Not the Next IRA: How Health Savings Accounts Shape Public Opinion

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Abstract Scholars suspect that public policies affect public opinion, but the empirical evidence is mixed, and contemporary theories advance offsetting predictions. This study examines two allegedly similar private investment account programs that differ in politically relevant ways. Statistical analyses show that owners of Individual Retirement Accounts (IRAs) and Health Savings Accounts (HSAs) experience policy feedback effects, but in opposite directions. More specifically, matched comparisons of respondents in a national survey indicate that IRA participants are more likely to favor Social Security privatization than individuals without IRAs. In contrast, HSA participants are less likely to prefer consumer-driven health coverage in which individuals are empowered to make choices. Overall, the findings suggest that policies alter public opinion preferences but that the effects depend on programmatic design and performance.

Studies of public opinion and public policy often probe the degree of responsiveness or representation in a democracy (e.g., Monroe 1998; Page and Shapiro 1983; Jacobs and Shapiro 2000; Manza and Cook 2002a; 2002b). For years, however, scholars have argued that policies affect the political climate rather than merely being affected by it. For example, as Lowi (1972: 299) once stated, "Policy determines policies," which is a variant on E. E. Schattschneider's (1935: 288) earlier comment, "New policies create a new politics" (also see Brown 1983; Heclo 1974). Research on these policy-opinion linkages falls under the broader umbrella of policy feedback effects, but that work began by focusing, and remains focused, on how policies alter elite politics and state actions over the course of

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many years (Pierson 1993; Skopcol 1992). Recently, there have been calls for work on how policies shape public opinion (Mettler and Soss 2004), but many important questions remain.

The premise underlying feedback effects—that public policies or programs alter political attitudes—is popular in society. For example, politicians and scholars decry the culture of dependence stemming from welfare receipt (Murray 1984). However, systematic investigations of this proposition "do *not* support the existence of a culture of dependence among the beneficiaries of government aid" (Schneider and Jacoby 2003: 231; emphasis original). Other studies of policy feedback effects with an attitudinal focus have also generated mixed empirical results (Gusmano, Schlesinger, and Thomas 2002; Soss and Schram 2007). But the lack of widespread empirical support has not stopped policy makers from trying to create a culture of independence via privatization (Cogan, Hubbard, and Kessler 2005; Moore and Kudlow 2004). And that raises an important question: if social insurance and welfare programs do not create dependence, will investment-oriented programs lead to a culture of independence, or at least to more support for individualistic privatization policies?

Two prominent private investing policies are in the areas of retirement (Individual Retirement Accounts or "IRAs") and health care (Health Savings Accounts or "HSAs"). This study probes some of the fundamental political questions and assumptions underlying IRAs and HSAs. Do IRAs generate attitudinal policy feedback effects, and if so, then are HSAs similar in the sense that they also encourage support for individualistic privatization policies? The findings suggest that the picture is much more nuanced than one might guess given the political dialogue. Both IRAs and HSAs alter political opinions, but only IRAs increase support for privatized individual retirement accounts. HSA participants are less supportive of individualized health care partly because of subtle differences in policy design and partly because of the overwhelmingly negative experiences among HSA participants thus far. Studying attitudinal policy feedback effects in this area helps illuminate and clarify the underlying theoretical issues.

Policy Feedback Effects and Private Accounts

Research on opinion-policy linkages in which policies are outputs of a political process (Easton 1953) has been challenged by scholars who contend that policies produce feedback effects (Pierson 1993). According

to this view, policies not only reflect public opinion but also shape it by setting agendas, identities, and interests (Pierson 2000; 1992). Or, in the words of Theda Skocpol (1992: 58), "As politics creates policies, policies also remake politics." The basic critique is related to the methodological challenges long associated with studies of democratic responsiveness (Page 1994). In particular, policies have an independent causal force that can define incentives, redistribute resources, and convey cues that define, arouse, or pacify constituencies (Soss and Schram 2007).

Much of the work on feedback effects and path dependency concerns political leaders and systems. Several prominent studies show how policies define interest groups and state capacities (e.g., Hall 1986; Skocpol 1992; Steinmo, Thelen, and Longstreth 1992). When policy feedback mechanisms are studied at the individual level, the focus tends to be on participation. This is the case in studies of how senior citizens organize to protect their interests with regard to Social Security (Campbell 2002; 2003). It is also the case for the transformative and educative effects of the GI bill (Mettler 2002) or social welfare programs (Soss 2000). However, while participation is vital, it is often done to advance policy preferences. A natural question is whether governmental programs affect political attitudes, especially the opinions that may have helped bring about the programs in the first place.

Attitudinal Policy Feedbacks

Policy feedback research on opinions takes place on multiple levels and generates a range of findings. One example of work primarily at the mass public level is Soss and Schram's (2007) study of the transition from Aid to Families with Dependent Children (AFDC) to Temporary Aid to Needy Families (TANF) in the mid-1990s. They use welfare reform as a test case to see if policies have impacts on the broader political climate — that is, the entire country as represented in public opinion surveys — not just participants. In particular, Soss and Schram claim their mission is to "address the use of policy design as a conscious political strategy and extend the study of feedback to elite efforts to alter the preferences, beliefs, and behaviors of broad mass publics" (ibid.: 111). They find that the policy change (welfare reform) made welfare less salient but did *not* transform views on welfare policy or beliefs about recipients and the poor. It also failed to deracialize welfare policy and did not produce political dividends for the Democratic Party or substantially increase public willingness to invest in public aid, especially when the data are pooled across the years.

