The Macroeconomics of Health Savings Accounts
(Preliminary and Incomplete)

Juergen Jung and Chung Tran*
Indiana University - Bloomington
30th April 2007

Abstract

We use an OLG model with heterogenous agents where agents can choose between a low deductible- and a high deductible health insurance. In addition, they can save tax free in a health savings account (HSA) if they choose the high deductible insurance. We study the effect of transitioning from a system with private health insurance for young agents and Medicare for old agents to a system with HSAs for young agents and Medicare for the old. We focus on whether HSAs can increase the number of insured workers and whether health expenditures can be contained. In addition, we investigate the effects on output, distributional issues and the effects on the government budget. Preliminary results from a numerical exercise indicate that HSAs decrease the premium of the high deductible insurance, increase the number of insured workers, increase savings, increase income and have a negative effect on the distribution of wealth. HSAs, under the current parameter setting, cannot decrease aggregate health expenditures.

JEL: H51, I18, I38,

Keywords: Health Savings Accounts, Medical Savings Accounts, Privatization of Health Care, Health Insurance Choice, Health Insurance, Numerical Simulation of Health Care

1 Introduction

According to Feldstein (2006), a desirable system to finance health care has to have three objectives: (i) prevent the deprivation of care because of patient’s inability to pay, (ii) avoid wasteful spending and (iii) allow health care to reflect different tastes of individuals. He uses these objectives to analyze health savings accounts (HSA) which were introduced as part of the 2003 Medicare legislation and concludes that they are promising.

A HSA is similar to an IRA or 401(k) in the sense that funds are deposited out of pretax income and can accumulate tax free. HSAs are combined with a high deductible but low premium catastrophic health insurance. The funds from HSAs can then be used to pay the deductible and also the premiums. Funds can also be withdrawn at a penalty for non-health care consumption.

*We would like to thank Gerhard Glomm, Kim Huynh, Michael Kaganovich and Rusty Tchernis for many helpful discussions. In addition, we would like to thank Elyce Rotella, Willard E. Witte and participants of the Jordan River Conference 2007 for helpful comments. Corresponding author: Juergen Jung, Indiana University - Bloomington, Tel.: 1-812-345-9182; E-mail: juejung@indiana.edu
1.1 Objectives of Medical Savings Account

Medical Savings Accounts (MSA) or Health Savings Accounts (HSA) have four broad objectives:

The first is to reduce health care costs by decreasing the demand for discretionary health care services. Since patients pay the deductibles from their own health savings accounts or out-of-pocket, they will consume (discretionary) health services more carefully, and hence circumvent the moral hazard problem of insurance contracts. MSAs therefore control low-cost routine expenses, something that managed care does not do very well according to Scandlen (2001). In addition, mismanagement and corruption are estimated to cost between 3% – 10% of the health budgets due to the complexity and intransparency of western health systems but also the lack of involvement of the patient (Dettling (2006)). Managed care in the U.S. has increased administrative costs considerably.

The cost savings function of HSAs is ambiguous though. Keeler et al. (1996) show that changes in health care expenditure after the introduction of MSAs range from a 1% increase to a 2% decrease whereas Ozanna (1996) found a decrease between 2% to 8%. Watanabe (2005) shows in a highly stylized partial equilibrium model that a MSA is a tax-preferred account that itself encourages health care consumption by lowering the effective price of health care. The cost-containment effect, on the other hand, comes from the high deductible of the attached catastrophic insurance plan.

The overall effect of the HSA program is ambiguous and depends on the relative strength on these opposing forces. Remler and Glied (2006) conclude that due to the already large amount of cost sharing that is present in today’s health insurance policies the estimation results of older studies overpredict the potential cost savings of HSAs. Heffley and Miceli (1997) show that MSAs have the potential to induce socially efficient levels of health activities and preventive care, raising the expected wealth of consumers without reducing insurers’ profits. Their model is a partial equilibrium model. Zabinski et al. (1999) use a microsimulation (MEDISIM) to show that a MSA combined with catastrophic health insurance will tend to crowd out comprehensive coverage due to the tax deductions offered for the funds that go into the health accounts. This results in premium spirals in the comprehensive coverage markets since the insurance pool of these markets erodes. These results are robust to a wide range of parameter assumptions. Aggregate effects from the reform might be positive although there’s increased exposure to risk. This raises equity concerns since health care systems that are based on individual savings will naturally lead to less equity.

Zabinski et al. (1999) further show that poorer families and families with children lose the most from the reform. They find self selection by low-risk families into the MSA system which leaves the high-risk families with the choice of paying higher premiums in the comprehensive plans or joining the MSA system. In both cases high-risk families lose compared to their pre-reform coverage. Eichner, McClellan and Wise (1996) in their analysis of longitudinal health insurance claims data from a large firm (300,000 employees) over a three-year period (1989 – 1991) find that about 80% of retirees are left with at least 50% of total HSA contributions, whereas 5% have less than 20% of their contributions left. In their simulation the authors do not account for any behavioral responses of employees that can be expected due to alleviating moral hazard. Also, in their simulations they use data on individuals who were employed throughout their lifetime. Their data suggest that although health expenditures are persistent for a few years, in general high expenditures levels typically do not last for many years.
The second objective addresses population ageing. Since MSAs and HSAs are fully funded systems, they are less exposed to demographic trends since each generation pays for its own services directly. This goal requires a high coverage rate which makes implementation difficult. Singapore is the only country so far that has reached an almost universal coverage rate with MSAs.

The third goal is to build up capital stock via savings (compulsory savings in the case of MSAs) to achieve high economic growth rates. Especially China is interested in this aspect of MSAs.

Finally, MSAs put patients back in the center of health care decision making. Patients influence the entire process of their medical treatments, which can also reduce the risk of ex-post moral hazard. Supporters of MSAs claim that incentives for prevention are inherent in these accounts, although critics state the opposite. The notion that individuals will have an incentive to adopt healthier lifestyles in order to limit their health care expenses is unsupported by any evidence so far according to Laditka (2001). This objective is especially important in the U.S. discussion, since U.S. society values the freedom of the consumer more than other countries.

These four goals are implemented to various degrees in the four countries that have experimented with MSAs so far. Schreyogg (2002) presents a summary for Singapore, South Africa, China and the U.S. according to these goals.

1.2 Motivation

We see the following challenge. Rising health care expenditures make a reform of the current health care system in the U.S. inevitable. Demographic trends that already put the Social Security system under pressure, will pose an even greater threat to the sustainability of the current medical system. Health savings accounts have been proposed to curb the ever rising costs by centering on the patient’s role of rational consumer of health care services. Research so far has focused on micro-simulations and partial equilibrium models to model moral hazard and adverse selection aspects of the insurance component of HSAs.

