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IS HEALTH INSURANCE A BAD IDEA? THE CONSUMER-DRIVEN PERSPECTIVE

*Timothy Stoltzfus Jost*¹

Unique among the developed nations of the world, the United States depends on private insurance to insure a majority of its residents.² Private insurance exists virtually everywhere in the world, but in most countries it merely supplements or complements a comprehensive public insurance program that covers all, or virtually all, of the population.³ There are complicated historical, political, and cultural reasons why we depend on private insurance for health coverage in the United States.⁴ It seems very unlikely, however, that we will abandon private health insurance as our primary form of health coverage in the foreseeable future.

Nevertheless, it seems clear, that private insurance coverage in the United States is on the decline. Employment-based insurance coverage probably peaked sometime in the late 1970s or early 1980s, and has been falling ever since, with a brief uptick in the late 1990s. Coverage has dropped from 73 percent of the population under 65 in 1999 to 66.5 percent in 2006.⁵ Even though public insurance coverage has been growing as private insurance coverage shrinks, the number of uninsured continues to rise, to 43.6 to 44.8 million, nearly 17% of the under-65 population in 2005-2006.⁶

1. Robert F. Willett Family Professor, Washington and Lee University., This article was submitted in August of 2007, and was current as of that date. It is based in part on my recently published book: TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* 54-69 (2007). I would like to thank the Frances Lewis Law Center and the Willett Family for research support.

2. See Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 433 (2004) (describing how other nations provide health care coverage).

3. ELIAS MOSSIALOS & SARAH M.S. THOMPSON, *VOLUNTARY HEALTH INSURANCE IN THE EUROPEAN UNION, FUNDING HEALTH CARE: OPTIONS FOR EUROPE* 128-31 (Elias Mossialos et al. eds., 2002)

4. See JOST, *HEALTH CARE AT RISK*, *supra* note 1.

5. CENTER FOR DISEASE CONTROL AND PREVENTION, *PERCENTAGE OF PERSONS UNDER AGE 65 YEARS WITH PUBLIC HEALTH PLAN COVERAGE AND PRIVATE HEALTH INSURANCE COVERAGE, BY AGE GROUP: UNITED STATES, 1997-2006* (2007), http://www.cdc.gov/nchs/data/nhis/earlyrelease/200706_01.pdf.

6. The lower figure is from: CENTER FOR DISEASE CONTROL AND PREVENTION, *NUMBER AND PERCENTAGE OF PERSONS WITHOUT HEALTH INSURANCE COVERAGE AT THE TIME OF INTERVIEW, BY AGE GROUP: UNITED STATES, 1997-2006* (2007),

Although most view the number of uninsured as a problem, a small, but very influential minority of American policy advocates consider “overinsurance” to be our most serious policy problem.⁷ The strength of this movement, known euphemistically as the consumer-driven health care (CDHC) movement, is demonstrated by the fact that these advocates succeeded in the waning moments of the 109th Congress, in expanding federal tax subsidies for health savings accounts (HSAs), their policy alternative to conventional health insurance.⁸

Since the early 1970s, a number of conservative and libertarian advocacy groups have kept up a steady drumbeat of criticism of our current private health insurance system.⁹ They claim that this system is the product of bad public policy, in particular of the employment-related health insurance tax subsidy.¹⁰ This subsidy, they charge, has resulted in employers offering and employees accepting far more insurance than would be purchased without the tax subsidy.¹¹

This excessive insurance, they claim, results in excess consumption and higher prices of health care. The tax subsidy decreases the price to consumers and thus increases the demand for health insurance, which in turn decreases the price to consumers and increases the demand for health

http://www.cdc.gov/nchs/data/nhis/earlyrelease/200706_01.pdf. The higher figure is from: Press Release, U.S. Census Bureau, Census Bureau Revises 2004 and 2005 Health Insurance Coverage Estimates (Mar. 23, 2007), available at http://www.census.gov/Press-Release/www/releases/archives/health_care_insurance/009789.html.

7. See MICHAEL F. CANNON & MICHAEL D. TANNER, *HEALTHY COMPETITION: WHAT’S HOLDING BACK HEALTH CARE AND HOW TO FREE IT* 46-58 (2005); JOHN C. GOODMAN, GERALD L. MUSGRAVE & DEVON M. HERRICK, *LIVES AT RISK: SINGLE-PAYER NATIONAL HEALTH INSURANCE AROUND THE WORLD* 4 (2004); JOST, *supra* note 1, at 35.