Another pioneering study at the level of mass policy feedbacks is Gusmano, Schlesinger, and Thomas's (2002) analysis of health care policies. They focus on feedbacks resulting from signaling (i.e., what elites say about the policy) and policy learning based upon personal experience.[1] They use the historical legacies of policies in employer-provided medical care, long-term care, and treatment of substance abuse. Because there was extensive personal experience with employer involvement in medical care as compared to long-term care or substance abuse, the public was much more willing to support mandates in this area. However, measures of policy experience and elites' signals are not in the analytical model.[2] Their findings generally point to the role of direct policy learning over signaling, "except in the relationship of support and the age of the respondent, where the predicted effects of signaling were consistent with each other" (ibid.: 761). Also, the authors admit, "our findings must be interpreted with caution . . . [because] the variables provide only rough proxy measures of policy feedback" (ibid.: 761). Instead, they conducted what they describe as a "series of indirect tests for the patterns of opinion one would expect to find if policy feedback were emerging from either the signaling or learning models" (ibid.: 746–747). Thus, in some instances the predictions for the different models overlap, and in other cases the evidence is not definitive, although their study boldly ventured where few had gone before.

Working from a different perspective, some studies concentrate on participants in particular programs rather than the mass public. For example, Soss (1999; 2000) conducted in-depth interviews with fifty public assistance recipients in the mid-1990s, then supplemented those interviews with ethnographic fieldwork and survey data. Soss asked why welfare recipients are "an especially quiescent group" in terms of political participation (Soss 1999: 363). Possible explanations are their preexisting background characteristics, the cultivation of personal traits of dependence, a demobilization effect, or the educative effects of welfare participation, akin to the work of Anne Schneider and Helen Ingram (1993), who suggest that target populations are socially constructed. Soss finds that Social Security Disability Insurance (SSDI), with its routinized procedures, elevates recipients' sense of governmental responsiveness, while Aid to Families

1. Gusmano, Schlesinger, and Thomas (2002) also consider exposure, or the length of time that citizens interact with a program to the point where they become "comfortable" with it (ibid.: 734). However, they acknowledge that "these effects are not necessarily mutually exclusive."

2. Instead, Gusmano, Schlesinger, and Thomas (2002) use detailed background policy research to argue, "There is clear evidence that elites devoted considerable resources to try to convince the public that employer responsibility was both possible and desirable" (ibid.: 746).

with Dependent Children (AFDC), in which welfare recipients encounter nonresponsive agencies, has the opposite effect. Yet Soss notes that the four explanations set forth in his article "are not mutually exclusive." While he does not find much support for passivity, his political learning argument "should be seen as a complement to the other two" (ibid.: 364). Thus, it seems that participation in welfare programs has a distinctive effect that is very likely from political learning via personal experience, but this could be due to several factors.[3]

Finally, some scholars contrast program participants with nonparticipants in a single study. Fay Cook and Edith Barrett (1992) conducted an extensive examination of virtually every major social insurance or welfare program in the United States (e.g., Social Security, AFDC, Medicaid, etc.). They are able to show how dispositions (self-interest, political predispositions) and attributions (whether the program works and whether the recipients are deserving) affect support for the American welfare state. Similarly, and as previously noted, Schneider and William Jacoby (2003) report that participation in various social welfare programs alters support for government spending and guaranteed jobs, but not much else once one controls for symbolic predispositions like partisanship or ideology and demographics. The authors conclude, in part, that "the impact of welfare participation on issue attitudes represents simple self-interest" (see also Cook and Barrett 1992; Soss 2000). In contrast, with programs like Social Security, which have an earned benefit structure, "the connection between individual experiences and political issues is virtually non-existent" (Schneider and Jacoby, 2003: 230).

To summarize, then, the attitudinal policy feedback literature has considered traditional governmental program like welfare, Medicaid, and Social Security or SSDI, as well as employer participation in health care, long-term care, and substance abuse, but there is no consensus regarding effects or the mechanisms underlying those effects. Moreover, vast portions of the traditional welfare state are hidden or being privatized in the form of accounts-based policies (e.g., Gottschalk 1999; Hacker 2002; Howard 1993). Few studies in this area consider whether programmatic participation in these new areas alters political judgments in the same way that it should for elites or mass publics in general. Because

3. In two of three statistical analyses with ANES data, Soss finds that SSDI differs from AFDC because the coefficients for SSDI are insignificant, but in two of the three cases they are close to being significant (i.e., $p < .20$). There were only 101 SSDI recipients in the data, compared with 82 AFDC participants. With more cases or alternative specifications, the effects of SSDI receipt might have been significant.

of the importance of personal experience (Schneider and Ingram 1993: 340–341), combined with our lack of understanding of how it leads to feedback effects, this article considers accounts-oriented governmental policies. These new programs are thought to be consistent with the individualistic culture in the United States (McClosky and Zaller 1984), but raw self-interest, which ought to be operating with investment accounts, is not easy to demonstrate in politics (Gomez and Wilson 2001; Sears et al. 1980; cf. Chong, Citrin, and Conley 2001). As I will argue, the structure of the programs and the experiences thus far shape policy preferences.

Investment Accounts for Retirement and Health Care

At first glance, Individual Retirement Accounts (IRAs) and Health Savings Accounts (HSAs) appear to be similar, but a closer look suggests that they differ in subtle and politically important ways. Consider, first, the origins and policy evolution of IRAs. Originally created in the Employee Retirement Income Security Act (ERISA) of 1974, IRAs were not expected to be a major feature of the tax code. The purpose of the law was to make it possible for employees without traditional employer pensions to save for retirement.

As originally conceived, contributions to IRAs were tax-deferred until the funds were withdrawn, with a 10 percent penalty for early withdrawal of the funds before age fifty-nine. But the key legislative debates during the early years of the program concerned who could use IRAs. When they were created, IRAs were strictly for employees who lacked pension coverage, but the 1981 Economic Recovery Tax Act changed that by allowing all taxpayers under age seventy and a half to contribute to a qualified plan, not just those who lacked an employer pension plan. It also raised the maximum annual contribution to $2,000 from $1,500, and it allowed participants to contribute $250 on behalf of a nonworking spouse. By the mid-1980s, however, policy makers determined that wealthy individuals were disproportionately advantaged by IRAs. In response, the Tax Reform Act of 1986 phased out the deduction for IRA contributions among high-income-earning workers who were already covered by an employer plan personally or through a spouse.

