Health Savings Accounts for Small Businesses and Entrepreneurs: Shopping, Take-Up and Implementation Challenges

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Abstract: A combination of high deductible health plans (HDHPs) and health savings accounts (HSAs) holds promise for expanding health insurance for small firms. We provide information on HSA take-up and shopping behavior from a 2008 survey of female small business owners, revealing that the HSA marketplace can be confusing for small firms. HSAs may have expanded access to health insurance for the smallest firms (under three employees), but not for small firms more generally. A sizable number of firms offering HSA-eligible insurance did not offer attached HSAs. Firms offering HSAs were satisfied with their experiences, but faced challenges in implementing them.

Keywords: Health savings accounts, health insurance costs, small business.

INTRODUCTION

Small businesses comprise the "weakest link" of the employment-based health insurance system of the United States, due to the considerable barriers they face in being able to access and afford insurance for their employees. Lacking the group size or negotiating power of larger firms, over half of small firms considered health care costs to be a "critical problem" in 2008 [1]. In 2008, only 49 percent of firms with three to nine workers were able to offer health benefits, compared to 99 percent of firms with 200 or more workers [2]. Despite the long-standing goal of American policy makers to increase the availability of affordable health insurance options for small firms, evidence suggests that rates of offer have actually fallen since the start of the decade [2]. Recently, a combination of high deductible health plans (HDHPs) and health savings accounts (HSAs) has been promoted as a consumer-oriented approach for allowing small businesses to provide affordable insurance [3].[1] Although HSAs have been available since 2004, almost nothing is known about how small firms shop for HDHPs and HSAs, nor the challenges they encounter in obtaining information about these plans during their search. Given the potential of these options to expand access to health insurance to small businesses, there is need for more information on how small businesses shop for these plans and whether there are any specific impediments to their search for a suitable insurance plan.

High deductible health plans (HDHP) require individuals to pay directly for the health care costs they incur up to a deductible.[2] Once the deductible is met, insurance coverage begins, although individuals may still be responsible for co-pays and co-insurance. Individuals may pay for health care costs that are not covered by insurance using funds that have been set aside in an HSA. HSAs are portable, tax-preferred saving devices that can only be opened for individuals and families enrolled in an HSA-eligible HDHP.[3] They allow workers to avoid taxes on current medical expenditures and to build savings that can be used for future medical expenses.[4] Both employers and employees may open and contribute to the HSA. While the primary motivation for a combination of HDHPs and HSAs has been to control the growth of health care expenditures by making consumers more price sensitive [4], advocates hope that HSAs will expand insurance coverage, including to employees of small businesses. In particular, small businesses might find premiums for HSA-eligible HDHPs to be inexpensive enough that they could now afford to offer health insurance to their workers, and the HSAs might make such HDHPs more palatable to employees [5, 6].

The popularity of HSAs has steadily increased over time. In January of 2008, 6.1 million people were covered by HSAs, up from 1.0 million three years before, with the small group the fastest growing segment in 2007 [7]. HDHPs coupled with HSAs or another savings option cover approximately eight percent of workers [8]. Previous research has shown that larger employers are more likely than smaller firms to be interested and involved with HSA-eligible HDHPs [7-9], and questioned whether HSAs are effectively reaching small businesses and their employees.

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[1]HDHPs and HSAs fall under the umbrella of consumer directed health care, which advocates argue can provide consumers with incentives to make better health care decisions and reign in cost growth and expand coverage.

[2]While there is no single definition as to what constitutes a "high deductible" and hence an HDHP, the Kaiser Family Foundation Employer Health Benefits 2008 survey defines plans with a deductible of at least $1,000 for an individual or $2,000 for a family to be HDHPs.

[3]HSAs must be combined with an insurance plan with a deductible of at least $1,100 for an individual and $2,200 for a family. The total out-of-pocket costs (excluding premiums) for the insurance plan cannot exceed $5,500 for individuals or $11,000 for families. The maximum HSA account contribution is $2,900 for an individual, and $5,800 for a family. These figures reflect the requirements for 2008, and the limits for future years will be indexed to inflation.

[4]HSA contributions are not subject to federal taxes when they are deposited, and unused sums may roll over and accumulate interest year after year. Qualified medical expenses are paid for by withdrawals from one's HSA. HSAs were established in December 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act.

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Gates *et al*. found that small firms with three to 49 employees were less likely to offer insurance, but conditional on offering insurance, they were equally likely to offer HDHPs [7]. Yet, conditional on offering HDHPs, small firms were less likely than larger firms to offer an HSA attached to an HDHP.[5] Instead of being a tool for the small and uninsured, HSAs have proven to be more popular with larger firms, which have more resources and which frequently already offered insurance in the first place. Furthermore, Gates *et al*. noticed a "churning" effect among smaller firms, which are less likely than larger firms to stick with HSAs from year to year [7]. Reasons for the limited embrace of HSAs on the part of small businesses are unknown. This paper addresses the gap by providing new information on HSA take-up and shopping behavior from a 2008 survey of small businesses owners.

Women-owned businesses are of particular interest in the market for small business health insurance for several reasons. First, women-owned businesses tend to be smaller on average than firms owned by men. While they comprise 28.2 percent of non-farm businesses in the U.S. in 2002, they accounted for only 6.5 percent of non-farm employees in 2002. The vast majority, 86 percent, had no paid employees besides the owner [10]. Secondly, women-owned businesses are growing in economic significance as the number of women-owned firms, the number of women-owned firms that hire workers, and the number of workers employed by such firms has all increased in recent years. Finally, the challenge of finding affordable health insurance options may be particularly acute for self-employed women and women-owned small businesses, as research shows the individual health insurance market may be more likely to reject women, and may charge women under 55 substantially more for health insurance than men of the same age [11, 12]. Accordingly, very small businesses owned by women may benefit substantially from HDHP-HSA combinations.

MATERIALS AND METHODOLOGY

Data. This paper is based on information provided by 646 business owners in response to a one-time web-based survey on HSAs and health insurance issues. Women Impacting Public Policy (WIPP) provided us with the unique opportunity to survey its membership base on this important issue. WIPP is a nationwide group of 20,000 female small-business owners that advocates for women-owned small businesses. In April 2008, WIPP sent out an e-mail announcement to its 2,500 closely-engaged "core" members with a web link to the online survey.[6] The survey stayed open for a period of one month, during which time 646 respondents completed the survey, yielding a response rate of 26 percent. This response rate is fairly typical of web-based surveys, and in fact, is higher than the response rates achieved by WIPP's own annual survey. The analysis presented here focuses on results from the 628 firms with 100 or less employees.

Over one-third of the firms in our set have less than three employees, and we know of no other survey that reaches firms of this size with questions about their HDHP offerings. Although the firms in our survey do tend to be small, they are actually more likely to have employees than women-owned firms generally (96 percent compared to 12 percent) [13]. Compared to all women-owned businesses, the firms in our survey are also more likely to be engaged in "professional, scientific, and technical services" (31 percent compared to 14 percent), manufacturing (8 percent compared to 2 percent), and wholesale trade (6 percent compared to 2 percent) [13]. They are less likely to be engaged in health care and social assistance (4 percent compared to 16 percent), retail trade (5 percent compared to 15 percent), "administrative support and waste management and remediation services" (2 percent compared to 9 percent), and "real estate and rental leasing" (2 percent compared to 8 percent). Although ours is a convenience sample, it allows us to perform exploratory analyses of experiences in the HDHP market among a population of very small business owners that has not yet been reached by other survey efforts.