8. Health Savings Accounts were created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, 117 Stat. 2066 (2003), and codified at I.R.C. § 223 (2007). Contribution limits were liberalized by the Health Opportunity Patient Empowerment Act of 2006 in the last minutes of the 109th Congress; see Press Release, United States Treasury, President Bush Signs Bill to Make Health Care More Affordable, Accessible (Dec. 20, 2006), available at <http://www.ustreas.gov/press/releases/hp209.htm>.

9. See JOST, *HEALTH CARE AT RISK*, *supra* note 1, at 70-85.

10. See JOHN F. COGAN, R. GLENN HUBBARD & DANIEL P. KESSLER, *HEALTHY, WEALTHY, AND WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM*, 15-16, 27-33 (2005); CANNON & TANNER, *supra* note 7, at 61-66; JOHN C. GOODMAN, GERALD L. MUSGRAVE & DEVON M. HERRICK, *PATIENT POWER: SOLVING AMERICA’S HEALTH CARE CRISIS*, 50-51 (1992).

11. CANNON & TANNER, *supra* note 7, at 62-65.

care.¹² Insured health care consumers buy far more health care products and services than they would if they had to pay for health care out of their own pockets. This is the phenomenon of moral hazard that insurance teachers talk about every day. Consumers also pay higher prices than they would pay without insurance because they have no incentive to shop around for lower price providers.¹³ The tax subsidy is, therefore, one of the most important reasons why health care costs so much in the United States¹⁴ While the moral hazard claims of CDHC advocates seem to be solidly based in neoclassical economic theory, they also are supported by the Rand Health Insurance Experiment, which found that insureds with higher deductible plans do in fact consume less health care.¹⁵

But there is more to their claims. CDHC advocates also argue that consumers who are not paying for health care out of their own pockets are less concerned about quality than they might be if they were paying for services themselves.¹⁶ At least, consumers have less reason to seek out comparative information regarding providers, which could support shopping based on quality as well as cost.¹⁷ Fully insured individuals also have less incentive to take care of themselves, to engage in healthy behaviors and seek preventive or early primary care, and thus are more likely to become ill and need health care¹⁸ (a claim, by the way, that the Rand study found no evidence to support).¹⁹

The ultimate solution to the problem of excess insurance—simply outlawing health insurance—is not embraced by even the most fervent market advocates. They understand the problem of catastrophic costs – of the highly skewed nature of health care costs that accounts for health insurance in the first place.²⁰ Few people can afford to pay out of pocket for a heart transplant or for the services required to respond to the major

12. CANNON & TANNER, *supra* note 7, at 62-63; COGAN, HUBBARD & KESSLER, *supra* note 10, at 29-30.

13. JOST, *supra* note 1, at 19.

14. *See supra* note 10.

15. *See* JOSEPH P. NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993); *see* JOST, *supra* note 1, at 120-28 (examining the findings of and critiquing the RAND HIE).

16. CANNON & TANNER, *supra* note 7, at 54-57.

17. *Id.*

18. GOODMAN et al., *supra* note 10, at 92-94.

19. NEWHOUSE, *supra* note 15 at 200-01, 208.

20. *See* Jost, *Why Can't We Do What They Do?*, *supra* note 2, at 436.

traumatic injuries caused by a car accident.²¹ Many of those afflicted with expensive chronic diseases would soon find themselves unable to afford further health care without health insurance. Bankruptcy solves the problems of some of those faced with enormous expenses and no insurance, but it only deals with already incurred costs and does not assure continuing access to care.²² Bankruptcy, moreover, only shifts the costs of care to providers, who themselves may be financially unable to absorb the loss.

Acknowledging the problems that would attend the elimination of health insurance, CDHC advocates rather call for limiting insurance to truly catastrophic expenses through the imposition of high deductibles.²³ Most, but not all, CDHC advocates also call for the creation of health savings accounts (HSAs) to be coupled with high-deductible health insurance plans (HDHPs).²⁴ They call for tax subsidies to cover contributions to the HSAs (whether contributions come from employers or employees) as well as the income from those plans and payments for high-deductible health plans.²⁵ Advocates contend that HSAs will introduce point-of-purchase competition into health care and save the cost of claims processing, thus reducing health care costs.²⁶ At the same time, they believe that HSAs will assure that consumers have funds available to purchase health care, thus assuring access, and will encourage consumers to shop for better quality products and services, thus improving quality. They even argue that moving to CDHC will expand insurance coverage, as catastrophic policies will be more affordable, both because they offer thinner coverage and because consumers will consume more cost consciously, bringing down insurance costs.²⁷

Over the past half decade the CDHC movement has been extraordinarily successful in public policy advocacy. Although tax subsidies for medical savings accounts were first introduced by the Health Insurance Portability and Accountability Act of 1996, they were subject to

21. According to recent estimates, heart transplants cost from \$50,000 to \$287,000, averaging \$148,000, while liver transplants cost from \$66,000 to \$367,000, averaging \$235,000. *Transplant*, CHFPATIENTS.COM, <http://www.chfpatients.com/tx/transplant.htm>.