However, the crackdown on the tax shelter did not last long. By the late 1990s, the pendulum swung again toward renewed expansion of and access to IRAs. Congress passed the Small Business Job Protection Act of

1996, which raised the limit on behalf of nonworking spouses from $250 to $2,000. The following year, the Taxpayer Relief Act of 1997 increased the income threshold for deductible contributions and distinguished between taxpayers who are covered by an employment-based plan and those who are not but whose spouses are covered, with variable thresholds for taxpayers in this latter group. The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) changed the law further, raising the limit on contributions beginning in 2002 to $3,000, and allowing "catch-up" contributions by people ages fifty and above. As of the late 2000s, virtually all individuals with earned income or their spouses with earned income could participate in an IRA. The only exceptions were certain people older than age seventy and a half with high incomes.

What should not be lost in the policy history is that there are two main types of IRAs that individuals may establish: Traditional and Roth IRA accounts. In Traditional IRA accounts, contributions are typically tax deductible, lowering the amount of a taxpayer's income that is subject to taxes (e.g., a $4,000 Traditional IRA account contribution for someone in the 25 percent tax bracket lowers the amount they pay in taxes by $1,000). Interest, dividends, and capital gains are not subject to tax while still in the account, but all withdrawals from the account are subject to federal income tax. In Roth IRA accounts, which were created as part of the 1997 Taxpayer Relief Act and named after former U.S. Senator William V. Roth of Delaware, initial contributions (i.e., taxes are paid on the income when the contribution is made) are nondeductible, but earnings accrue tax-free, and all withdrawals are tax-exempt. There are also no mandatory age seventy and a half distribution rules as there are with traditional IRAs.

By the first decade of the twenty-first century, the limits on IRA contributions were $5,000 per worker, whether or not that worker was in an employer pension plan, with another $5,000 for a nonworking spouse and an additional $1,000 catch-up provision for workers ages fifty and older. Income limits for tax deductions phase out between $50,000 to $60,000 for unmarried individuals, $80,000 to $100,000 for spouses in an employer-provided plan, and $150,000 to $160,000 for married couples with a spouse not covered. As of 2008, the contribution limit was $5,000 for Roth IRAs as long as income is below $101,000 for individuals and $159,000 for married couples filing jointly, with the contribution limit phased out gradually above those levels. In 2006, the Congress made it easier for high-income taxpayers to contribute to Roth IRAs, and the EGTRRA extends the "Roth account" concept to 401(k) and 403(b) plans

by creating Roth versions of those investment plans. (For more information, see the Congressional Budget Office at www.cbo.gov or IRS Publication 590.)[4]

By the end of 2003, IRAs were the largest component of the $11.6 trillion U.S. retirement market, representing more than one out of every four retirement dollars. Roughly 45 million households, or 40 percent of all households, owned IRAs in 2004, with more than one-fifth of all financial assets held in an IRA for the typical IRA-owning household (Holden et al. 2005). In a June 2005 survey by CBS News and the *New York Times*, 68 percent of respondents said they currently had retirement savings invested in a 401(k) plan, an IRA, or a Keogh plan. These figures represent considerable growth over time. In the first year IRAs were available, Americans made $1.4 billion in tax-deductible IRA contributions. This figure rose to $4.8 billion by 1981 and exploded to more than $28.3 billion in 1982 after the passage of the Economic Recovery Tax Act of 1981, which, as mentioned earlier, made the IRAs universal by allowing any taxpayer to contribute to a plan and raising the income limits.[5] As of 1983, however, a Gallup survey found that only 7.5 percent of respondents (126 individuals out of 1,660 in the poll) reported participating in an employer payroll deduction for an IRA. Thus, IRAs grew from relatively modest beginnings to a well-known and respected retirement institution within thirty years of their inception.

Even though it is widespread today, IRA participation is far from random. For example, individuals responsible for IRA investment decisions in households are more likely to hold college degrees and to have higher income. In a 2004 report, 57 percent of IRA households were found to

4. IRAs are often created as employees roll over funds from employer-sponsored plans, such as a 401(k), when leaving a workplace rather than using them to start new savings accounts. Since 1978, section 401(k) of the Internal Revenue Code has allowed for-profit businesses to establish salary-reduction plans. According to the Congressional Budget Office, 401(k)s are the most common form of defined-contribution plan and are offered not only by for-profit businesses but also by some nonprofits and state and local governments. In 2005, 73 percent of the employees of medium-sized and large businesses and 33 percent of the employees of small establishments participated in 401(k) plans. Most employers match at least a portion of their workers' contributions, but about 30 percent of participating employees received no contributions from their employer in 2005. Section 403(b) of the Internal Revenue Code has allowed certain nonprofit organizations to set up salary reduction plans for their employees. Those plans, also known as tax-sheltered annuities, are subject to the same limits on employee contributions that are placed on 401(k) plans. If an employee has both types of plan, the limits apply to the sum of 401(k) and 403(b) contributions.

5. The 1978 Revenue Act also created other IRA vehicles, such as Simplified Employer Pension (SEP) IRAs. References to IRAs in this study include a wide variety of retirement investing accounts, such as 401(k), 403(b), 457, and Keogh plans.

have a college or postgraduate degree, compared with 28 percent of non-IRA households. The median income for a decision maker in an IRA household is $62,500, compared with $35,000 in a non-IRA household. These wealth disparities are also reflected in differences in household finances: IRA holders have $172,100 in median household financial assets (excluding a primary residence), compared with $21,700 for non-IRA families. They are also older. According to the Investment Company Institute, the median IRA holder is forty-nine years old, compared to forty-five in a household without an IRA and forty-seven for all U.S. households. Such gaps have been observed elsewhere, and such disparities make it important to control for these factors when conducting empirical analyses (Engen, Gale, and Scholz 1996).