We find a lack of good economic models that incorporate macroeconomic implications of reforming one of the largest public programs. Since at this point there is no reliable data on HSAs available and the discussion about HSAs is increasingly polemic, we think there is need for economic analysis that is model based, allows for policy predictions and is supported by economic theory. Given the inconclusiveness of empirical evidence substantial insight can be gained from a carefully designed simulation.

In order for such a model to be convincing it must include an adequate representation of intertemporal consumption choice and major institutional features of HSAs. The institutional features in place as put forward in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 are:

(i) HSA are tax free trust accounts to be used primarily for aping medical expenses, (ii) contributions are made with pre-tax dollars, (iii) interest earnings are not taxable, (iv) anyone under age 65 who has a qualified high deductible health insurance plan (a deductible of at least $1,000 for an individual and $2,000 for a family) is eligible to establish an HSA, (v) there’s a penalty of 10% if funds are withdrawn to pay for non-medical expenditures before the age 65, (vi) after 65 funds can be withdrawn and spent for nonhealth purposes after paying normal income taxes.
We focus on the macroeconomic aspects of HSAs. With the exception of Watanabe (2006) we do not know of any model that concentrates on the macroeconomics of the introduction of health savings accounts. Since a possible reform of Medicare and Medicaid in favor of HSAs would affect the single largest public program we think it is useful to analyze the impact of HSAs in various forms on existing programs and the effects on the government budget.

Imrohoroglu, Imrohoroglu and Joines (1998) model the savings effects of individual retirement accounts. Their framework is similar to ours in the sense that agents have two alternative savings mechanisms; tax favored savings with a penalty for early withdrawal and standard savings with a market interest return. Jeske and Kitao (2005) provide a mechanism to model the institutional details of private insurance and Medicare insurance in their work on health insurance choice. Palumbo (1999) estimates a health uncertainty model using U.S. data. In both these models health expenditures are exogenous. Suen (2006) uses a variant of a Grossman (1972) model with endogenous expenditure on medical treatments that increase the health capital of an agent. He investigates how growth in health expenditures is driven by technological factors and health accumulation. Khwaja (2002) and Khwaja (2006) provide estimates for a structural health uncertainty model with endogenous health expenditures. These two papers concentrate on the moral hazard of the Medicare program and finds that the introduction of Medicare increases health expenditures but does only minimally increase health damaging behavior like smoking, drinking alcohol and reduced exercising.

We use an OLG model with health uncertainty that is similar to Imrohoroglu, Imrohoroglu and Joines (1998), Jeske and Kitao (2005), and Suen (2006) and calibrate it to match the wealth distribution of the U.S.

Medical expenses are endogenous in our model and used to build up health capital. We then introduce HSAs and study the shift from employer provided private insurance to HSAs. Since the potential cost savings of HSA are ambiguous we conduct sensitivity analysis on various cost savings scenarios. In addition, we study the effect of HSAs on output and the wealth distribution.

The paper is structured as follows. The next section describes the model and contains the equilibrium definitions. In section 5 we conduct policy experiments. We conclude in section 6. The Appendix contains all detailed derivations of the steady state solutions.

2 The Model

We use an overlapping generations framework. Agents work for \( J_1 \) periods and then retire for \( J - J_1 \) periods. In each period there is an exogenous survival probability of cohort \( j \) which we denote \( \pi_j \). Agents die for sure after \( J \) periods. Deceased agents leave an accidental bequest that is taxed and redistributed equally to all agents alive.\(^1\) Population grows exogenously at net rate \( n \). We assume stable demographic patterns, so that similar to Huggett (1996), age \( j \) agents make up a constant fraction \( \mu_j \) of the entire population at any point in time.

\(^1\) An alternative redistribution method is to redistribute the after tax bequests to newly born cohort or to working cohorts. It turns out that the results are not affected by the way the government redistributes bequests.
The fraction $\mu_j$ is recursively defined as

$$
\mu_j = \frac{\pi_j}{(1 + n)^{\mu_{j-1}}}
$$

The fraction dying each period (conditional on survival up to the previous period) can be defined similarly as

$$
\nu_j = \frac{1 - \pi_j}{(1 + n)^{\mu_{j-1}}}
$$

2.1 Preferences

The consumer values consumption and health, so that her within period preferences are

$$
u(c_j, h_j) = \left(\frac{c_j^\eta h_j^{(1-\eta)}}{1 - \sigma}\right)^{1-\sigma}.
$$

2.2 Production of Health

We use the idea of health capital as introduced in Grossman (1972). In this economy there are two commodities: a consumption good $c$ and medical care $m$. The consumption good is produced via a neoclassical production function that is described later. Each unit of consumption good can be transformed into $\frac{1}{m}$ units of medical care. All medical care is used to produce new units of health. The accumulation process of health is given by

$$
h_j = \phi m_j^\xi + (1 - \delta (h_j)) h_{j-1} + \varepsilon_j,
$$

where $h_j$ denotes the current health status, $\phi m_j^\xi$ denotes the production of new health with inputs of medical care $m$ with parameters $\phi, \xi > 0$, $\delta (h_j)$ is the health deterioration rate which depends on the current health status. This partly captures the 'immediacy' of health expenditures. The longer the agent waits to treat her health shock, the worse her health gets. Finally, $\varepsilon_j$ is an age dependent health shock, where $\varepsilon_j \leq 0$.

The agent has to decide how much to spend out-of-pocket on medical care. We only model discretionary health expenditures $m_j$ in this paper. Income will have a strong effect on total medical expenses since health expenditures are endogenous in our model. Our setup assumes that given the same magnitude of health shock $\varepsilon_j$ a richer individual will outspend a poor individual. This may be realistic in some circumstances. However, a large fraction of health expenditures are probably non-discretionary (e.g.