22. See Melissa B. Jacoby, *The Debtor Patient: In Search of Non-Debt Based Alternatives*, 69 BROOK. L. REV. 453, 456-57, 462 (2003-2004).

23. GOODMAN et al., *supra* note 10, at 231-32.

24. *Id.*, CANNON & TANNER, *supra* note 7, at 66-68.

25. CANNON & TANNER, *supra* note 7, at 67; Cogan, Hubbard, & Kessler, *supra* note 10, at 35-38.

26. GOODMAN et al., *supra* note 10, at 249-250.

27. *Id.* at 250.

many restrictions and never really caught on.²⁸ The Medicare Modernization Act of 2003 (“MMA”), however, greatly expanded tax subsidies for health care accounts, which it rechristened health savings accounts, or HSAs.²⁹

The MMA offers a tax exclusion to employers and a deduction to employees for funds contributed by an employer or employee to an HSA. The HSA must, however, be coupled with a HDHP, which must, in 2007, have a deductible of at least \$1100 a year for a single individual or \$2200 a year for family coverage.³⁰ The catastrophic policies that accompany an HSA must also have caps on out of pocket expenditures, which cannot exceed \$5500 for an individual and \$11,000 for a family in 2007.³¹ The tax subsidies for contributions to the HSA for 2007 only extend to contributions up to, for 2007, \$2850 for individual coverage and \$5650 for family coverage.³² Under the MMA, tax-deductible contributions were also limited to the amount of the deductible, but this limit was removed by Congress in legislation late in 2006.³³

Money contributed to an HSA can be spent for “qualified medical expenses,” without being subject to income tax, but withdrawals are subject to both income tax and to a 10% excise tax if it is spent for other purposes.³⁴ “Qualified medical expenses” are broadly defined to include many things not covered by traditional health insurance, such as nonprescription drugs. HSA expenditures are controlled only by very

28. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2037 (1996). Too few people signed up for the HIPAA demonstration project to allow program evaluation. General Accounting Office, *Medical Savings Accounts: Results from Surveys of Insurers*, 1 (1998).

29. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201, and codified as amended at I.R.C. § 223. For a careful examination of these provisions, see Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 548-56 (2005).

30. I.R.C. §§ 223(c)(2)(A)(i)(I) & (II) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>. The insurer may, however, cover preventive medical expenses, such as screenings or vaccinations, before the deductible is met. I.R.C. § 223(c)(2)(C), I.R.S. Notice 2004-23, 2004-15 I.R.B. 725.

31. I.R.C. §§ 223(c)(2)(A)(ii)(I) & (II) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>

32. I.R.C. § 223(b) (2000). See also 2007 HSA Indexed Amounts, available at <http://www.ustreas.gov/offices/public-affairs/hsa/07IndexedAmounts.shtml>.

33. H.R. 6408, § 303, 110th Cong. (2007).

34. I.R.C. § 223(f) (2000).

infrequent audits by IRS auditors who have no health care expertise³⁵. It is likely, therefore, that HSA expenditures will be limited only by the imagination, on the one hand, and good faith, on the other, of their owners.

If HSA funds are not spent for health care, they can be withdrawn for any purpose once the account holder dies, becomes disabled, or reaches the age of 65.³⁶ HSA funds may continue to be withdrawn after age 65 for qualified medical expenses, including Medicare premiums, free from taxation.³⁷ If they are used for other purposes after age 65, withdrawals are taxed as income, but no penalties attach.

The HSA has been joined by another new health savings device, the health reimbursement account or HRA. The HRA was created not by a statute but rather by the IRS. In 2002, the IRS determined that existing legislation authorized the offer of tax subsidies for employer contributions to health savings vehicles fully funded by employers.³⁸ The HRA is attractive to employers because the accounts can be held as notional accounts and need not be fully funded and because the funds in them also need not go with the employee if he or she leaves employment.