Health Savings Accounts (HSAs), while more recent, had a similar low-profile start. HSAs were created by the Medicare bill signed by President Bush on December 8, 2003, and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. According to guidelines issued by the U.S. Department of Treasury, adults can contribute to an HSA if they have health coverage under a qualified high-deductible health plan, have no other first-dollar medical coverage (e.g., beyond accident, disability, dental care, vision care, or long-term care, which are permitted), are not enrolled in Medicare, and cannot be claimed as a dependent on someone else's tax return. The 2008 deductible amounts (and index thereafter for inflation) are $1,000 for individuals and $2,200 for families.[6] Annual out-of-pocket expenses cannot exceed $5,600 for individuals and $11,200 for families (the 2009 levels are $5,800 and $11,600). Individuals can make HSA contributions of $2,900 each year (or $3,000 in 2009). The comparable family coverage contribution limits were $5,800 in 2008, although individuals fifty-five and older can make additional catch-up contributions of $900 in 2008 and $1,000 in 2009 and beyond.

The money in the HSA is designed to pay for "qualified medical expenses" permitted under federal law. This includes most medical, dental, and vision care, as well as over-the-counter drugs such as aspirin. Individuals cannot use the money to pay medical insurance premiums.[7] The money may be used to pay for medical expenses of the individual with

6. In 2009, the minimum deductibles rise to $1,150 for individuals and $2,300 for families.

7. The exceptions are when individuals are receiving unemployment benefits, using COBRA continuation coverage, paying for a long-term care contract, and Medicare premiums and deductibles for Medicare Parts A, B, C, or D.

the high-deductible plan, as well as spouses or dependent children, even if they are not covered by the HDHP. Funds can also be used for other nonqualified medical expenses, but they are treated as taxable income and subject to an additional 10 percent tax penalty. However, after age sixty-five, the 10 percent penalty no longer applies. Individuals can also tap the HSA funds without penalty if they become disabled and enroll in Medicare.

Originally included in the Medicare Modernization Act of 2003 to appease conservatives in return for their support for the massive new prescription drug entitlement (see Oberlander 2007: 196), HSAs offer several advantages over traditional health care coverage. The key benefit is the lower monthly premium in exchange for a higher deductible, which should make insurance more affordable. Individuals divert some of their annual income into an HSA on a pretax basis to help pay the cost of the deductible if the health insurance is used. Any remaining money compounds from year to year, except a small part that pays for administering the account. With HSAs, individuals make their own decisions about how much money to put in the account, which medical expenses to pay with the account, and which investments to make. In addition, HSAs are portable. Individuals can keep their HSAs if they switch jobs, become unemployed, move to another state, or change their marital status. Finally, upon the account owner's death, HSA funds can be inherited as part of their estate.

Divergent Policy Experiences and Feedback Effects

HSAs are part of a movement toward consumer-directed health plans (CDHPs) in America (Davis 2004; Halvorson 2004). The goal is to save money by making individuals aware of the costs associated with health care. The premise is that if consumers are isolated from the costs of care, they will make different and perhaps unwise decisions about their medical care. Whether individuals have enough information to be consumers in the health marketplace is still hotly contested, and there is evidence to suggest that health care consumers do not enjoy haggling with doctors and other medical care providers.[8]

8. In a Kaiser Family Foundation survey of individuals with CDHPs during the summer of 2006, only 32 percent agreed (strongly or somewhat) with the statement "I am comfortable negotiating with my doctors' offices about the price I pay for health care." Similarly, 27 percent agreed with a statement that read, "I believe that I can get a better deal from my doctors on the price of health care services than my insurance company can," and just 18 percent felt that they personally could get a better deal on hospital care than insurance companies could.

Some leaders believe HSAs will revolutionize health care in the United States. HSAs are an updated version of Medical Savings Accounts (MSAs),[9] but distinct from Flexible Spending Accounts (FSAs), in which individuals estimate their out-of-pocket health expenditures and pay for them with pretax dollars. Consumers can sign up for HSAs with banks, credit unions, insurance companies, and other approved financial companies. Employers may also set up a plan for employees. HSAs are still relatively new. While the estimates vary somewhat, the number of U.S. workers enrolled in HSAs through their jobs grew only slightly, to 2.7 million in 2006 from 2.4 million in 2005 (Feldman et al. 2005).[10] However, President George W. Bush used his 2006 State of the Union Address to call for new tax policies that would establish 21 million HSAs by the end of the decade (White House 2006).

These explosive growth projections are one reason the *New York Times* suggested that HSAs will be "the next IRA," in reference to the popularity of individual retirement accounts (Dash 2006). However, this movement toward "consumerism" in health care has social implications that go far beyond medical care delivery and cost cutting. HSAs are a central part of attempts to create an "investor class," or an "ownership society" in which individuals take on added responsibility for their well-being (Brown, Kuttner, and Shapiro 2005; Moore and Kudlow 2004; Swartz 2004). Thus, a political calculation underlies HSAs and attempts to expand them.

The basic logic was captured in the *Atlanta Journal-Constitution* shortly after HSAs were enacted in 2003 as a part of the Medicare prescription drug bill. An editor tried to soothe readers who were concerned about the huge entitlement by stating, "Bush's legislative brilliance, conservatives fervently hope, will be to spend big, buying not more welfare state dependency, but greater personal responsibility—and eventually,

9. Created in the late 1990s with pilot programs in 2001 and 2002, MSAs were intended to be funded by employers or individuals, but not both, as with HSAs. The MSA contribution levels were 65 percent of the deductible for individuals and 75 percent of the deductible for families, as compared with 100 percent of the deductible for HSAs. The out-of-pocket maximum for MSAs was $3,350 in 2003 for individuals and $6,150 for families, as compared to $5,000 for individuals and $10,000 for families in 2004 for HSAs. MSAs have been superseded by HSAs. It is no longer possible for people to join an MSA, but participants can maintain their unused account funds.