Methods. This paper proceeds in three sections. In the first section, we use descriptive statistics to characterize the respondents and their responses to the survey. In the second section, we more closely examine those firms that offered HSA-eligible insurance along with HSAs to their employees. In the third and final section, we explore HSA-related shopping activity. As our survey was a convenience sample of a unique population, we were unable to make the data nationally representative by applying statistical weighting techniques.

Survey Questions. The survey asked firms a range of questions related to employee health insurance offerings and insurance shopping activities, with particular attention paid to firms' experiences with HSA-eligible HDHPs and HSAs.

For firms that offered insurance, we asked if they offered HSA-eligible plans and attached HSAs, and why they did or did not. We asked if the firm offered insurance prior to the introduction of the HSA-eligible plan, if the firm's insurance offerings had to be altered to become HSA-eligible, and about any contributions made to HSA accounts. Finally, we asked these firms about the biggest challenges they faced during HSA rollout, their overall level of satisfaction with HSAs, and anything they had learned through their experience. For firms that offered insurance but no HSA-eligible plan, we asked them why they did not, if the firm ever offered one in the past (and if so, why it stopped), and if it is considering one for the future.

We asked all firms a series of questions about whether or not they shopped for HSA-eligible plans. These questions covered vendor types used, the number of quotes received from each type of vendor, and if the firm has an HSA-eligible plan, the type of vendor that sold that plan.

Finally, we asked all firms a series of questions related to firm characteristics, including the number of owners, legal classification (partnership, LLC, etc.), whether or not the firm was 51 percent or more owned by women, whether or not any owners are racial or ethnic minorities, number of

[5]Although individuals may open an HSA without help from their employer, firms may lessen the administrative burden on their employees by setting up the HSAs for them.

[6]The membership base of WIPP is comprised of approximately 20,000 members, including 2,500 closely engaged "core" members. According to the president of WIPP, the 2008 annual membership survey conducted by WIPP using the same contact list generated 278 responses (personal communication, B. Kasoff, 2008).

Table 1. Respondents of the WIPP HSA Survey with 100 or Fewer Employees

Categories	All Respondents	Breakdown by Health Insurance Status
Number of Firms Included in Analysis	**628**	
Offer Health Insurance	**61%**	
Do not offer HSA-eligible insurance		65%
Offer HSA-eligible insurance		35%
Do not offer HSA attached, as a percent of those offering HSA-eligible insurance		22%
Offer HSA attached, as a percent of those offering HSA-eligible)		78%
Contribute to HSA, as a percent of those offering an attached HSA		56%
Do not contribute, as a percent of those offering and attached HSA		44%
No Health Insurance	**39%**	
Contribute to HSA		5%
Do not contribute to HSA		95%
Demographics		
Average number of owners	2.1	
Average number of employees	11.1	
Mostly (51% or more) owned by women	89%	
Any racial-ethnic minority owners	19%	
Average firm age (years)	15.1	
Average number of locations	4.6	
Establishments in more than one state	13%	

years in business, locations, number of employees, annual payroll, annual revenue, and industry.

RESULTS

Characterizing the Responses. We received a total of 646 responses to our survey. In this paper, we report findings for the 628 firms of 100 employees or less. Table **1** provides a summary of the characteristics of these survey respondents. Most firms in our survey were quite small: 35 percent had two or fewer employees, 36 percent had three to nine employees, 17 percent had 10-24 employees, and 13 percent had 25 or more employees. A majority, 55 percent, of firms said that they offered insurance to their employees, with an additional six percent stating that they offered insurance but made employees pay 100 percent of the costs. Preferred Provider Organization (PPO) plans were the most common type of health insurance offered by those firms that offered insurance, with 52 percent firms that offer health insurance offering PPO plans. PPO plans had the highest employee enrollment for 64 percent of the firms that offered insurance, while health maintenance organizations (HMOs), point of service (POS), and traditional fee-for-service (FFS) plans had the highest enrollment for 21 percent, 10 percent, and four percent of firms that offer insurance, respectively. Any of these may be combined with an HSA-eligible HDHP. Of firms that offered insurance and reported insurance type, 23 percent offered more than one type of insurance plan. This figure was related to firm size, with four percent of firms of fewer than three employees and 38 percent firms of 25 or more employees offering more than one type of plan.

Of firms offering insurance, 35 percent offered at least one HSA-eligible plan. Of these, 78 percent offered an attached HSA, though individual workers may set up their own HSA when their employer does not offer one. Contingent on offering an HSA, 56 percent of firms contributed to them. On average, firms participating in the survey had about 2.5 owners, 11.1 employees, 4.6 locations (usually in one state), and had been in existence for 15.1 years (see Table **1**). As our target population would suggest, the vast majority of firms are majority women-owned, meaning that 51 percent or more of the ownership is held by women. Nearly one-fifth had at least one owner of a racial or ethnic minority. Almost half of firms in our survey are S corporations,[7] and 41 percent were based in the South. A plurality of firms, 31 percent, were involved in "professional, scientific, and technical services," with the next most common industry, wholesale trade, accounting for only six percent of firms in our survey.

Overall, 16 percent of the firms in our study offered HSA-eligible insurance with an attached HSA [2].[8] In order to examine the firm characteristics associated with HSA take-up, we performed a multivariate logistic regression predicting take-up among those firms that offered insurance. Column 1 of Table

[7]"S corporations," so called because they are described under Subchapter S of Chapter 1 of the IRS code, operate under a regime similar to C corporations in regards to their liability, and like partnerships or sole proprietorships in regards to their tax treatment.

[8]For the sake of comparison, the Kaiser/HRET survey reports that in 2008, about 8.2 percent of all firms offered HDHPs with an attached HSA or health reimbursement account (HRA).