HSAs and HRAs have grown quite quickly over the past two years, although the number enrolled in these plans, like everything else about them, is contested. The Employee Benefits Research Institute estimates that about 1.3 million Americans are enrolled in a consumer-driven plan, though another 8.5 million Americans have a plan with a deductible high enough that they could set up an HSA.³⁹ The Center for Health Systems change estimates that about 1.43 million Americans have an employment-based HSA and 1.3 million have an HRA.⁴⁰ AHIP, the health insurance trade association, claims that 4.5 million Americans are in HSA-compatible

35. I.R.C. § 223(d)(2) (2000). Rev. Rul. 2003-102, 2003-38 I.R.B. 559; I.R.S. Notice 2004-2, 2004-2 I.R.B. 269.

36. I.R.C. § 223(f)(4) (2000).

37. I.R.C. §§ 223(d)(2)(C)(iv), (f)(1) (2000).

38. Rev. Rul. 2002-41.

39. Paul Fronstin & Sara R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey*, Employee Benefit Research Center, Issue Brief No. 300, December, 2006.

40. Jon Gabel, Jeremy Pickreign, & Heidi Whitmore, *Behind the Slow Growth of Employer-Based Consumer-Directed Health Plans*, Center for Studying Health System Change, Issue Brief No. 107, December 2006, available at <http://www.hschange.org/CONTENT/900/900.pdf>.

plans.⁴¹ CDHC advocates claim that the number of Americans in consumer-driven plans will grow to 15-30 million over the next 5 to 10 years,⁴² but CDHC growth, rapid in the first two years, seems to have leveled off, at least in the employment-related market.⁴³

There has been a great deal of speculation as to how CDHC will affect health care in general and the health insurance market in particular.⁴⁴ Advocates believe, of course, that it will bring down costs while improving quality and access. Skeptics have worried that CDHC will lead to favorable selection, as healthy individuals and families choose consumer driven plans, leaving those with costly medical problems in comprehensive plans, which will become ever more costly as they cover a smaller and more

41. AHIP.org, *January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans*, Ctr. for Policy and Research, April 2, 2007, available at http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAREport.pdf.

42. See U.S. Department of the Treasury, *Dramatic Growth of Health Savings Accounts*, <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/fact-sheet-dramatic-growth.pdf> (14 million by 2010); *Health Savings Account Enrollees Predicted to Rise to 30 Million by 2009*, BUSINESS WIRE, May 10, 2007, available at <http://www.allbusiness.com/services/business-services/4342771-1.html>.

43. Fronstin & Collins, *supra* note 39, at 6.

44. Much of this speculation is found in the large and growing law review literature on consumer-driven health care and HSAs. For a sampling of the law review literature examining the policy implications of consumer-driven health care, see generally Marshall Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 2 J. HEALTH & BIOMEDICAL L. 1 (2007); W. Eugene Basanta, *Consumer-Driven Health Care: Legal and Policy Implications*, 29 J. LEGAL MED. 1 (2007); Arnold J. Rosoff, *Consumer-Driven Health Care: Questions, Cautions, and an Inconvenient Truth*, 28 J. LEGAL MED. 11 (2007); Michele Melden, *Guarding Against the High Risk of High Deductible Health Plans: A Proposal for Regulatory Protections*, 18 LOY. CONSUMER L. REV. 403 (2006); David Pratt, *Healthy, Wealthy, and Dead: Health Savings Accounts*, 19 ST. THOMAS L. REV. 7 (2006); Amy Monahan, *The Promise and Peril of Ownership Society Health Policy*, 80 TUL. L. REV. 777 (2006); John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J. L. REF. 531 (2005); and Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients*, 69 BROOK. L. REV. 485 (2004). See also, exploring more closely the implications of consumer-driven health care for the legal relationships of patients and health care professionals and providers, Mark A. Hall and Carl E. Schneider, *Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008); Peter D. Jacobson and Michael R. Tunick, *Consumer-Directed Health Care and the Courts: Let The Buyer (And Seller) Beware*, 26(3) HEALTH AFF., May/June 2007 at 704; Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS. 159 (2006); and E. Haavi Morreim, *High -Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207 (2006).

expensive population, the familiar insurance death spiral.⁴⁵ Skeptics also wonder whether consumers have the information, or perhaps even the ability, to make wise consumer choices in health care.⁴⁶ The Rand HIE, for example, found that although insureds with higher deductibles did consume less health care, they cut back on high value health care to the same extent they cut back on low value health care.⁴⁷