10. Later I present evidence suggesting that most participants in CDHPs had a choice with respect to their style of coverage, and according to the Kaiser Foundation, only 19 percent of employees choose a consumer-driven plan when given a choice (Fuhrmans 2007). If the focus is on high-deductible consumer-driven plans generally rather than HSAs only, the growth figures appear to be higher. According to a study by America's Health Insurance Plans, as of January 2008, roughly 6 million Americans were enrolled in high-deductible coverage plans, up from 4.5 million in 2007, and 3.2 million in 2006.

therefore, a smaller role for government in our lives." The same article quotes former House Speaker Newt Gingrich as saying, " 'Once the first 5 million people have health savings accounts, they are never going to give them up' " and " 'You never saw a liberal try to take back IRAs' " (Wooten 2003). The implication, as articulated years ago by conservatives (Butler 1983; Butler and Germanis 1983), is that investment accounts foster public support for privatization in both health care and retirement.

Although they do not express it in precisely these terms, HSA proponents like Gingrich expect attitudinal policy feedback effects. Despite calls for more research on ideological effects (Mettler and Soss 2004), the feedback literature concentrates on participatory acts like voting (Campbell 2002; Mettler 2002; Soss 2000; cf. Soss and Schram 2007; Gusmano, Schlesinger, and Thomas 2002). At present, scholars know little about how participation in policies or programs affects political beliefs, despite the widely held view that personal accounts increase support for privatization policies. I will argue that we should examine programmatic details and experiences before developing directional expectations of policy feedback processes.

Experiences with IRAs and HSAs differ in politically important ways. IRAs are back-loaded from a policy feedback standpoint, and the IRA-related experiences of participants is mostly limited to choosing investments and reviewing investment reports. Retirement investing, especially for IRA participants, ought to be popular because of the relatively low day-to-day effort required to maintain the accounts and the lower levels of risk exposure. Once retirement investors commit their money to the stock market, they can invest for the long run, and are often encouraged to do so (Siegel 2002). The fund-it-and-forget-it mentality is pervasive; many people rarely check their investments or rebalance their portfolios to the degree that experts recommend (Dorsey 2004). Progress is measured in terms of years or decades, which gives IRA and 401(k) investors time to weather stock market swings and recessions.

In contrast, HSAs require a choice of medical coverage that will be in effect in any given year and the high deductibles constrain behavior immediately, as does the need to divert money into the savings account to pay for the deductible. That means HSAs differ from other investment accounts in several important ways. First, HSAs demand much more attention and cognitive engagement. There are the burdens of comparing plans, selecting one, managing the investments, shopping for low-cost treatments, and submitting reimbursement paperwork. These accounts also place more risk on HSA owners (e.g., stock market risk, the risks of

exceeding HSA assets). If they experience health problems, owners of a depleted HSA might be in trouble, with no recourse except family help or Medicaid. Moreover, while the consumerism movement can help cut overall health costs, it takes effort to make choices, and consumers will likely be frustrated by the lack of information (Fronstin and Collins 2005). Finally, participation in HSAs might be voluntary, as it is with IRAs, but it could also occur when companies shift workers out of employer-sponsored health plans involuntarily, generating resentment.

Thus, although they seem similar to IRAs in some respects, HSAs will likely generate different political considerations. In particular, I expect personalized policy feedback effects in both domains, but the direction of these effects should differ. I hypothesize that IRA participants will be more supportive of privatization in the retirement policy arena (Hypothesis 1). In contrast, HSA participants should be less supportive of privatization in health care because early reports have not been favorable (Fronstin and Collins 2005). That is, we should observe less public support for privatized health policies among HSA participants than among nonparticipants (Hypothesis 2). To summarize, then, HSAs should have policy feedback effects, but not necessarily as "the next IRA." The policy feedback effects are due to experiences — positive in the case of IRAs and negative in the case of HSAs — which will lead to feedback effects among participants but in opposite directions.[11]

Design, Data, and Methods

One way of studying the effect of a public policy on political attitudes would be to implement a field experiment with participants randomly assigned to varying levels of programmatic participation (e.g., Newhouse

11. The underlying assumption here is that privatization attitudes are formed as people canvass relevant considerations in their minds (Zaller 1992). HSAs and IRAs generate different considerations that people use to form their opinions. As will be argued later, most HSA participants are not satisfied with their coverage. In contrast, IRA participants have little to worry about, since they receive little immediate feedback. Whether or not their investments will be adequate to fund their retirement will not be known for years or, in some instances, decades. The predictions here differ from the attitudinal policy feedback effects framework that Soss and Schram (2007) advance. According to their model, all policies can be arrayed on two dimensions. The first dimension is visibility, and the other is proximity (Soss and Schram 2007: 121; also see Hacker 2002). The expectation from the Soss and Schram framework would seem to be for no policy feedbacks among IRA participants (due to its high visibility, which influences participants and nonparticipants alike, as well as the distant nature of the effects) but for potential, nondirectional feedbacks among HSA participants. However, their theory focuses on mass feedback effects, not personalized or experiential effects.

1993; King et al. 2007). While such a design would avoid several methodological problems, executing it on a large scale would be exceedingly expensive, and it would be hard to create realistic treatments that mimic the experience of holding a real investment account (Barabas and Jerit 2008). An alternative approach might be to observe individuals before and after they participate in a policy, preferably with a comparison group of individuals who do not participate in the program. In these situations, it is advantageous to have longitudinal panel data (i.e., multiple pre- and post-treatment observations) to rule out inferential threats (Shadish, Cook, and Campbell 2002). Regrettably, randomized field experiments and longitudinal designs are not feasible here.

Nevertheless, participation in IRAs and HSAs constitute a quasi-experiment (Cook and Campbell 1979) in sense that we can see how participants compare to nonparticipants at a given moment in time. Such a research strategy is, however, contingent upon the availability of public opinion data that has (1) measures of IRA or HSA investment account participation and (2) attitudinal responses on corresponding privatization policies. The next section describes the available data, and then I detail several methodological considerations.