Table 2. Marginal Effects Estimates of Predictors of Offering HSAs, Offering Health Insurance, and Shopping for HSA-eligible Insurance

	Logit: Offer HSA|Offer Health Insurance	Logit: Offer Health Insurance	Logit: Shopped for HSA-Eligible Insurance	Logit: Shopped for HSA-Eligible Insurance/Offer Health Insurance
N	232	429	247	227
FFS	**0.55** (0.25)**	n/a	**0.40** (0.12)**	**0.40** (0.12)**
HMO	-0.01 (0.07)	n/a	0.04 (0.09)	0.05 (0.1)
POS	0.09 (0.10)	n/a	**0.23** (0.1)**	**0.22** (0.1)**
Number owners – 2 or more	0.06 (0.06)	0.07 (0.07)	0.11 (0.08)	0.14* (0.08)
Legal: partnership	0.11 (0.16)	-0.01 (0.19)	-0.02 (0.18)	-0.03 (0.18)
Legal: self-employed	0.06 (0.16)	**-0.32** (0.10)**	0.01 (0.19)	-0.04 (0.23)
Legal: LLC	0.08 (0.15)	**-0.25** (0.10)**	0.14 (0.14)	0.17 (0.14)
Legal: C-Corp	0.05 (0.08)	-0.09 (0.10)	-0.08 (0.1)	-0.07 (0.1)
Women-owned	0.05 (0.07)	-0.07 (0.12)	0.06 (0.12)	0.09 (0.12)
Minority-owned	-0.07 (0.07)	**-0.19** (0.09)**	-0.12 (0.11)	-0.11 (0.12)
Firm age 8 to 12 yrs	-0.09 (0.08)	**0.26** (0.08)**	0.12 (0.12)	0.04 (0.13)
Firm age 13 to 20 yrs	-0.01 (0.09)	**0.19** (0.09)**	-0.11 (0.12)	-0.16 (0.12)
Firm age 21+ yrs	0.09 (0.10)	**0.25** (0.09)**	0.12 (0.12)	0.07 (0.13)
Multiple locations	-0.07 (0.06)	-0.07 (0.07)	-0.04 (0.08)	-0.06 (0.08)
Multistate (dummy)	-0.03 (0.07)	0.16* (0.10)	0.07 (0.11)	0.06 (0.12)
Region: Northeast (dummy)	-0.09 (0.06)	**0.21** (0.08)**	-0.02 (0.1)	-0.01 (0.11)
Region: Midwest (dummy)	-0.11* (0.06)	0.12 (0.09)	-0.08 (0.11)	-0.08 (0.11)
Region: West (dummy)	0.13 (0.09)	0.02 (0.09)	-0.04 (0.1)	0 (0.11)
Number of employees 3-9	-0.03 (0.10)	0.06 (0.10)	-0.03 (0.13)	0.02 (0.14)
Number of employees 10-24	-0.04 (0.12)	-0.02 (0.14)	0.04 (0.16)	0.11 (0.16)
Number of employees 25+	0.05 (0.16)	**0.39** (0.09)**	-0.19 (0.18)	-0.16 (0.19)
Payroll $50k-$249,999	0.10 (0.14)	**0.26** (0.08)**	0.13 (0.14)	0.06 (0.16)
Payroll $250k-$999,999	0.30* (0.16)	**0.45** (0.07)**	0.26* (0.14)	0.2 (0.16)
Payroll >=$1M	0.40 (0.24)	**0.28** (0.12)**	**0.39** (0.12)**	**0.35** (0.14)**
Revenues $250k-$999,999	**-0.20** (0.08)**	**0.23** (0.08)**	-0.09 (0.13)	-0.11 (0.14)
Revenues >=$1M	-0.20 (0.13)	**0.30** (0.11)**	-0.16 (0.16)	-0.18 (0.17)
a) Agriculture, forestry, fishing, hunting, mining, construction, manufacturing	**-0.14** (0.05)**	-0.15 (0.11)	-0.18* (0.11)	-0.18 (0.11)
b) Wholesale trade, retail trade, transport.	**-0.15** (0.05)**	-0.14 (0.12)	-0.17 (0.12)	-0.17 (0.12)
c) Information, finance, insurance	0.05 (0.09)	0.13 (0.11)	0.1 (0.11)	0.11 (0.12)
d) Real estate, management, admin., arts, entert., rec., accommodation	-0.05 (0.10)	-0.27* (0.14)	0.16 (0.18)	0.21 (0.18)
e) Education, health care, social assistance	-0.10 (0.09)	-0.14 (0.18)	-0.26 (0.16)	-0.23 (0.18)
g) Other services (except public admin.)	-0.09 (0.06)	0.04 (0.10)	**-0.25** (0.1)**	**-0.25** (0.11)**

**** Significant at 0.05 level.**
* Significant at 0.10 level.
Standard errors in parenthesis.

2 shows the marginal effects estimates number of controls for firm, industry, and insurance type, considering only those firms that offer health insurance to their employees.[9] While our raw data show that firms with fewer employees are less likely to offer health insurance, the marginal effects estimates show that the effect is statistically insignificant when other variables are controlled for (see Table **2**).

Column 2 of Table **2** predicts the offering of health insurance over the same list of firm controls, although for obvious reasons the insurance type offered to employees has not been included as a predictor variable. Older firms, firms with more employees, firms with larger payrolls, and firms with greater revenues were more likely to offer health insurance.

Firms that Offer HSA-eligible Insurance with HSAs. Overall, 16 percent of the firms in our study offered HSA-eligible insurance with an attached HSA. The proportion of all firms offering HSA-eligible insurance with an attached HSA varies by firm size, with eight percent of firms with two or fewer employees offering, compared to 12 percent of firms with

[9]These coefficients may be interpreted as the incremental change in the probability of offering an HSA when the predictor variable changes from 0 to 1.