An alternative way of formulating this problem and reducing the state space would be to let total health expenditure $m_j$ enter the utility function directly. Again total health expenditures of the household at age $j$ are discretionary only. Depending on the realization of the health state $\varepsilon_j$ the relative weight in the utility function of discretionary health expenditures $m_j$ changes, so that

$$
u(c_j, m_j, z_j) = \left(\frac{c_j^\gamma z_j^\varepsilon_j}{1 - \sigma}\right)^{1-\sigma},
$$

where $\gamma (\varepsilon_j)$ is a decreasing function in the health status variable $\varepsilon_j$. As the health state worsens, the consumer puts more weight on health expenditures in her utility function. Another way of thinking about this is health maintenance. If health deteriorates, the health maintenance costs are higher and therefore the consumer is willing to spend more on health care which establishes new relative rates of marginal utilities between consumption and health expenditures.
health expenditures due to a catastrophic health event that requires surgery etc.). In such cases a poor individual could still incur large health care costs. We do not cover this case in the current model.\textsuperscript{3}

### 2.3 Exogenous Process

The exogenous health shock $\varepsilon_j$ can take on five different states, $\varepsilon_j = \{1, 2, 3, 4, 5\}$: 1. Poor, 2. Fair, 3. Good, 4. Very Good and 5. Excellent.\textsuperscript{4} The variable follows a Markov process with age dependent transition matrix $P_j$, where transition probabilities from one state to the next depend on past health shock $\varepsilon_j$ so that an element of transition matrix $P_j$ is denoted

$$P_j(\varepsilon_j, \varepsilon_{j-1}) = \Pr(\varepsilon_j|\varepsilon_{j-1}, j).$$

### 2.4 Human Capital

Effective human capital over the life-cycle evolves according to

$$e_j = e^{\beta_0 + \beta_1 j + \beta_2 j^2} \text{ for } j = \{1, ..., J_1\},$$

where $\beta_0, \beta_2 < 0$ and $\beta_1 > 0$.

### 2.5 Insurance, Health Savings Accounts and Out-of-Pocket Medical Expenses

When agents are young and working they can buy private health insurance. Insurance companies offer two policies, a low deductible policy with deductible $\rho$ and copayment rate $\gamma$ at a premium $p_j$ and a high deductible policy with deductible $\rho'$ and copayment $\gamma'$ at a premium $p'_j$. These premia are tax deductible.\textsuperscript{5}

Health savings accounts (HSAs) are tax sheltered accounts that can only be set up in combination with a high deductible health insurance. Funds in the HSA accumulate tax free at the market interest rate. Health expenses can be paid for with funds from the HSA without ever paying income tax. If funds are withdrawn to pay for other consumption expenses the forgone income tax has to be paid plus a tax penalty of $\tau_m$. Also, at age 65 funds can be withdrawn and spent for non-health purposes after paying normal income taxes.

\textsuperscript{3}One method would be to distinguish between discretionary and non-discretionary health expenditures. The consumer can freely decide on how much to spend on discretionary health expenditures $m_j$ (e.g. preventive health check-ups, upgrades in hospitals, etc.) but incurs non-discretionary health expenditures $\overline{m}(\varepsilon_j)$ which are a function of her health shock $\varepsilon_j$ (e.g. hospital visits due to serious health problems, emergency health care, etc.). The total out-of-pocket health expenditure would then be denoted

$$o(m_j) = \min[p_m \overline{m}(z_j) + p_m m_j, \rho + \alpha (p_m \overline{m}(z_j) + p_m m_j - \rho)].$$

\textsuperscript{4}We use this classification because the data that we use to estimate the transition probabilities distinguishes these five health states.

\textsuperscript{5}Cutler and Wise (2003) report that about two thirds of the population younger than 65 is covered by some form of private insurance. The majority of these contracts is offered via employment contracts and premiums paid are thus tax deductible. Only 10% of these contracts are bought directly from insurance companies by the households. Premiums for these contracts are not tax deductible. For simplicity we assume that all private insurance contracts offered to the young population are offered via their employer and are thus tax deductible. Jeske and Kitao (2005) present a model where this is modelled specifically. We abstract from this detail in this paper.
In order to be insured against a health shock, households have to buy insurance the period before their health shock is realized. Agents in their first period of life are thus not covered by any insurance. The household’s out of pocket health expenditure when young and working if $j \leq J_1 + 1$ is therefore denoted

$$o^W(m_j) = \begin{cases} \min[p_{m,\text{ins}}m_j, \rho + \gamma(p_{m,\text{ins}}m_j - \rho)], \quad \text{with the low deductible insurance} \\ \min[p_{m,\text{ins}}m_j, \rho' + \gamma'(p_{m,\text{ins}}m_j - \rho')], \quad \text{with the high deductible insurance} \end{cases},$$

where $p_{m,\text{ins}}$ is the relative price of health expenditures paid by insured workers. An uninsured worker pays a higher price $p_m > p_{m,\text{ins}}$. The copayment rate $\gamma$ is the fraction the household pays after the insurance company pays $(1 - \gamma)$ of the post deductible amount $m_j - \rho$. Since households have to buy insurance before health shocks are revealed, the generation that is in its first year of retirement at $J_1 + 1$ (the 'recently retired') is still insured under the private policy plan.

In addition, household can save $a^m_j$ in HSAs tax free at the market interest rate if they bought a high deductible insurance. Agents can only contribute to their HSAs when they are young. Agents who have to pay $o(m_j)$ out-of-pocket medical expenses can pay this directly with savings from their HSAs. If they oversave in HSAs they can roll over the account balance into the next period. Savings accumulate tax free. If agents decide to use the savings account funds to pay for non-health related expenses, then they have to pay a tax penalty at rate $\tau_m$. This acts as a punishment for spending money on non-health related expenses as it is introduced in the regulations of health savings accounts. This penalty only applies to agents younger than 65 years. Agents older than 65 can use the money in the health savings accounts for non-health related expenses without having to pay the tax penalty $\tau_m$. They have to pay income taxes though on income spent in this way.

If they undersave and the funds in the HSAs do not cover medical expenses, then the household uses standard savings income to pay for the residual medical expenses and consumption at old age.

In addition, there is an upper limit on savings for health savings accounts. According to the Medicare Modernization Act of 2003 the maximum that can be contributed is the lesser of the amount of the high deductible $\rho'$ or the upper limit $\bar{\rho} = $2,600 for an individual ($5,150 for a family) so that the maximum contribution $\bar{a}^m$ is

$$\bar{a}^m = \min[\rho', \bar{\rho}].$$

After retirement all agents are covered by Medicare. Each agent pays a fixed premium $p^{Med}$ every period for Medicare. Medicare then pays a fixed fraction $(1 - \gamma^{Med})$ of the health expenditures that exceed the amount of the deductible $\rho^{Med}$. The total out of pocket expenditures of a retiree are

$$o^R(m_j) = \min[p_{m,Med}m_j, \rho^{Med} + \gamma^{Med}(p_{m,Med}m_j - \rho^{Med})], \quad \text{if } j > J_1 + 1,$$

where $p_{m,Med}$ is the price of health expenditures that retirees with Medicare have to pay. Agent’s out of pocket expenses when retired can still be paid with funds from the HSAs. The Medicare premium also qualifies for penalty free deductions from the HSAs. In addition Medicare is financed by a payroll tax $\tau^{Med}$. We assume that old agents $j > J_1 + 1$ do not purchase private health insurance and that their health costs are covered by Medicare and their own resources plus social insurance (e.g. Medicaid) if
2.6 The Household Problem

The state vector of a household not counting age \( j \) is \( x = (a, a^m, h, in, \varepsilon) \in S \times Z \) where 
\[ S \subset R_+, \quad Z = \{ \varepsilon_1, \varepsilon_2, \varepsilon_3, \varepsilon_4, \varepsilon_5 \} \]
for 5 different health shocks. For each \( (x) \in D(x) \) let 
\( \Lambda_j(x) \) denote the measure of age-\( j \) agents with \( (x) \in D \). The fraction \( \mu_j \Lambda_j(x) \) then 
denotes the measure of age-\( j \) agents with \( x \in D \) with respect to the entire population of 
agents in the economy.