Survey Data on IRAs, HSAs, and Privatization Preferences

Pollsters have asked about Social Security preferences often since the mid-1990s (Barabas 2006; Shaw and Mysiewicz 2004). Publicly available survey data on varieties of privatized health care are far less common. Using the iPoll archive at the Roper Center for Public Opinion Research, I identified two surveys that asked privatization attitudinal measures along with various forms of investing and enrollment in IRAs or HSAs. The first nationally representative survey, fielded by CBS News and the *New York Times* from June 10 to 15, 2005, includes variables on retirement account participation in addition to common demographics and partisanship variables that will also be included as controls (n = 1,111). One question asked about retirement-related investments: "Do you currently have any retirement savings invested in a 401-K plan, I-R-A, or Keogh (KEE-oh) plan?" Respondents who answered this question affirmatively are considered IRA participants.

Because IRAs are the policy blueprint for efforts to partially privatize Social Security, it is natural to look for the effects of participation in an IRA on Social Security privatization measures. The Social Security

privatization outcome measure for the IRA analysis was the following: "Some people have suggested allowing individuals to invest portions of their Social Security taxes on their own, which might allow them to make more money for their retirement, but would involve greater risk. Do you think allowing individuals to invest a portion of their Social Security taxes on their own is a good idea or a bad idea?" The good idea/bad idea formulation is considered a more colloquial way of ascertaining policy preferences (i.e., favor or oppose) and it performs similarly according to other studies (Barabas 2006). This outcome measure will be used to test the first hypothesis, which suggests that individuals who participate in IRA-style retirement accounts will be more likely to think Social Security privatization is a good idea.[12]

The options for studying HSA participation and attitudes were more limited. Immediately after the 2004 presidential election, International Communications Research (ICR) fielded a survey on the health care policy agenda that was sponsored by the Harvard School of Public Health and the Kaiser Family Foundation. At the time of the survey (November 4–28), HSAs were still quite new. They had only been in existence for eleven months since President Bush authorized them as a part of the Medicare Modernization Act in late 2003. Perhaps not surprisingly, then, fewer than half of the sample (47 percent) reported having heard the term "Health Savings Account," and less than a third (30 percent) knew what it meant. And while most respondents reported receiving health insurance through their employer (57 percent, or 802 of 1,396 respondents), only fifty-six of them were enrolled in an HSA at the time of the survey.[13] An indicator of HSA participation serves as the main independent variable

12. The wording mentioned above was given to half of the sample. Another half was randomly selected to receive a question with a minor variation in wording: "Some people have suggested allowing individuals to invest *a portion of their Social Security taxes on their own into a small number of authorized investment funds*, which might allow them to make more money for their retirement, but would involve greater risk. Do you think this is a good idea or a bad idea?" The addition of the italicized words increases the percentage of "good idea" responses a few points, but not enough to alter any of the findings in the analyses reported later, so the responses were combined into a single measure.

13. Three people over age sixty-five reported having HSAs, but HSAs are primarily for non-Medicare-eligible individuals, so those cases were excluded. A sample of fifty-six respondents might seem small, but HSA participation was relatively rare in the larger population, and other studies of feedback have also used small samples. For example, Soss (1999) compares interviews with twenty-five AFDC welfare clients and twenty-five SSDI recipients. In general, the small sample only serves to make it harder to find effects. Monte Carlo simulations with small-sample maximum-likelihood models show that Type II errors are common (i.e., failing to reject a null hypothesis of no effect when it should be rejected), while Type I errors are rare (Hart and Clark 1999). As such, any bias is likely to be in the direction of null findings.

in the analysis, in addition to the same battery of control variables as mentioned for the IRA analysis. The outcome measure is an item in that same survey asking respondents whether they prefer a consumer-driven form of privatized health care, which is discussed in more detail in the next section.

Varieties of Privatization

Before moving to the empirical analyses, it is important to say a few words about the "privatization" policies under consideration here. Employer-provided health insurance in the United States, while heavily subsidized through government tax incentives, is generally considered private. In other words, HSAs are already nongovernmental policies. In that sense, HSAs are already further along the privatization continuum than the current Social Security system. Thus, efforts to create individual Social Security accounts would transform the system more, comparatively speaking, from the government to a decentralized system of individual accounts.

However, as with Social Security privatization, the question used as the dependent variable in the case of the HSA analyses moves policy in the direction of individualized control. The question was worded this way: "Would you prefer to have your employer or your spouse's employer pay for all or part of your health insurance at work, or would you rather buy health insurance yourself, with the employer giving you the cash amount they would have contributed — or doesn't it make much difference to you?" The question does not ask whether individuals want HSAs from their employers. Rather, the question asks whether respondents would rather buy health insurance themselves, much like what Republican presidential candidate John McCain proposed in 2008 as part of his health care reform plan in the United States.[14]

The use of the term *privatization* for the health insurance policy proposal under consideration here fits with a broader notion of individual control and decision making. According to E. S. Savas (2005), in countries with state-owned enterprises, such as postsocialist countries and countries

14. According to policy positions stated on www.JohnMcCain.com in mid-2008, "health care should be available to all and not limited by where you work or how much you make." Families would be given a tax credit so they could "choose the insurance provider that suits them best and the money would be sent directly to the insurance provider." Similarly, media reports cast McCain's plan as market-based: "McCain's prescription would seek to lure workers away from their company health plans with a $5,000 family tax credit and a promise that, left to their own devices, they would be able to find cheaper insurance that is more tailored to their health-care needs and not tied to a particular job" (Shear 2008: 1).

of western Europe, privatization might mean transfer of enterprise ownership, in whole or in part, to private hands (aka "denationalization"). However, the United States has few state-owned enterprises, so privatization is part of a larger "new public management" idea. Savas construes privatization broadly as something that includes everything from contracts governments make with for-profit or nonprofit firms to providing goods through the marketplace. Public-private partnerships are also a form of privatization, as are delegation and divestment. The same goes for health insurance voucher systems (Savas 2005: 204), which allow individuals to make more choices akin to the health insurance "privatization" policy change studied here.