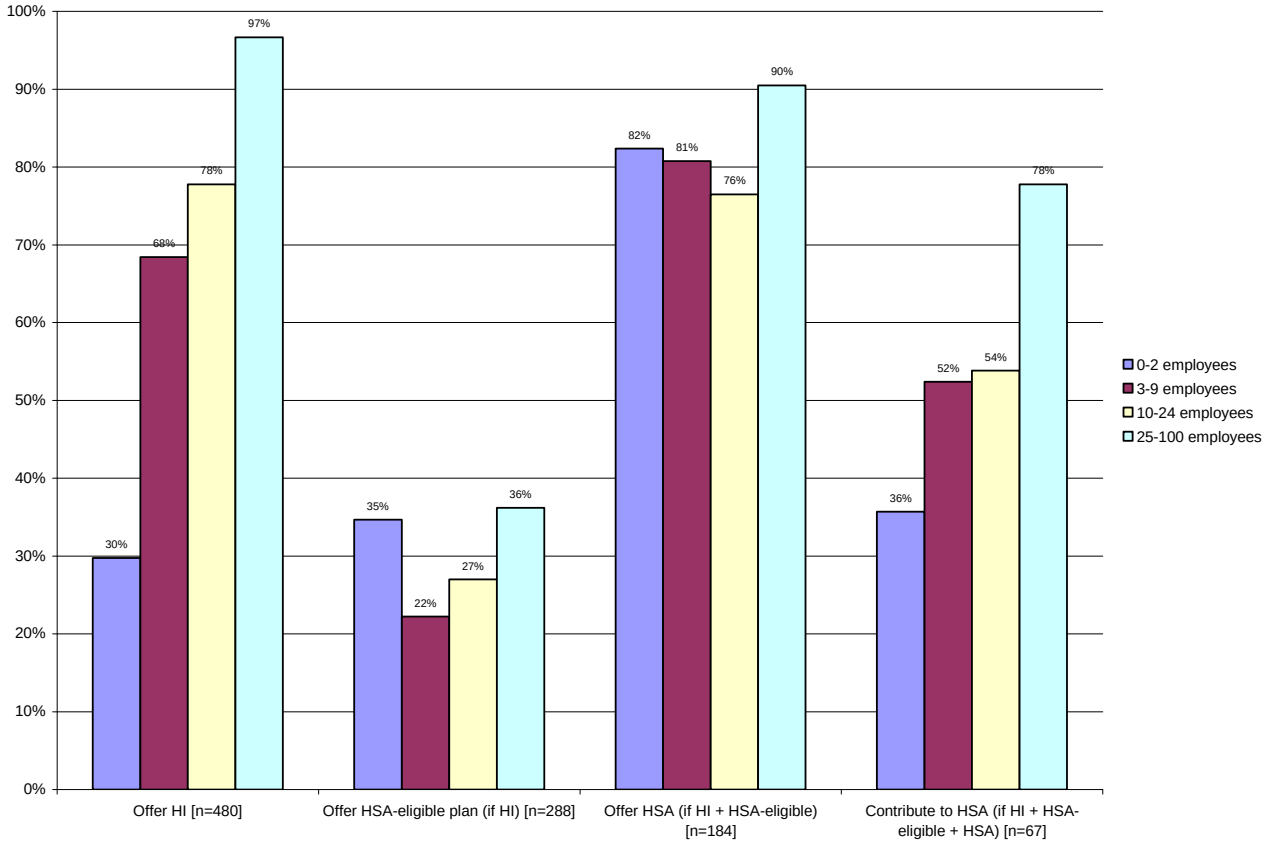


Fig. (1). Health insurance offerings by firm size.

three to nine employees, 16 percent of firms with 10-24 employees, and 32 percent of firms with 25 or more employees. However, conditional on offering insurance, the smallest firms are no less likely to offer HSA-eligible accounts or HSAs (see Fig. **1**).[10,11] Most firms that offered HSAs to their employees contributed to the HSA accounts. The average annual contribution of firms that contributed to their employees' HSAs was $1,914.25, with a range from $60 to $5,850 and a standard deviation of $1,557. One-third of these firms contributed less than $1,000.[12] If we include the minority of firms that offered HSAs but did not contribute to them, the average annual contribution drops to $1,063.47 [14].[13] Smaller firms were less likely to contribute, with only 36 percent of firms of zero to two employees contributing, compared to 53 percent of firms of three to 24 employees, and 78 percent of firms of 25-100 employees (see Fig. **1**). Most contributing firms made regular payments, with 39 percent contributing along with each paycheck, and another 37 percent contributing on some other periodic basis. Less than a fifth, 18 percent, gave 100 percent of their contributions up front. Another five percent volunteered in a text response that they contributed monthly.

The 16 percent of firms that offered HSAs were different in some ways to those that did not. On average, firms that offered HSA-eligible insurance with an attached HSA were less likely than other firms to be self-employed (eight percent versus 16 percent), to have any owners that are racial or ethnic minorities (nine percent versus 21 percent), or to be involved in wholesale and retail trade (three percent versus 13 percent). These same firms were more likely to be C corporations (26 percent versus 17 percent), were more likely to have operations in more than one state (22 percent versus 12 percent), have more employees (19 percent versus 10 percent), and were more likely to be involved in financial and insurance services (14 percent versus four percent).

Every firm that offered an HSA reported receiving quotes from vendors for HSA-eligible plans in the past year. More than half of the firms (62 percent) offering HSAs reported that they purchased their HSA-eligible accounts through a traditional insurance broker (see Fig. **2**) [15].[14] Less

[10]Statistical tests used were Fisher's exact tests and chi-square tests. The lack of significant associations may be due to a lack of power. Note that our results are not directly comparable with the patterns obtained from the Kaiser/HRET survey in Gates *et al*. (2008), since our data focus on firms under 100 and include firms with less than three employees, unlike this earlier study.

[11]Once again, note that individuals may themselves attach an HSA to an HDHP set up by their employer.

[12]In 2007, the statutory limit for contributions to HSAs was $2,850 for single coverage and $5,650 for family coverage.

[13]In 2007, Kaiser/HRET data showed that the average firm contribution to HSAs stood at $428 for single coverage, and $714 for family coverage. These figures rose to $838 and $1,522, respectively, in 2008. If only contributing firms are included, average contributions in 2008 stood at $1,139 for single coverage and $2,067 for family coverage.

[14]Findings from the National Small Business Poll indicate that this overwhelming reliance on health insurance agents or brokers may inhibit

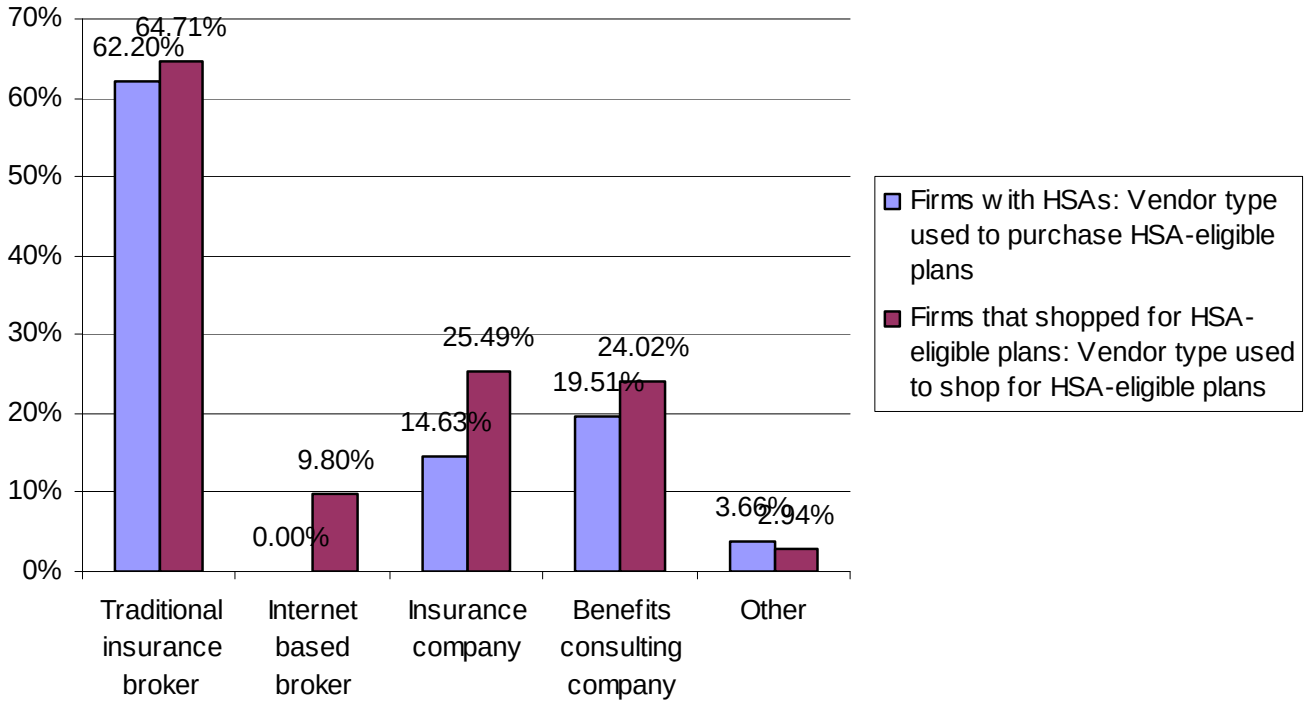


Fig. (2). HDHP shopping behavior, by vendor types used.

frequently used for quotes were benefits management companies (20 percent) and insurance companies (15 percent). No firm in our sample purchased HSAs from an internet-based broker.