With HSAs we have to distinguish in each period between agents that contribute to 
HSAs and those that take funds out of HSA. Among those who do not contribute each 
period, we again have to distinguish between those that use these funds for health related 
expenditures and those that use them for consumption. The latter have to pay a penalty 
tax when they are younger than 65 years old.

**Workers (Younger than 65)**

The household problem for young agents \( j = \{1, \ldots, J_1\} \) who are net contributors can 
be formulated recursively as

\[
V(a_{j-1}, a^m_{j-1}, h_{j-1}, in_{j-1}, \varepsilon_j) = \max_{\{c_j, m_j, a_j, a^m_j, in_j\}} \left\{ u(c_j, h_j) + \beta \pi_j E \varepsilon [V(a_j, a^m_j, h_j, in_j, \varepsilon_{j+1}) \mid \varepsilon_j] \right\}
\]

s.t.

\[
c_j + a_j + 1_{\{in_j=2\}} a^m_j + o^W (m_j) + 1_{\{in_j=1\}} p_j + 1_{\{in_j=2\}} p'_j = \bar{w}_j + R (a_{j-1} + T_{B eq} + T_{I n s p r o f i t}) + R^m a^m_{j-1} - Tax_j + T_j^{SI},
\]

\[
0 \leq NI_j \leq \bar{a}^m,
\]

\[
0 \leq a_j, a^m_j.
\]

---

\(^6\) According to Jeske and Kitao (2005) many older agents purchase various forms of supplementary 
insurance. The fraction of health expenditures covered by such insurances is small. According to the 
Medical Expenditure Panel Survey (MEPS) 2001, only 15\% of total health expenditures of individuals 
older than 65 is covered by supplementary insurances. Cutler and Wise (2003) report that 97\% of people 
above age 65 are enrolled in Medicare which covers 56\% of their total health expenditures. Medicare 
Plan B requires the payment of a monthly premium and a yearly deductible. See Medicare and You 
(2007) for a brief summary of Medicare.
where

\[
o^W(m_j) = \begin{cases} 
\min[p_{m,Ins}m_j, \rho + \gamma(p_{m,Ins}m_j - \rho)] & \text{if } in_{j-1} = 1, \\
\min[p_{m,Ins}m_j, \rho' + \gamma'(p_{m,Ins}m_j - \rho')] & \text{if } in_{j-1} = 2, \\
p_{m,m} & \text{if } in_{j-1} = 3,
\end{cases}
\]

\[
NW_j = R^m a_{j-1}^m - o^W(m_j) - 1_{(in_{j}=1)}p_j - 1_{(in_{j}=2)}p_j',
\]

\[
NI_j = a_j^m - \max[0, NW_j],
\]

\[
\tilde{w}_j = \left(1 - 0.5\tau^{Soc} - 0.5\tau^{Med}\right) we_j,
\]

\[
Tax_j = \tilde{\tau}(\tilde{y}_j^W) + 0.5\left(\tau^{Soc} + \tau^{Med}\right)\left(\tilde{w}_j - 1_{(in_{j}=1)}p_j - 1_{(in_{j}=2)}p_j'\right),
\]

\[
\tilde{y}_j^W = \tilde{w}_j + r\left(a_{j-1} + T^{Beq} + T^{Insprofit}\right) - NI_j,
\]

\[
T_j^{SI} = \max\left[0, c + Tax_j - \tilde{w}_j - R\left(a_{j-1} + T_j^{Beq} + T_j^{Insprofit}\right) - \left(R^m a_j^m - o^W(m_j)\right)\right].
\]

Variable \( c \) is consumption, \( a_j \) is savings into next period, \( a_j^m \) is savings in HSAs per period, \( o^W(m_j) \) is out-of-pocket health expenditure, \( m_j \) is total health expenditure, \( p_j \) is the health insurance premium (that is only paid when the agent has at least \( T_p \) income after health shock and taxes, where \( p < T_p \); otherwise the agent cannot afford insurance in the private market)\(^7\), \( \tilde{w}_j \) is wage income net of the employer contribution to Social Security and Medicare, \( R \) is the gross interest rate paid on last periods savings \( a_{j-1} \) and accidental bequests \( T_j^{Beq}, Tax_j \) is total taxes paid and \( T_j^{SI} \) is Social Insurance (e.g. Medicaid and food stamp programs).

The fact that we use \( \tilde{w}_j \) in the tax base for income tax \( \tilde{\tau}(\tilde{y}_j^W) \) leads to a double taxation of a portion of wage income due to the flat payroll tax \( 0.5\left(\tau^{Soc} + \tau^{Med}\right)\left(\tilde{w}_j - p_j\right) \) that is added. This mimics the institutional feature of income and payroll taxes (Social Security Tax Reform (Art#3)).

\( NW_j \) is net wealth in the health savings account after subtracting out-of-pocket health expenses and insurance premiums, \( NI_j \) is net investment in the HSA, \( we_j \) is the effective wage income.

The function \( \tilde{\tau}(\tilde{y}_j^W) \) captures progressive income tax, \( 0.5\left(\tau^{Soc} + \tau^{Med}\right)\left(\tilde{w}_j - p_j\right) \) is the payroll tax that the household pays for Social Security and Medicare, and \( \tau^mNI_j \) is the penalty tax for non-qualified withdrawals from the HSA, \( \tilde{y}_j^W \) is the tax base for the income tax composed of wage income and interest income on savings and accidental bequests and the net contributions to HSAs are tax deductible. Since in this case the agent does not make contributions so that \( NI_j < 0 \), the agent actually has to pay income taxes on these non-qualified deductions.

For net contributors it has to hold that \( NI_j \geq 0 \), that is next periods funds in the HSA \( a_j^m \) have to be larger than the funds at the beginning of the period minus the allowed health related expenditures (e.g. out-of-pocket health expenses \( o^W \) and insurance premia \( p_j \) that can be financed with HSA funds).