By way of summarizing, then, in the case of the HSA analyses, the policy change used as the dependent variable is to move toward more individual responsibility, from employers to individuals. In the case of the IRA analyses, the policy change in the dependent variable would move most of the responsibility for retirement income support from the government to individuals. While there is a difference in the degree of privatization, both policies end up with privatization in the form of individual responsibility; the starting point for HSA analyses is employer-provided health coverage, while for IRAs it is relative to a government policy, albeit one that is financed through individual and employer payroll taxes. As with the coding of the Social Security privatization measure, the health care privatization outcome measure was coded as 1 if the respondent favors individualized health care and zero otherwise. According to Hypothesis 1, IRA participants should be *more* likely to favor individualized private accounts. According to Hypothesis 2, HSA enrollees should be *less* likely to favor individualized care.

Methods Used to Compare Program Participants to Nonparticipants

Given the cross-sectional data used here and the nature of the comparisons that will be made, it is reasonable to wonder whether the individuals who own IRAs or who have HSAs differ in consequential ways from those who do not. In other words, even though the samples were selected at random, the behaviors are not. It might be possible to compare participants to nonparticipants, as with past research (e.g., Soss 1999; Schneider and Jacoby 2003), but any differences could be due to selection. If IRA participants look different than nonparticipants on some attitudinal measure, it might be due to underlying differences in who opens these accounts,

such as wealth or education, rather than the experience of participating in the program.

To mitigate these concerns, I employ matching techniques. The goal of propensity score matching is to construct and compare groups of subjects that are otherwise similar except that one group receives the treatment while the other group does not. Numerous matching methods have been developed (see D'Agostino 1998 for a review) since the inception of these techniques more than twenty-five years ago (Rosenbaum and Rubin 1983). Political scientists have used propensity score matching to estimate treatment effects in observational (i.e., quasi-experimental) studies of deliberation and get-out-the-vote efforts in which the treatments were not randomly assigned in a uniform fashion (Barabas 2004; Imai 2005).

The goal of this technique is to match program participants (i.e., IRA or HSA enrollees) with respondents who are similar except that they do not have these investment accounts. In both studies I employ the MatchIt software (Ho et al. 2007; 2006) in version 2.6.1 of *R* to "pre-process" the data with nearest-neighbor one-to-one matching and matches within the convex hull (King and Zeng 2006; 2007). Both matching models use logit specification to predict account ownership as a function of socioeconomic characteristics.[15] While matching methods are not as good as experimental random assignment, these techniques reduce bias and model-based dependencies (Dehejia and Wahba 1999; King and Zeng 2006; Ho et al. 2007).[16] Finally, missing data could be especially problematic given the sample sizes, so missing demographic responses (i.e., income, age, gender, race, education) were imputed with the Amelia II software routine when respondents refused to provide this information (King et al. 2001). Mul-

15. Logit is used to estimate a propensity score, then the observations are matched to the nearest similar score under the nearest-neighbor technique. The convex hull procedure is more complex (see King and Zeng 2006), but it involves selecting observations that have common support inside a multidimensional shape in which the covariates of the matching model are used to construct the boundaries. It is typically more restrictive than the nearest-neighbor technique, which means that more observations are not matched and dropped from the analysis.

16. While matching methods are helpful for overcoming possible selection effects, they are not a perfect solution. In particular, they are heavily dependent on the set of variables available for matching. One concern is that there might be unobservable factors shaping both one's decision whether or not to participate in an HSA or IRA and one's attitudes toward privatization. Of course, those factors would have to be unrelated to other factors that are included (e.g., socioeconomic status, partisanship, or ideology). Nevertheless, matching on the observables measured in this data set may thus miss these factors. For example, one potentially omitted factor might be whether or not people are generally forced into HSAs by employers who no longer want to cover them. Evidence on HSA enrollment decisions or options were not directly measured in the data sets used here, but they appear in other data sets that are discussed after the empirical analyses. Also, the matches were evaluated for degree of match (e.g., Kolmogorov-Smirnov tests, bias reduction statistics, Q-Q plots), and alternative matching models were explored to make sure the results did not depend on the particular matching models used.

tiple imputation has been used widely in the social sciences (e.g., Barabas 2004; Lacy 2001), and the results reported below do not hinge on my use of this procedure.

Even though techniques like matching and imputation are being used in the background, the analyses will not have a dramatically different feel than other forms of statistical analyses. In fact, I will begin with the unmatched data before showing two additional models with the matched data (i.e., a subset of the data are balanced on a series of socioeconomic factors) for each style of account that explores the attitudinal feedback effects. In addition to the key variable of interest (i.e., IRA or HSA participation), the models include control variables for demographic factors, partisanship, and ideology that researchers have shown to be related to public support for privatization preferences (e.g., Barabas 2006; Cook and Jacobs 2002; Page 2000). Although the data will have been matched, using standard estimation techniques with controls is still advised (Ho et al. 2007) because it provides further precautions against imbalances that may not have been removed. Finally, since the main focus of the study is attitudinal feedback effects, the coefficients for each model of privatization support will be translated into predicted probabilities to judge the relative effects of IRA or HSA account ownership.

Empirical Analyses and Evidence

The first step in the analysis is to predict IRA and HSA account ownership. Table 1 presents two matching models using logistic regression to predict whether someone owns an Individual Retirement Account or a Health Savings Account as a function of five demographic variables, partisanship, and ideology. Perhaps not surprisingly, education, income, and age are significant predictors ($p < .05$), while race and gender have no significant effect on IRA ownership. However, the coefficients for partisanship and ideology are positive and significant (a coefficient of .35 and $p < .05$ for each). The models suggest that Republicans and conservatives are more likely to invest, which means that failing to account for these compositional differences in programmatic participation could lead to biased inferences, especially since Republicans and conservatives are likely to have distinct views on Social Security privatization.[17]

17. The independent variables are on a 0-to-1 scale, and the top category is coded as follows: *IRA or HSA* (1 = has IRA or HSA account), *Education* (1 = postgraduate), *Income* (1 = over $100,000), *Age* (1 = age 95 or older), *Race* (1 = white, Asian, or Latino), *Gender* (1 = male), *Partisanship* (1 = Republican), and *Ideology* (1 = conservative).