Supporters have hoped that HDHPs with attached HSAs might help small firms that previously could not afford insurance to do so for the first time. In our data set, 90 percent of firms with three to nine employees and all firms of 10 or more employees offered insurance prior to the HSA, but only 57 percent of firms with zero to two employees did.[15] This is consistent with the hypothesis that HDHPs with attached HSAs enhance the availability of insurance to employees of the very smallest firms, even if they do not seem to do so for larger small firms. Among those firms that previously offered insurance, 62 percent reported that they had to modify their offerings to become eligible for HSAs.

Of firms that offer HSA-eligible insurance plans, an average of 54 percent of employees were enrolled in one. This average was significantly higher for firms that also offered attached HSAs (60 percent versus 30 percent), consistent with the notion that HSAs make HDHPs more attractive to employees.

Firms that offered HSAs generally seemed satisfied by their experiences, with 48 percent "somewhat satisfied" and another 37 percent "very satisfied." Although we did not ask employees about their experiences, prior research has indicated some amount of dissatisfaction by HSA enrollees [16, 17]. Judging by the combined number of "very important" and "somewhat important" selections, the most important reason appears to be that HDHPs have lower premiums. The next most popular response was the ability of HSAs to roll over unused balances, which most of the firms felt was "very important." A majority of firms also thought that making employees aware of their own costs, encouraging employees to manage their own care, and making premiums more predictable were all at least "somewhat important." Few firms indicated that they offered HSAs in order to help recruit or retain workers.

The three most important challenges faced during the initial enrollment and roll-out period were all related to employee education (see Fig. **3**). More than half of firms felt that "answering employee questions" and "employee education/communication" were at least "somewhat important." These concerns were reinforced by some of the text responses we elicited about lessons these firms learned through their experiences (see further details below).

We asked firms that offered insurance and HSAs: "Given your experience in implementing an HSA, what have you learned that you wish you had known at the outset?" We received 47 text responses. Communication, education, and

HSA take-up, as brokers frequently fail to discuss the HSA option with small employers.

[15]Firms that offered HSA-eligible insurance were asked, "Did your firm offer any health insurance before offering an HSA-eligible plan?"

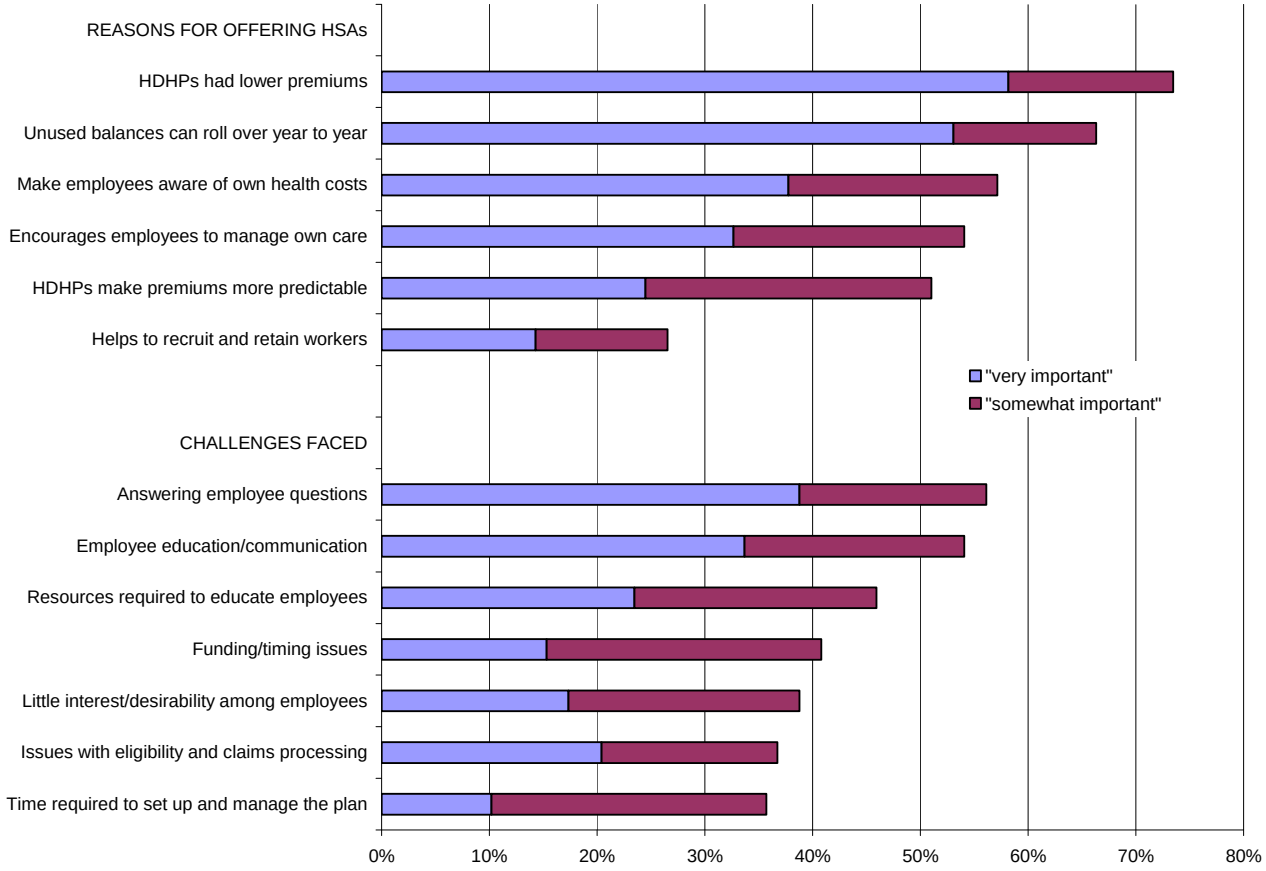


Fig. (3). Reasons for offering HSAs and challenges faced. **Note:** N=98 for "reasons for offering" and for "challenges faced".

confusion were common themes. These comments referred to the difficulty educating their employees about HSAs, the challenges as an owner in setting up an HSA, or praised their vendors' ability to explain the system. Some comments could be classified as having dealt with cost, particularly high and persistent cost of prescription drugs, which have the ability to rapidly deplete HSAs given the high deductibles involved in HSA-eligible HDHPs. Other comments addressed customer service and consumer issues, such as low interest rates paid on HSA accounts, claims processing difficulties, providers that do not know how to bill HSAs, and the fact that patients must keep track of all claims. Another group of responses had strong praise for HSAs, with some expressing regret that their firm did not begin offering HSAs earlier. A lack of interest on the part of employees was also mentioned by some of comments.