\(^7\) We assume that private health insurance is offered by the employers; the premia are therefore tax deductible.
For net non-contributors the corresponding constraints are

\[ NI_j < 0, \]
\[ Tax_j = \tilde{\tau} (\bar{W}_j) + 0.5 (\tau^{soc} + \tau^{med}) (\tilde{w} (\varepsilon_j) - p_j) - \tau^m NI_j. \]

The other constraints are the same as for contributors. Net non-contributors draw funds from HSAs beyond what is allowed so that \( NI_j < 0 \) and therefore pay the penalty tax \( \tau^m \) on the part spent on non-health related expenditures \( \tau^m NI_j \).

The social insurance kicks in when all funds, returns on \( a_{j-1} \) and \( a^m_{j-1} \) are depleted, therefore these terms do not show up in the definition of \( T^{SI}_j \). The Social Insurance program \( T^{SI}_j \) guarantees a minimum consumption level \( \bar{c}_j \). If Social Insurance is paid out then automatically \( a_j = a^m_j = 0 \) and \( in_j = 3 \) (the no insurance state) so that Social Insurance cannot be used to finance savings, savings into HSAs and private health insurance.

Agents can only buy insurance if they have sufficient funds to do so. Whenever

\[ p_j < \tilde{w}_j + R (a_{j-1} + T^{Beq}_j) + R^m a^m_{j-1} - o^W (m_j) - Tax_j, \text{ or} \]
\[ p'_j < \tilde{w}_j + R (a_{j-1} + T^{Beq}_j) + R^m a^m_{j-1} - o^W (m_j) - Tax_j, \]

then buying insurance becomes an option. The social insurance program will not pay for their health insurance. In their last working period agents decide whether to buy Medicare insurance or not. This determines their insurance state in the first period of retirement.

**Retired Agents**

Retired agents in their first period of retirement are insured under Medicare if workers in their last period decided to buy into Medicare Plan B. From then onwards retirees always buy Medicare insurance until they die. Retirees in general, that is all agents with age \( j > J_1 \) are not allowed to make tax exempt contributions to HSAs anymore (that is agents older than 65). So they are all classified as net non-contributors. In addition, the tax penalty \( \tau^m \) for non-health expenditures of HSA funds does not apply anymore. The individual has to pay income tax though, if she uses HSA funds for non-health related expenditures.

The household problem for retired agents \( j = J_1 + 1 \) who is a non-contributor and pays no penalty can be formulated recursively as

\[
V (a_{j-1}, a^m_{j-1}, h_{j-1}, in_{j-1}, \varepsilon_j) = \max_{\{ c_j, m_j, a_j, a^m_j \}} \left\{ u (c_j, h_j) + \beta \pi_j E_{\varepsilon} [V (a_j, a^m_j, h_j, in_j, \varepsilon_{j+1}) | \varepsilon_j] \right\}
\]

\[
c_j + a_j + a^m_j + o^W (m_j) + p^m_j = R (a_{j-1} + T^{Beq}_j) + R^m a^m_{j-1} - Tax_j + T^{soc}_j + T^{SI}_j,
\]

\[
NI_j = 0,
\]

\[
0 \leq a_j, a^m_j, \quad (3)
\]
where
\[
o^R (m_j) = \begin{cases} 
\min \left\{ p_{m,Med} m_j, \rho + \gamma (p_{m,Med} m_j - \rho) \right\} & \text{if } in_j = 1, \\
p_{m, m} & \text{if } in_j = 2,
\end{cases}
\]
\[
NW_j = R^m a_{j-1}^m - o^W (m_j) - p_j^{Med},
\]
\[
NI_j = a_j^m - \max \left\{ 0, NW_j \right\},
\]
\[
Tax_j = \tilde{\tau} \left( g_j^R \right),
\]
\[
g_j^R = r \left( a_{j-1} + T_j^{Beq} \right) - NI_j,
\]
\[
T_{j}^{SI} = \max \left\{ 0, \zeta + o^W (m_j) + Tax_j + p_j^{Med} - R \left( a_{j-1} + T_j^{Beq} \right) - R^m a_{j-1}^m - T_j^{Soc} \right\}.
\]

Non-contributors who use HSA funds for non-health related expenses have to pay income tax on these funds (no penalty $\tau^m$ applies for agents older than 65). Therefore constraint (3) changes to
\[
NI_j < 0,
\]
and all other conditions are the same as in the previous case.

### 2.7 Insurance companies

Insurance companies clear their budget constraint within each period (cross subsidizing across generations is allowed):
\[
(1 + \omega) \sum_{j=2}^{J_1+1} \mu_j \int I_{\{in_j=1\}} (1 - \gamma) \max \left\{ 0, p_{m,Ins} m_j (x) - \rho \right\} d\Lambda_j (x) \tag{4}
\]
\[
= \sum_{j=1}^{J_1} \mu_j \int I_{\{in_j=1\}} p_j (x) d\Lambda_j (x),
\]
\[
(1 + \omega) \sum_{j=2}^{J_1+1} \mu_j \int I_{\{in_j=2\}} (1 - \gamma') \max \left\{ 0, p_{m,Ins} m_j (x) - \rho' \right\} d\Lambda_j (x) \tag{5}
\]
\[
= \sum_{j=1}^{J_1} \mu_j \int I_{\{in_j=2\}} p_j' (x) d\Lambda_j (x),
\]

where $\omega$ is a markup factor that determines the profits $T^{Insprofit}$ of insurance companies, $I_{\{in_j=1\}}$ is an indicator function equal to one whenever agents bought the low deductible health insurance policy. Since agents have to buy their insurance one period prior to the realization of the health shock, first period agents are not insured. We clear low and high deductible insurances separately. Profits are distributed back to households in a lump-sum fashion.

### 2.8 Firms

Firms produce according to a general Cobb-Douglas production function and solve
\[
\max_{\{K, L\}} \left\{ AK^{\alpha_1} L^{\alpha_2} - qK - wL \right\}, \tag{6}
\]

taking $(q, w)$ as given.
2.9 Government

The government taxes workers income (wages, interest income, interest on bequests) at a progressive tax rate \( \tilde{\tau}(\tilde{y}_j) \) which is a function of taxable income \( \tilde{y} \).

Accidental bequests are redistributed in a lump-sum fashion to all households

\[ \sum_{j=1}^{J} \mu_j \int T_{j}^{Beq}(x) \, d\Lambda_j(x) = \sum_{j=1}^{J} \nu_j \int a_j(x) \, d\Lambda_j(x) + \sum_{j=J+1}^{J} \nu_j \int a_j(x) \, d\Lambda_j(x), \quad (7) \]

where \( \nu_j \) denotes the deceased mass of agents aged \( j \) in time \( t \). An equivalent notation applies for the surviving population of workers and retirees denoted \( \mu_j \).