Empirical evidence as to how CDHC is working out remains sketchy. It seems to be working out very well for banks. HSAs are the kind of low interest savings accounts that used to be the bread and butter of banks but that have been hard to market in recent years because they are bad financial investments. The HSA market is worth billions to banks, not just because banks pay low interest on these deposits, but also because they collect fees for establishing the accounts and for transactions.⁴⁸ HSAs also seem to be working out quite well for insurance companies that specialize in these accounts, several of which have bought or partnered with banks, and some of which are managing the accounts themselves.⁴⁹ Finally, HSAs are working out very well for wealthy individuals looking for a retirement tax shelter. Individuals in high tax brackets who have the choice of doing so are well advised to buy a eligible high deductible policy, cover any medical expenses from the deductible, and invest the legal maximum in the HSA, leaving it there for retirement to accumulate tax-free returns. This strategy could allow, by one scenario, a tax-free accumulation of \$1.5 million by retirement over a 40 year period.⁵⁰

It is less clear how CDHC is working out for employers, who purchase much of the private health insurance in the U.S., and for providers. High deductible policies are obviously somewhat less expensive than comprehensive policies, but if employers make a significant contribution to their employees' HSAs, they do not necessarily pay less overall.⁵¹ Some

45. JOST, *supra* note 1, at 133-134.

46. *Id.* at 137.

47. NEWHOUSE, *supra* note 15, at 162.

48. James G. Knight, *What HSAs Mean for Banks*, AMERICAN BANKER, April 29, 2005, available at <http://americanbanker.com/article.html?id=20050428X7JY10TC&queryid=630711033&hitnum=2>; Eric Dash, *Health Savings Promise a Windfall for U.S. Banks*, REDORBIT NEWS, Jan. 29, 2006, available at <http://www.redorbit.com/news/display/?id=373206>.

49. See JOST, HEALTH CARE AT RISK, *supra* note 1, at 23.

50. *Id.* at 22.

51. Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits*, 2006 ANNUAL SURVEY, at 5 (2006), available at <http://www.kff.org/insurance/7527/>.

providers welcome the possibility of being able to bill consumers directly rather than to deal with insurers, but in fact most consumer-driven policies are structured so that the provider bills the insurer in any event, and the insurer then collects from the HSA.⁵² This assures consumers access to the insurer's bargaining power, but means that there is little savings in transaction costs. To the extent that providers bill consumers directly, they will experience savings in transactions costs and probably be able to charge higher prices, but they also have more risk exposure if consumers are unable to pay the bill.

The most important question, however, is how does consumer-driven health care affect consumers? First, there is some evidence of favorable selection toward consumer-driven plans, which seem to be chosen by those in better health, but the effect is not clear.⁵³ Because high deductible and high coinsurance plans have become quite common in recent years, even before the MMA, CDHC plans might be quite attractive to people with high medical costs because the law at least requires a cap on out-of-pocket limits. There is more evidence that CDHC plans are chosen by wealthier and better educated subscribers, which is not surprising.⁵⁴

There is also some evidence that CDHC reduces health care spending and use, and that participants in CDHC plans use more preventive care (which can under the law be excluded from deductibles) and comply better with prescribed treatment regimes.⁵⁵ Evidence on cost-savings, however, is still weak and confounded by the possibility of favorable selection, while evidence of quality improvement is far from conclusive. Some studies, for example, find that CDHC members are more likely to delay or forego needed medical care or the use of necessary medications.⁵⁶

The most troubling emerging evidence is that CDHC is further eroding the modest level of health care solidarity that private health insurance has brought about in this country. The public health insurance systems of all other developed countries are based, in the end, on the idea of solidarity—the belief that we are all at risk of disease and injury, that we all need to be

52. Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 408 (2005).

53. Melinda Beeuwkes Buntin, et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFFAIRS 516, 519, available at http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfulltext=and&resourcetype=1&disp_type=&author1=&fulltext=&pubdate_year=2006&volume=25&firstpage=516.

54. *Id.*; JOST, HEALTH CARE AT RISK, *supra* note 1, at 139.