HSA Shopping. Nearly one-third of all firms in our survey reported that they shopped for HSA-eligible insurance plans. Of those firms that did shop for HSA-eligible plans, 54 percent offered HSA-eligible insurance to their employees. On average, the firms that reported shopping contacted 2.7 vendors about HSA-eligible insurance, received 3.4 quotes from those vendors for HSA-eligible insurance, and received 3.9 quotes from those vendors for traditional fee-for-service insurance. Among firms that reported shopping for HSA-eligible insurance, we saw no evidence that firms that wound up offering HSA-eligible insurance or HSAs were more thorough shoppers (in terms of number of vendors contacted or quotes received) than those that did not.

Column 3 of Table **2** reports marginal effects estimates of shopping behavior using the same controls featured in the regression from column 1. We find that firms with FFS and POS plans, as well as firms with revenues of $1,000,000 or greater, are more likely to shop for HSA-eligible plans. Firms in our sundry "other services" industry category were also more likely to shop for HSA-eligible insurance. Column 4 repeats column 3, but conditions the analysis on the offering of health insurance.

Traditional insurance brokers were by far the most popular vendor for receiving quotes about HSA-eligible plans, used by almost two-thirds of the firms that received such quotes (see Fig. **2**). The next most popular vendor type used for quotes for HSA-eligible insurance were insurance companies, used by less than half as many firms as traditional insurance brokers. Benefits management companies were close behind insurance companies. Internet insurance brokers were in fourth place, used by only 10 percent of firms that received quotes for HSA-eligible plans (see Fig. **2**).

Firms that Offered HSA-eligible Plans but did not Attach an HSA. Of the 20 percent of firms in our survey that offered HSA-eligible plans (N=128). Although individual workers may set up HSAs themselves, this points to potential missed opportunities for firms to increase the affordability of health

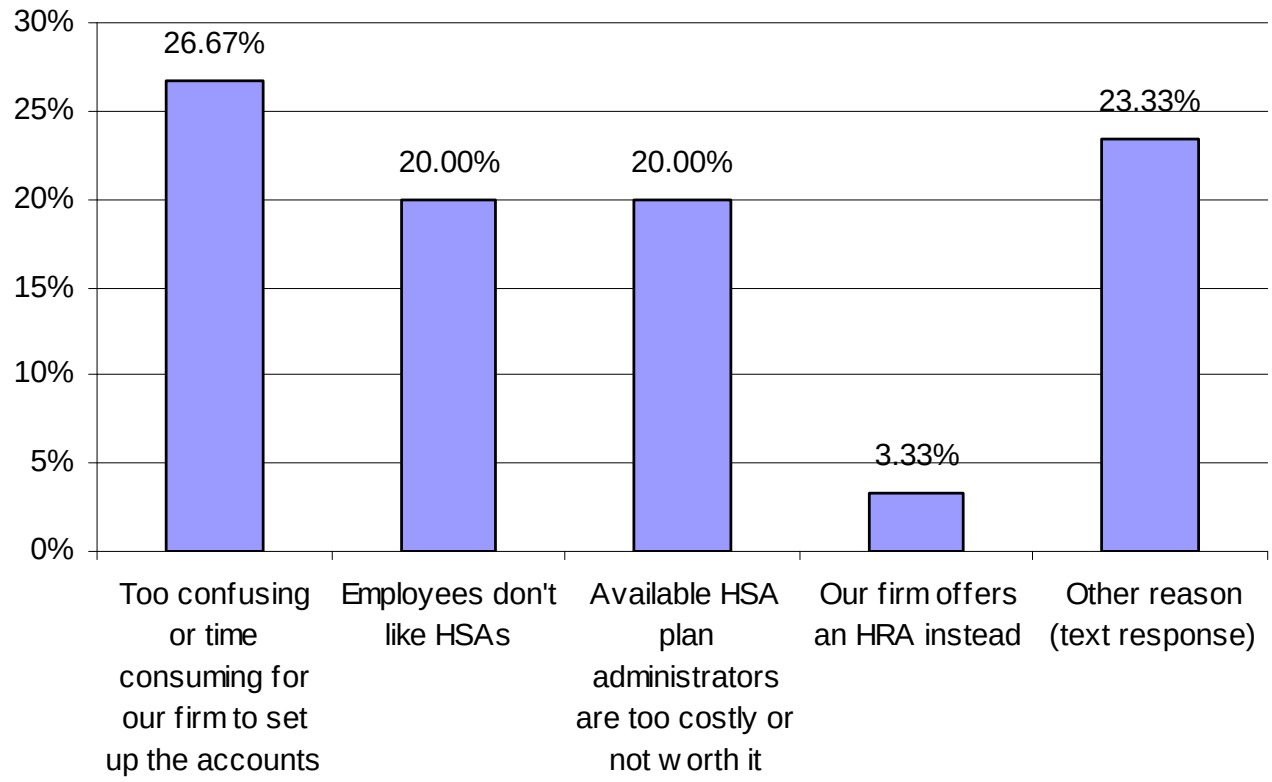


Fig. (4). Reasons for not offering an HSA attached to an HSA-eligible plan.

care for their employees. An HSA protects employees from taxes, making it easier to afford the out of pocket costs associated with an HDHP, and may be set up at little financial cost to the employer, with the employee making all contributions.

These firms tended to be small, with 21 percent having two or fewer employees, 36 percent with three to nine employees, 29 percent with 10-24 employees, and 14 percent with 25 or more employees. When asked why they did not offer an attached HSA, about 27 percent of these firms selected that it was "too confusing or time consuming for our firm to set up the accounts" (see Fig. **4**). Tied for the next most popular reason were "employees don't like HSAs," and "available HSA plan administrators are too costly or not worth it." Only three percent said that they offered a different type of savings account instead. Another 23 percent of firms gave text responses, including, "employees not interested," "noone wants it (sic)," "Employees cannot afford it," "Employees set up their own HSA of choice," "don't know," "ours is a flexible spending account," and "our broker never explained it well. We are likely going to offer it in Aug at renewal. Working on it now."

Firms that did not Offer HSA-eligible Plans. Firms that did not offer HSA-eligible plans were asked why they did not, and their answers are also informative about the market for HDHPs. The most frequently selected reason for not offering HSA-eligible plans was that it was too confusing or time consuming to sort through all the information about them (see Fig. **5**). This is consistent with the finding that the largest challenge faced by those who did offer HSA-eligible plans was communication and education about the plans themselves. The second most frequently selected reason was that the lack of "value" with HSA-eligible plans: they cost too much and/or provide too little.