The Social Security program is self-financing

\[ \sum_{j=J+1}^{J} \mu_j \int T_{j}^{Soc}(x) \, d\Lambda_j(x) \]

\[ = \sum_{j=J+1}^{J} \mu_j \int 0.5\tau^{Soc} \, \left[ x_j(x) + 0.5\tau^{Soc} \left( \tilde{w}_j(x) - 1_{\{in_j(x)=1\}} p_j - 1_{\{in_j(x)=2\}} p_j' \right) \right] \, d\Lambda_j(x), \quad (8) \]

The Medicare program is self-financing (and paid on a pay-as-you go basis so that the insurance premiums do not accumulate interest from last period)

\[ \sum_{j=J+1}^{J} \mu_j \int \left( 1 - \gamma^{Med} \right) \max \left( 0, m_j(x) - \rho^{Med} \right) \, d\Lambda_j(x) \]

\[ = \sum_{j=J+1}^{J} \mu_j \int \left[ 0.5\tau^{Med} \, \left[ x_j(x) + 0.5\tau^{Med} \left( \tilde{w}_j(x) - 1_{\{in_j(x)=1\}} p_j - 1_{\{in_j(x)=2\}} p_j' \right) \right] \right] \, d\Lambda_j(x) \]

\[ + \sum_{j=J+1}^{J} \mu_j \int p_j^{Med} \, d\Lambda_j(x). \]

The government budget is balanced so that

\[ G + \sum_{j=1}^{J} \mu_j \int T_{j}^{SI}(x) \, d\Lambda_j(x) = \sum_{j=1}^{J} \mu_j \int Tax_j(x) \, d\Lambda_j(x). \quad (10) \]

2.10 Equilibrium

**Definition 1** Given the exogenous number of health shock realizations \( Z \), transition probabilities \( P_{Z \times Z} \), realizations of health shocks \( \varepsilon_{1 \times M} \), the survival probabilities \( \{\pi_j\}_{j=1}^{J} \) and the exogenous government policies \( \{\tilde{\tau}(\tilde{y}_j), \tilde{\tau}^K\}_{j=1}^{J} \), a competitive equilibrium **with health savings accounts** is a collection of sequences of distributions \( \{\mu_j, \Lambda_j(x)\}_{j=1}^{J} \) of individual household-worker decisions \( \{c_j(x), a_j(x), a_j^{\tau^K}(x), m_j(x), in_j(x)\}_{j=1}^{J} \), aggregate stocks of physical capital and labor \( \{K, L\} \), factor prices \( \{w, q, R, r\} \) such that

(a) \( \{c_j(x), a_j(x), a_j^{\tau^K}(x), m_j(x), in_j(x)\}_{j=1}^{J} \) solves the consumer problem (2),
(b) the firm first order conditions hold

\[\begin{align*}
    w &= \alpha_2 \frac{Y}{L}, \\
    q &= \alpha_1 \frac{Y}{K}, \\
    R &= q + 1 - \delta,
\end{align*}\]

(c) markets clear

\[\begin{align*}
    K' &= S = \sum_{j=1}^{J} \mu_j \int (a_j (x) + a_m^j (x)) d\Lambda_j (x), \\
    L &= \sum_{j=1}^{J} \mu_j \int e(j, \varepsilon_j (x)) d\Lambda_j (x),
\end{align*}\]

(d) the aggregate resource constraint holds

\[\begin{equation}
    G + S + \sum_{j=1}^{J} \mu_j \int (c_j (x) + p_m (x) m_j (x)) d\Lambda_j (x) = Y + (1 - \delta) K,
\end{equation}\]

(e) the government programs clear so that (7), (8), (9), (10) and hold,

(f) the budget constraints of insurance companies (4, ??) hold

(g) the distribution is stationary

\[\Lambda_j (x') = \int 1_{\{a' = a(x), \ a'^m = a^m(x), \ m' = m(x)\}} P (\varepsilon', \varepsilon) d\Lambda_{j-1} (x),\]

where 1 is an indicator function.

3 Solving the Model

We solve the model backwards discretizing \(a, a^m, \) and \(h.\) Choosing the optimal health level from a grid allows us to substitute out \(m_j\) of the optimization problem via the law of motion of health, expression (1). Instead of choosing how much to spend on health in period \(j,\) the consumer picks the new health level \(h_j\) directly. Health expenditure \(m_j\) is then the residual

\[m_j = \left[ h_j - (1 - \delta (h_j)) h_{j-1} - \varepsilon_j \right] \frac{1}{\phi}.\]

This method turns out to be simpler than picking \(m_j\) directly, since that would require an additional discretization over \(m_j.\) An alternative specification would be to let depreciation be a function of current health expenditures, \(\delta (m_j).\) However, if the function \(\delta (m_j)\) is nonlinear we cannot easily solve for \(m_j\) anymore which would increase the computational burden.

Solving the model we use a hybrid algorithm that combines Euler equation iteration with value function iteration. First order conditions of the optimization problem are used to find next periods optimal capital stock \(a'.\) The appendix contains the derivations of the first order- and Envelope conditions for the penalty- and non-penalty paying workers.
and retirees. We then use a grid search over $a^m$ and $h$ that directly maximizes the value function.

4 Calibration (Incomplete)

Table 2 contains parameters that we pick to solve the model.

4.1 Savings Limit in HSAs

There is a savings upper limit for health savings accounts. According to the Medicare Modernization Act of 2003 the maximum that can be contributed is the lesser of the amount of the high deductible $\rho'$ or $\bar{\rho} = $2,600 for an individual and $5,150 for a family. Since we optimize for an individual the maximum contribution $\bar{a}^m$ is

$$ \bar{a}^m = \min [\rho', 2,600] . $$

The tax penalty for withdrawing funds from HSAs before the age of 65 and using them on non-health related consumption is $\tau^m = 10\%$.

4.2 Taxes

Social security taxes are $\tau^{Soc} = 2 \times 6.2\%$ on earnings up to $97,500. This contribution is made by both employee and employer. Medicare taxes are $\tau^{Med} = 2 \times 1.45\%$ on all earnings again split in employer and employee contributions (see Social Security Update 2007 (2007)). The income tax rates are summarized in table 1 and reflect U.S. income tax rates as of 2005.