55. JOST, HEALTH CARE AT RISK, *supra* note 1, at 145.

56. Fronstin & Collins, *supra* note 39, at 26, 29.

healthy to be productive members of society, and we ought all to contribute to the cost of health care to the extent of our ability to the cost of providing health care for all.⁵⁷ Employment-based health insurance has sustained a weak version of solidarity in the United States. Within employment settings, most employees have more or less equal access to health insurance, subsidized by the taxpayer, and with costs arguably borne somewhat disproportionately by higher income employees.⁵⁸

If employers move toward high deductible policies, however, an ever greater proportion of the cost of health care is going to be passed directly on to employees, particularly sick employees. Recent research shows that the majority of employees in high deductible plans are not offered a choice by their employer; they are simply given the high-deductible plan.⁵⁹ Thirty percent of employees with CDHC's moreover, receive no employer contribution to an HSA, and over half receive less than \$1000 per year.⁶⁰ Lower income employees, moreover, often contribute little or nothing themselves to an HSA. 27% of individuals in CDHC plans with incomes of less than \$50,000 a year contribute nothing to their HSA according to the EBRI survey.⁶¹ Of those who have had HSAs for a year or more, 23 percent rolled over nothing at the end of the year, 26%, \$500 or less.⁶² Overall 14% had nothing in their accounts at the time of the survey, 16% more \$200 or less.⁶³ 44% of those who did not open an account said that they did not do so because they did not have money to put into the account, 19% said that the tax benefits were not attractive enough to justify it.⁶⁴

Of course, high deductible accounts mean high exposure for those with high health care costs, and overwhelming evidence has emerged in recent years that consumers with high deductible accounts who lack health savings accounts forego necessary health care. Adults with health problems who have deductibles above \$500 (and particularly those with incomes below \$35,000 a year) are much more likely than those with lower deductibles to not fill a prescription, not get needed specialist care, to skip a

57. Jost, *Why Can't We Do What They Do*, *supra* note 2, at 433-34.

58. See Mark Pauly, *The Tax Subsidy To Employment-Based Health Insurance and the Distribution of Well-Being*, 69 *LAW & CONTEMP. PROBS.* 83, 89 (2006).

59. Fronstin & Collins, *supra* note 39, at 14. The same is true for about 2 in 5 employees in plans with HSAs/HRAs, Kaiser Family Foundation/Health Research and Educational Trust, *supra* note 50 at 103.

60. Kaiser Family Foundation, *supra* note 51, at 105.

61. Fronstin & Collins, *supra* note 39, at 18.

62. *Id.*

63. *Id.*

64. *Id.* at 14.

recommended test or follow-up visit, or report having a medical problem for which they have not sought medical care.⁶⁵ Patients with high deductibles are also much more likely to have medical bill or medical debt problems.⁶⁶ Nearly half of “underinsured” adults identified by a recent survey were contacted by a collection agency in the year prior to the survey regarding medical bills, while more than one-third said that they had to change their lives dramatically to pay for medical bills.⁶⁷

To put it bluntly, whatever else CDHC may accomplish, it seems to be bringing us tax subsidized retirement savings for the rich, high deductible health plans and financial misery for the poor. If one believes that health insurance is a bad idea, that health insurance must be seriously curtailed to bring about consumer choice and efficient markets, this cost in solidarity may be acceptable.

If one believes, however, that insurance is ultimately about solidarity, not efficiency, these issues are troubling. Health insurance obviously contributes to solidarity between the sick and the healthy, but can also build solidarity between the poor and the wealthy. Health insurance is also about security—knowing that when you need health care you will be able to get it, and to get it without missing a rent payment or a car payment. Efficiency is a good thing, of course, and the efficient distribution of health care should be encouraged. But the evidence that CDHC is bringing us efficiency is at best equivocal. The evidence that it is bringing about the breakdown of solidarity and threatening security is stronger. Health insurance is, in fact, a good idea, and we must look for ways to achieve efficiency while preserving what little risk sharing still exists in this country—perhaps even building on it. But how we can achieve this is beyond the scope of this essay.⁶⁸

65. See Karen Davis, Michelle M. Doty and Alice Ho, *How High Is Too High? Implications of High-Deductible Health Plans*, Commonwealth Fund Pub. No. 816, 2005, at 9, available at http://www.commonwealthfund.org/usr_doc/816_Davis_how_high_is_too_high_impl_HD_HPs.pdf?section=4039.

66. *Id.* at 11.

67. Cathy Schoen, et al., *Insured But Not Protected: How Many Adults are Underinsured?* HEALTH AFFAIRS, at w5-296, June 14, 2005, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289>.

68. See JOST, HEALTH CARE AT RISK, *supra* note 1, at 189-204 (exploring this topic further).