Many firms that did not offer HSA-eligible plans provided optional text-based reasons as to why they did not. The reasons offered tended to differ between firms that did and did not offer insurance, perhaps because of the underlying differences in firm size. Of firms that did not offer insurance, the most commonly mentioned "other" reason for not offering an HSA-eligible plan was that the firm had too few employees, with about a third of comments mentioning this.[16] Other frequent responses were that their employees had other sources of insurance,[17] or that HDHPs were associated with poor value.[18] A few firms acknowledged that they knew little about HSAs.[19]

The optional text reasons offered by firms that did offer insurance tended to follow a different distribution, perhaps reflecting the fact that these firms tended to have more employees. The biggest group of responses dealt with cost

[16]Twenty-seven firms, or 33 percent of 82 comments.
[17]Twelve comments, or 15 percent of 82 comments.
[18]Eleven comments, or 13 percent of 82 comments.
[19]Six comments, or 7 percent of 82 comments.

and value.[20] The next biggest group of responses spoke to some particular firm characteristics that made HSA-eligible plans a poor match (three of these firms claimed that they were ineligible).[21] Some firms left comments that acknowledged a lack of awareness (such as, "Don't know about them," "Have not had the time to research the option") or exhibited some confusion (such as, "not available in NY state," "employees lose funds if they don't use them") about HSAs or HSA-eligible plans.[22] Other comments claimed a lack of interest by employees or employers,[23] referred to the administrative hassle involved with HSAs,[24] or said that they had too few employees.[25]

Of firms reporting that they did not offer HSA-eligible insurance plans at the time of the survey, 29 percent reported considering them for the future. This is slightly higher than other recently published estimates [14];[26] this may reflect different wording of questions, selection into the survey based on personal interest, or a growing awareness and curiosity about HSAs. We found that the rate of consideration for the future was higher for firms that had shopped for HSA-eligible plans (42 percent) than it was for those that did not (24 percent).

Among firms without HSA-eligible plans, firm size appeared to have a positive relationship with considering HSAs in the future; however this association was not statistically significant. A total of 28 percent of firms that answered the question reported considering HSAs in the future, but this value ranged from 24 percent for firms with zero to two employees, to 29 percent for firms with three to nine employees, to 35 percent for firms with 10-24 employees, to 36 percent with firms with 25 or more employees.

DISCUSSION

HDHPs and HSAs have become very popular in policy circles. Advocates of consumer directed health care support expanded access to HSAs as an important way to help "put the family in charge of what they pay for." Health policy advocates have been particularly hopeful that HSAs would bring health insurance to a sector of the economy that was chronically uninsured – entrepreneurs and employees in small businesses.

Our findings support findings from prior studies that while smaller firms are less likely to offer insurance, conditional on offering insurance, they are no more likely to offer HSA-eligible HDHPs as larger firms. This means that employees of larger firms are more likely than employees of smaller firms to have access to HDHPs and HSAs.

While HSAs do not appear to have expanded access to health insurance overall, we do find some evidence that they have expanded health insurance offering among the smallest firms – those with under three employees.

Our study goes a step further than previous research by delving into the HSA shopping experience, the challenges experienced by HSA implementation, and the reasons that HSAs were rejected by firms that chose not to offer them. Our unique sample allows us to obtain detailed and targeted information about the HSA experience from small businesses – the sector of the economy that policy makers had hoped would be quick to adopt HSAs. Our work reveals the main impediments to HSA adoption among businesses that chose to offer HSAs.

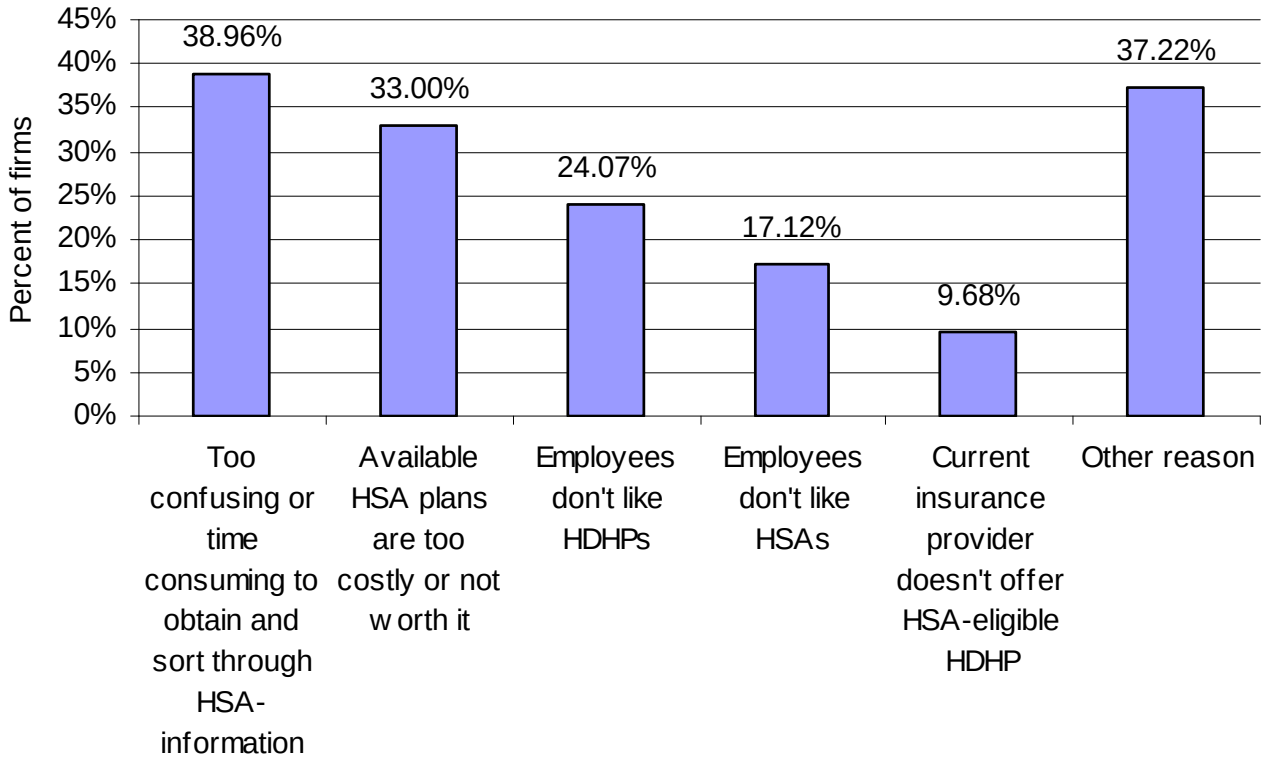
Prior research indicates that it is difficult for consumers to obtain information (about treatments and prices) needed to make health decisions and this leads to dissatisfaction with HSAs [17]. Our findings support and add to this, by highlighting the challenges employers face in explaining HSAs to their employees. Consistent with previous research by McDevitt and colleagues [18], we found educating and communicating with employees to be the largest challenge faced by small firms implementing HSAs.

We also observed that in addition to the employees, many employers experienced difficulty navigating the HDHP market, or even understanding what HSAs were. This lack of awareness about available options may also be inhibiting take-up, and for firms that do not offer HSAs, may even be a greater factor than cost. Prior research suggests that this may be because health insurance agents and brokers frequently fail to discuss HSAs with small employers [15].

A sizable number (22 percent) of firms that offered HSA-eligible insurance did not offer attached HSAs to their employees, although doing so would be a fairly low-cost way for firms to shield their employees from taxation. The most commonly cited reason for not offering an attached HSA was that it was "too confusing or time consuming for our firm to set up the accounts." It would presumably be more efficient from a societal perspective for a firm to set up the accounts than for each of its employees to learn how to set up an account of his or her own (of course, these economies of scale will not be large for the smallest firms). The firms themselves may find that offering an HSA makes their portfolio of health insurance offerings that much more attractive to potential talent.