We use the tax structure given in table 1 directly to determine the marginal income tax for each individual. We thereby assume that the maximum income level is $350,000 and then divide the income groups into percentile using this upper bound. In our model we then determine the maximum income in each iteration given market prices. We then determine the income percentile for each individual and apply the appropriate marginal income tax to that individual.\footnote{Alternatively, Miguel and Strauss (1994) estimated a tax function that mimics the progressivity of the U.S. income tax system. This functional form is

$$ \tilde{\tau} (\tilde{y}) = a_0 \left( \tilde{y} - (\tilde{y}^{-a_3} + a_2) \frac{1}{\frac{1}{a_1} - 1} \right) , $$

where $y$ is total income earned and $\tilde{\tau} (\tilde{y})$ represents total taxes paid. Parameter $a_0$ is the limit of marginal taxes in the progressive part as income goes to infinity, $a_1$ determines the curvature of marginal taxes and $a_2$ is a scaling parameter. Average and marginal tax rates are then $\frac{\tilde{\tau}(\tilde{y})}{\tilde{y}} = a_0 \left( 1 - (1 + a_2 \tilde{y}^{-a_3})^{\frac{1}{a_1}} \right)$ and $\tilde{\tau}' (\tilde{y}) = a_0 \left( 1 - (1 + a_2 \tilde{y}^{-a_3})^{\frac{1}{a_1} - 1} \right)$ respectively. This functional form is often used in calibrated life-cycle modelling (e.g. Smyth (2005), Jeske and Kitao (2005) and Conesa and Krueger (2005)).}

5 Policy Experiments (Preliminary Results)

We run numerical exercises for two types of models. First, agents can only choose one type of insurance. We then use a more realistic model where agents can choose between a high deductible insurance and a low deductible insurance simultaneously. If they choose the high deductible insurance policy they are also able to start a HSA.
5.1 Model 1: One Insurance Choice

In this model variant agents can only choose between one type of insurance. We calculate four separate regimes. In regime (1) agents cannot buy any health insurance, in (2) agents can buy a low deductible insurance, in (3) agents can buy a high deductible insurance, and in (4) agents can buy a high deductible insurance and save in a HSA. Steady state results are reported in table 3.

The regime without private health insurance and without Medicare yields the largest output (see first column in table 3). Consumption levels are highest in this regime so that the welfare measure (we aggregate the value of the utilities over all agents) is highest. Medical expenditure is low and the aggregate health state, as a consequence, is also low compared to the other regimes.

Introducing insurance choice in regime 2 and 3 increases the number of the insured working population slightly from 0% to 1% of the population. All retired workers are insured by Medicare in regime 2, 3 and 4. The introduction of insurance increases aggregate health expenditures from 11% to 14% of GDP as can be seen in column 2 and 3 under position $p_{m}M/Y$. This increase in health expenditures leads to a decrease in savings and hence to a decrease in steady state output. This decrease is enough to lower aggregate welfare and increase the Gini coefficient.

In regime 4 we allow the agents to save tax free in a HSA. The HSA has to be linked to a high deductible insurance. This policy decreases the price of insurance from 5.265 (4.939) in regimes 2 (3) to 3.994 in regime 4 (see fourth column in table 3). The lower insurance premium leads to an increase in the fraction of insured workers from 1% to 4.7%. Health expenditures increase to 15% of GDP and consumption increases as well. Compared to the insurance choice regimes 2 and 3, the regime with HSA improves welfare and lowers the Gini coefficient. However, compared to the no-insurance case, even HSA cannot improve welfare.

HSA do not decrease health expenditures as a fraction of GDP, $p_{m}M/Y$. This is due to an increase in income that follows from a higher savings rate.

Figure 1 reports aggregate asset holdings, aggregate holdings in HSAs, aggregate health expenditures and aggregate consumption per age group. From the two top panels we see that asset holdings are highest close to retirement at age 65. Under the no-insurance regime aggregate health expenditures of the oldest population drops sharply, whereas with health insurance (the old population is 'forced' to hold Medicare insurance) health expenditures of the elderly continues to increase until age 75.

In summary we find that if agents can only choose one insurance type at a time, the introduction of insurance decreases output and welfare and increases health expenditures and health status. This result will have to be tested more carefully since the welfare decrease depends a lot on the elasticities between consumption and health states.

5.2 Model 2: Two Insurance Choices

In this model agents can choose between two types of insurance policies, a low deductible health insurance and a high deductible health insurance. If they choose a high deductible insurance the agent can in addition save funds in a HSA.

---

9We cannot compare column 1 in table 3 to column 1 in table 4 because we used a different human capital profile in the numerical exercis for model 2. In a future draft we will run model 1 and model 2 on the same set of parameters.
We calculate three separate regimes: In regime (1) all agents (young and old) are without insurance, in regime (2) agents can buy a low or high deductible insurance without HSAs being available, and finally in regime (3) HSAs become available to agents who chose the high deductible insurance. We present the steady state results in table 4.

In model 2 the no insurance regime (first column) is dominated in terms of output and welfare by the insurance regimes (columns 2 and 3). Introducing insurance choice leads to 0.1% of workers buying the low deductible insurance and 2.6% buying the high deductible insurance (all old agents are again ‘forced’ into Medicare by definition). Health insurance leads to an increase in expenditures in medical care from 6.5% of GDP to 11.3% of GDP. The lower effective price of medical services allows agents to save more, so that output increases. This leads to an additional income effect, so that aggregate welfare (measured as the sum over all utilities) increases.

Introducing HSAs (column 3 in table 4) lowers the price of the high deductible insurance from 4.241 to 3.803. The lower premium leads to an increase in the number of insured workers from 2.6% of workers buying the high deductible insurance without HSA to 18.3% with HSA. The fraction of workers buying the low deductible insurance also increases slightly. The latter is a reaction to the income effect. The income effect is caused by higher savings due to the tax deductibility of savings in HSAs. Despite this increase in output in regime 2 and 3, the Gini coefficients in these regimes stay above the one in regime 1, the case without any insurance. This income effect is also the cause for an increase in health care spending from 11.3% to 15% of GDP.

This preliminary exercise seems to indicate that the insurance pool can be widened with the introduction of HSAs but that health care costs cannot be contained. Figure 2 reports aggregate asset holdings, aggregate holdings in HSAs, aggregate health expenditures and aggregate consumption per age group. From the two top panels we see that asset holdings are highest close to retirement at age 65. Contrary to figure 1 we observe a double spike in asset holdings in HSAs, one around age 45 and another around age 65. Under the no-insurance regime and under the insurance regime without HSAs aggregate health expenditures of the young are extremely low, whereas HSAs increase health expenditures of the young population.

6 Conclusion

Preliminary results indicate that HSA decrease the price of high deductible insurance, increase the number of insured workers and lead to increased savings and income. The increase in the number of insured workers under the high deductible insurance does not come at the expenses of agents holding the low deductible insurance. HSAs, under the current parameter setting, cannot decrease health expenditures.

References


Watanabe, Masahito. 2005. “When Do Health Savings Accounts Decrease Health Care Costs?”.


