48</sup> Salganicoff and Beckerman, p. 23.

<sup>49</sup> Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Harvard University Press: 1996), pp. 338-339.

<sup>50</sup> See Friedman, p. 19.

<sup>51</sup> See John C. Goodman, "Medical Savings Accounts: An Idea Whose Time Has Come," in Arnett, p. 147; and "Questions Linger about whether CD plans are controlling costs," *Consumer Driven Healthcare*, September 2003, <http://www.nhionline.net/> (subscription required).

<sup>52</sup> Newhouse *et al.*, pp. 338-339.

<sup>53</sup> "MSAs: IRS Announcement 2002-90 Providing 2002 Not Cut-Off Year for Archer MSA Pilot Project Under I.R.C. Section 220; Announcement 2002-90 is scheduled to appear in Internal Revenue Bulletin 2002-40, dated Oct. 7, 2002," Bureau of National Affairs, Inc., September 30, 2002, <http://pubs.bna.com/ip/BNA/DER.NSF/9311bd429c19a79485256b57005ace13/786388900f76c37885256c42000d9e53?OpenDocument> (subscription required).

<sup>54</sup> Author's calculations based on "Monthly Rates for Individuals and Families; Effective July 1, 2003," Blue Shield of California, p. 5. In the same way, HSAs protect employers from the bite of premium inflation. A majority of small employers report they would either change the coverage they offer their employees (54 percent) or drop coverage entirely (15 percent) if faced with another 15 percent premium increase like that faced by many employers in 2003. In 2002, the most common change small businesses made to their health benefits was to increase deductibles and co-payments. (Paul Fronstin, *et al.*, "Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey," Employee Benefit Research Institute *Issue Brief*, No. 253, January 2003, pp. 5-6, <http://www.ebri.org/pdfs/0103ib.pdf>.) HSAs can cover those deductibles and co-payments on the same tax-preferred basis as the premiums, and allow employers to confine inflationary pressures to a smaller part of their health benefits package.

<sup>55</sup> Author's estimates based on average annual premium increase in California's individual health insurance market (6.5 percent) from 1997-2002. Melinda Beeuwkes Buntin *et al.*, "Trends and Variability in Individual Insurance Products in California," *Health Affairs*, September 24, 2003, p. 8, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.449v1.pdf>.

<sup>56</sup> National Women's Law Center.

<sup>57</sup> Collins *et al.*, p. 3.

<sup>58</sup> Salganicoff and Beckerman, pp. 30-35.

<sup>59</sup> Salganicoff and Beckerman, p. 7.

<sup>60</sup> Collins and Strumpf, p.1.

<sup>61</sup> Misra, p. 171.

<sup>62</sup> "Women in Retirement," Employee Benefits Research Institute *Facts from EBRI*, November, 2001, <http://www.ebri.org/facts/1101fact.pdf>.

<sup>63</sup> Misra, p. 173.

<sup>64</sup> Collins and Strumpf, p.1.



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<sup>65</sup> About one-quarter of large employers plan to move retirees to some type of health savings account with catastrophic coverage. Enhancing HSAs would enable retirees to augment their employers' contribution with more tax-free savings. Frank McArdle, et. al., "The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey," Kaiser Family Foundation/Hewitt Associates, December 04, 2002, pp. 43-44, <http://www.kff.org/content/2002/20021205a/6061v4.pdf>.

<sup>66</sup> Internal Revenue Service, Statistics of Income, Individual Income Tax Returns 2000, Publication 1304 (Rev. 04-2003). The IRS notes that data for some income strata "should be used with caution due to the small number of sample returns on which [they are] based." Despite limitations, these are the only data available on MSA returns. Moreover, IRS data for 2000 are more comprehensive than data for prior years, which have been cited by opponents of Archer MSAs. See *Congressional Record*, June 29, 2001, p. S7148, (using 1998 data).

<sup>67</sup> Matthew J. Eichner and David A. Wise, "Little Saving and Too Much Medical Insurance: Medical Savings Accounts Could Help," in David A. Wise, ed., *Personal Saving, Personal Choice*, Stanford: Hoover Institution Press, 1999, pp. 89, 92.

<sup>68</sup> Aïssatou Sidimé, "A Difference in Policy," *San Antonio Express-News*, April 15, 2002, <http://news.mysanantonio.com/global-includes/printStory.cfm?xla='saen'&xlb=0&xlc=671718>.

<sup>69</sup> See Michael Bond et. al., "Reforming Medicaid," National Center for Policy Analysis Policy Report No. 257, February 2003, <http://www.ncpa.org/pub/st/st257/st257.pdf>.

<sup>70</sup> Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis Study, No. 234, June 2000, <http://www.ncpa.org/studies/s234/s234.html>.

<sup>71</sup> U.S. Government Printing Office, "Budget of the United States Government, Fiscal Year 2005," p. 32, <http://www.whitehouse.gov/omb/budget/fy2005/pdf/budget/prosperity.pdf>.

## ABOUT IWF

The Independent Women's Forum, founded in 1992, is a nonprofit, nonpartisan, educational organization. IWF provides a voice for women who believe in individual freedom and personal responsibility, and who embrace common sense over divisive ideology.



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