In addition, we observe an overwhelming reliance on traditional brokers by firms that shopped for HSAs. This may reflect that the in-person communication provided by traditional brokers is critical to helping employers understand how HSAs work. Anecdotal evidence about the WIPP population suggests that interpersonal relationships between brokers and employers play an even larger role for women-owned firms. In order to increase the rate of HSA take-up it may be useful to educate employers and other insurance purchasers about what HDHPs and HSAs are, how they are administered, and what their particular advantages are for firms faced with high insurance premiums. Furthermore, incentives to traditional brokers to encourage them to explain how HSAs work, and further exploration into other vendor arrangements may encourage take-up. Firms operating in the financial or insurance sectors were more likely than other types of firms to be involved in HSAs, perhaps reflecting their greater awareness and understanding of health plan options.

[20]Eighteen comments, or 25 percent of 72 comments.
[21]Sixteen comments, or 22 percent of 72 comments.
[22]Fifteen comments, or 21 percent of 72 comments.
[23]Ten comments, or 14 percent of 72 comments.
[24]Seven comments, or 10 percent of 72 comments.
[25]Six comments, or 8 percent of 72 comments.
[26]According to the Kaiser/HRET's 2007 Annual Report, 20 percent of firms without HSA-eligible HDHPs report being somewhat or very likely to offer one in the next year.



Note: This graph combines the responses of two survey questions, one asked to 250 firms that offer insurance, and one asked to 166 firms that did not but had heard of HSAs. Respondents could select more than one response. Response options "Employees don't like HDHPs" and "Current insurance provider doesn't offer HSA-eligible HDHP" were only available to firms that offered insurance.

Fig. (5). Reasons for not offering HSA-eligible Plans.

Firms that participated in HSAs were usually satisfied with their experiences, and a few respondents made a point to express just how pleased their firms were. Still, we found that firms implementing HSAs faced numerous challenges. Some spoke of lack of employee interest, while others were concerned with how quickly an employee's HSA account could be drained by the persistent cost of prescription drugs.

While our study provides a useful look at HDHP and HSA experience for small businesses, this analysis does have its limitations. We rely on a convenience sample of women-owned small businesses. WIPP members chose whether or not to respond to our survey, and some respondents chose not to answer all survey questions. Given that our sampling frame is unique, it is impossible to derive reliable sampling weights to attain nationally representative estimates. Because ours is a convenience sample, and because no other health insurance market surveys have reached this unique population of women-owned very small businesses, its representativeness is uncertain. However, these limitations do not take away from the fact that we can provide a detailed picture of the HDHP and HSA experience for an understudied segment of small businesses.

The overarching and recurring theme of our study seemed to be a pattern of confusion and a lack of knowledge about HDHPs, by both firms and their workers. If policy makers are interested in bringing this experience to new and possibly more resistant firms, it will be necessary to educate employees as well as employers about the workings and advantages of these plans.

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REFERENCES

[1] Phillips Bruce D, Wade Holly. Small business problems and priorities. Washington, DC: NFIB Research Foundation; 2008

[cited 2009 Jun 16]. Available from http://www.nfib.com/ResearchFoundation.aspx

[2] Claxton G, DiJulio B, Finder B, Jarlenski M. Employer health benefits: 2008 annual survey. Menlo Park, CA: Kaiser Family Foundation and Health Research & Educational Trust 2008a.

[3] Blumenthal D. Employer-sponsored insurance--riding the health care tiger. N Engl J Med 2006; 355(2):195-202.

[4] Remler DK, Glied SA. How much more cost sharing will health savings accounts bring? Health Aff (Millwood) 2006; 25(4): 1070-8.

[5] House Committee on Ways and Means. Statement of the National Federation of Independent Business; 2004 Mar 4; Washington, DC: House Committee on Ways and Means; 2004 [cited 2008 Oct 31]. Available from: http://ftp.resource.org/gpo.gov/hearings/108h/23794.pdf

[6] The White House, Office of the Press Secretary. Fact sheet: expanding access and increasing the affordability of health insurance through health savings accounts. Washington, DC: The White House; 2004 [cited 2008 Oct 9]. Available from: http://www.whitehouse.gov/news/releases/2004/08/20040809-14.html

[7] Gates SM, Kapur K, Karaca-Mandic P. Consumer-directed health plans and health savings accounts: have they worked for small businesses? Forum Health Econ Policy 2008; 11(2): 1-20. [cited 2008 Aug 12]. Available from: http://www.bepress.com/fhep/11/2/4

[8] Claxton G, Gabel JR, Dijulio B, *et al*. Health benefits in 2008: premiums moderately higher, while enrollment in consumer-directed plans rises in small firms. Health Aff (Millwood) 2008; 27(6): w492-502.

[9] Claxton G, Gabel J, Gil I, *et al*. What high-deductible plans look like: findings from a national survey of employers, 2005. Health Aff (Millwood). 2005; Suppl Web Exclusives: W5-434-41.

[10] Lowrey Y. Women in business, 2006. A demographic review of women's business ownership. Washington, DC: Office of Advocacy, U.S. Small Business Administration 2006; Report No.: 280.

[11] Codispoti L, Courtot B, Swedish J. Nowhere to turn: how the individual health insurance market fails women. Washington: National Women's Law Center; 2008 [cited 2008 Nov 1]. Available from: http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf

[12] Pear R. Women buying health policies face a penalty. The New York Times 2008; October 30; p. A23.

[13] U.S. Census Bureau. Women-owned firms: 2002. 2002 economic census: survey of business owners. Company statistics series. Washington, DC: U.S. Census Bureau 2006 [cited 2010 Jan 19]. Available from: http://www2.census.gov/econ/sbo/02/sb0200cswmn.pdf

[14] Claxton G, Gabel J, DiJulio B, *et al*. Health benefits in 2007: premium increases fall to an eight-year low, while offer rates and enrollment remain stable. Health Aff (Millwood) 2007; 26(5): 1407-16.

[15] Dennis WJ. National small business poll: purchasing health insurance: NFIB Research Foundation 2007.

[16] Fronstin P, Collins SR. Early experience with high-deductible and consumer-driven health plans: findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief 2005; (288): 4-28.

[17] Agrawal V, Ehrbeck T, Packard KO, Mango P. Consumer-directed health plan report - early evidence is promising. Insights from primary consumer research. Pittsburgh, PA: McKinsey & Company; 2005 June [cited 2009 Feb 27]. Available from: http://www.ahipresearch.org/pdfs/ConsumerDirectedHealthPlanReport_Promising.pdf

[18] McDevitt R, Beeuwkes-Buntin M, Damberg C, Lore R, Park H. The CDHP implementation experience with large employers. Washington, DC: Watson Wyatt Worldwide; 2007 [cited 2009 Oct 9]. Available from: http://www.watsonwyatt.com/us/research/featured/CDHP_slidedeck.pdf

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