7 Appendix

7.1 Tables

<table>
<thead>
<tr>
<th>Yearly Income Level:</th>
<th>Income Tax Rate: $\tau$</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to $7,150$</td>
<td>$10%$</td>
</tr>
<tr>
<td>$7,151 - $29,050$</td>
<td>$15%$</td>
</tr>
<tr>
<td>$29,051 - $70,350$</td>
<td>$25%$</td>
</tr>
<tr>
<td>$70,351 - $146,750$</td>
<td>$28%$</td>
</tr>
<tr>
<td>$146,751 - $319,100$</td>
<td>$33%$</td>
</tr>
<tr>
<td>over $319,100$</td>
<td>$35%$</td>
</tr>
</tbody>
</table>

Table 1: Source: http://taxes.yahoo.com/rates.html

<table>
<thead>
<tr>
<th>Parameters</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$J_1 = 5$</td>
<td>$\rho^{Med} = 0.1$</td>
</tr>
<tr>
<td>$J_2 = 3$</td>
<td>$\gamma^{Med} = 0.3$</td>
</tr>
<tr>
<td>$\sigma = 2$</td>
<td>$\rho = 0.3$</td>
</tr>
<tr>
<td>$\beta = 1$</td>
<td>$\gamma = 0.4$</td>
</tr>
<tr>
<td>$\eta = 0.75$</td>
<td>$\rho' = 1.3$</td>
</tr>
<tr>
<td>$\alpha = 0.33$</td>
<td>$\gamma' = 0.4$</td>
</tr>
<tr>
<td>$\delta = 1 - 0.98(70/J)$</td>
<td>$\varepsilon = [0., 0.8, 1.8]$</td>
</tr>
<tr>
<td>$\phi = 1$</td>
<td>$a_{Grid} = [0, ..., 40]_{1 \times 31}$</td>
</tr>
<tr>
<td>$\xi = 0.4$</td>
<td>$a_{\theta Grid} = [0, ..., 10]_{1 \times 10}$</td>
</tr>
<tr>
<td>$\delta_h = 1 - 0.94(60/J)$</td>
<td>$h_{jGrid} = [0.01, ..., 12]_{1 \times 15}$</td>
</tr>
</tbody>
</table>

State Space $31 \times 10 \times 15 \times 8 \times 3 \times 2$

Table 2: Parameters for Calibration
Table 3: 4 Regimes: [1] No Insurance, [2] Low Deductible Insurance without HSAs, [3] High Deductible Insurance without HSAs, and [4] High Deductible Insurance with HSAs. In this steady state agents can only choose one type of insurance at a time.
<table>
<thead>
<tr>
<th></th>
<th>noInsurances-noHSA</th>
<th>2-Insurances-noHSA</th>
<th>2-Insurances-HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output-$Y$</td>
<td>29.534</td>
<td>29.732</td>
<td>29.735</td>
</tr>
<tr>
<td>Capital-$K$</td>
<td>10.301</td>
<td>10.512</td>
<td>10.516</td>
</tr>
<tr>
<td>$K/Y$</td>
<td>2.790</td>
<td>2.829</td>
<td>2.829</td>
</tr>
<tr>
<td>Asset-$a$</td>
<td>10.301</td>
<td>10.518</td>
<td>10.301</td>
</tr>
<tr>
<td>HSA-$a^m$</td>
<td>0.000</td>
<td>0.000</td>
<td>0.229</td>
</tr>
<tr>
<td>Health-Capital-$H$</td>
<td>3.331</td>
<td>3.606</td>
<td>3.698</td>
</tr>
<tr>
<td>HealthCapital/$Y$</td>
<td>0.902</td>
<td>0.970</td>
<td>0.995</td>
</tr>
<tr>
<td>Health-Expenditures-$pmM$</td>
<td>1.818</td>
<td>3.363</td>
<td>4.464</td>
</tr>
<tr>
<td>$pmM/Y$</td>
<td>0.062</td>
<td>0.113</td>
<td>0.150</td>
</tr>
<tr>
<td>$C/Y$</td>
<td>0.349</td>
<td>0.315</td>
<td>0.326</td>
</tr>
<tr>
<td>Human-Capital-$Hk$</td>
<td>1.596</td>
<td>1.596</td>
<td>1.596</td>
</tr>
<tr>
<td>Interest-Rate-$R$</td>
<td>1.076</td>
<td>1.075</td>
<td>1.075</td>
</tr>
<tr>
<td>Wages-$w$</td>
<td>12.397</td>
<td>12.480</td>
<td>12.481</td>
</tr>
<tr>
<td>Social-Security-Tax-$\tau^{Soc}$</td>
<td>0.207</td>
<td>0.209</td>
<td>0.215</td>
</tr>
<tr>
<td>Income-Tax</td>
<td>5.878</td>
<td>5.910</td>
<td>5.425</td>
</tr>
<tr>
<td>Social-Insurance-$T^{Si}$</td>
<td>0.052</td>
<td>0.040</td>
<td>0.040</td>
</tr>
<tr>
<td>Insured-Workers-Low(in%)</td>
<td>0.000</td>
<td>0.001</td>
<td>0.010</td>
</tr>
<tr>
<td>Insured-Workers-High(in%)</td>
<td>0.000</td>
<td>0.026</td>
<td>0.183</td>
</tr>
<tr>
<td>Insured-Workers(in%)</td>
<td>0.000</td>
<td>0.027</td>
<td>0.193</td>
</tr>
<tr>
<td>All-Insured(in%)</td>
<td>0.000</td>
<td>0.279</td>
<td>0.406</td>
</tr>
<tr>
<td>Insurance-Premium-$p^{Low}$</td>
<td>0.000</td>
<td>5.085</td>
<td>3.913</td>
</tr>
<tr>
<td>Insurance-Premium-$p^{High}$</td>
<td>0.000</td>
<td>4.241</td>
<td>3.803</td>
</tr>
<tr>
<td>Medicare-Premium-$p^{Med}$</td>
<td>0.000</td>
<td>4.587</td>
<td>4.709</td>
</tr>
<tr>
<td>Accidental-Bequests-$T_{Beq}$</td>
<td>0.045</td>
<td>0.045</td>
<td>0.046</td>
</tr>
<tr>
<td>Government-Spending-$G$</td>
<td>5.827</td>
<td>5.870</td>
<td>5.385</td>
</tr>
<tr>
<td>Gini-Coefficient</td>
<td>0.420</td>
<td>0.432</td>
<td>0.441</td>
</tr>
<tr>
<td>Agg.Welfare</td>
<td>-478.825</td>
<td>-447.924</td>
<td>-463.302</td>
</tr>
</tbody>
</table>

7.2 Figures

Figure 2: Aggregate asset holdings, aggregate holdings in HSAs, aggregate medical expenditures, and aggregate consumption for 3 regimes. [1] no insurance regime, [2] insurance choice without HSA, and [3] insurance choice with HSAs.