Table 1 Models of Individual Retirement and Health Savings Account Ownership Health Savings Account

	Individual Retirement Account	Health Savings Account
	CBS / NYT Data	ICR / Harvard Data
Education	1.34**	.90*
	(.26)	(.62)
Income	2.41**	1.89**
	(.25)	(.52)
Age	.01**	.11
	(.00)	(.59)
Race	.20	.00
	(.24)	(.55)
Gender	−.16	.24
	(.14)	(.28)
Partisanship	.35**	.08
	(.19)	(.46)
Ideology	.35**	−.34
	(.21)	(.47)
Constant	−2.72**	−4.69**
	(.36)	(.76)
N	1,111	1,029

Note: The entries are logit coefficients (1 = has IA or HSA; 0 = does not) with standard errors in parentheses. See text for details on the samples, question wording, and estimation techniques.

**$p \leqslant .05$; *$p \leqslant .10$ (one-tailed)

In contrast, HSA ownership is much more heterogeneous. As table 1 shows, only education and income predict HSA ownership in the last column of estimates with the ICR data. All of the other coefficients fail to show sizable effects, and many of them are not even close to attaining statistical significance ($p > .15$). These very simple matching models were selected after trying alternative specifications (i.e., interactions terms) and observing their bias reduction properties with Q-Q plots and Kolmogorov-Smirnov tests. Also, to avoid post-treatment bias, I did not match on any variables (e.g., opinion measures) that might plausibly be affected by the treatment of participating in an investment account. However, attitudinal factors are indirectly incorporated through terms for partisan identifiers and ideology.[18]

18. Auxiliary analyses show that HSA owners are not unusually conservative or liberal. HSA enrollees are no more likely to favor importing drugs from Canada, negotiating drug prices for Medicare, early Medicare for those ages fifty-five to sixty-four, and medical malpractice reform. Thus, HSA enrollees do not seem unusually discontented compared with other respondents.

Table 2 The Relationship between IRAs or HSAs and Public Support for Privatization Policies

	Individual Retirement Accounts (IRAs) and Social Security privatization preferences			Health Savings Accounts (HSAs and health care privatization preferences		
	Unmatched	Nearest-neighbor	Convex hull	Unmatched	Nearest-neighbor	Convex hull
IRA	.20**	.22**	.25*	—	—	—
	(.09)	(.12)	(.16)			
HSA	—	—	—	−.82**	−.97*	−1.44**
				(.42)	(.62)	(.67)
Education	.82**	.87**	.76**	.72**	2.02	1.83
	(.12)	(.13)	(.21)	(.31)	(2.22)	(2.09)
Income	.86**	.87**	.70**	−.32	1.08	1.59
	(.13)	(.15)	(.28)	(.26)	(1.88)	(2.08)
Age	−.13	−.19	−.28	.28	−1.40	−1.62
	(.16)	(.18)	(.34)	(.29)	(1.61)	(1.57)
Race	.23*	.26*	.57**	−.39**	—	—
	(.15)	(.18)	(.34)	(.24)		
Gender	−.02**	−.02**	−.01**	.38**	.85	.66
	(.00)	(.00)	(.01)	(.15)	(.81)	(.65)
Partisanship	.09	.04	−.25	.12	.04	−.16
	(.15)	(.17)	(.76)	(.22)	(1.08)	(1.26)
Ideology	.10	.07	.03	−.10	−.45	.33
	(.21)	(.25)	(.86)	(.34)	(2.45)	(2.53)
Constant	−.59**	−.62**	−.53	−1.62**	−3.37*	−3.11
	(.21)	(.25)	(.86)	(.34)	(2.45)	(2.53)
N	1,093	910	371	668	94	70

Note: All coefficients are probit estimates with standard errors in parentheses. For the IRA models, the dependent variable is coded as 1 = Respondent thinks Social Security privatization is a good idea, 0 = other responses. For the HSA models, the dependent variable is coded as 1 = Respondent would rather buy health insurance him/herself, 0 = other responses.

** $p \leq .05$; * $p \leq .10$ (one-tailed)

IRA Ownership and Public Support for Social Security Privatization

Table 2 presents the main set of statistical estimates that are used to evaluate the hypotheses concerning attitudinal feedback. In all cases, the main independent variable, *IRA*, is positive and significantly related to attitudes toward Social Security privatization. For example, in the IRA models data in the first column, the .20 coefficient indicates that individuals who own IRA accounts are significantly ($p < .05$) more likely to think that priva-

tizing Social Security is a good idea. Moreover, these effects hold when controlling for common predictors of support for Social Security privatization. High levels of education and income are significantly associated with more support for privatization, while African Americans (coded 0 on the race variable) and women are negatively predisposed toward privatization.

The estimates in the second and third columns of table 2 have the same structure but use the matched data. Both sets of estimates confirm the general story presented with the unmatched data (and Hypothesis 1), albeit at reduced significance levels. Individuals who own IRA accounts are more likely than their otherwise similar matched counterparts without IRAs to favor Social Security privatization. The coefficient for the nearest-neighbor technique is .22 ($p < .10$), and the coefficient on the matched convex hull sample is even larger at .25, but standard errors are bigger due to the much smaller sample size ($p < .10$). In both models, many of the same background characteristics remain significant (i.e., education, income, race, and gender). All three model estimates are consistent with the directional Hypothesis 1 that there should be more support for Social Security privatization among IRA participants.

HSAs and Public Support for Individualized Health Care

The second half of table 2 presents the statistical estimates for HSA ownership to evaluate the second hypothesis. As expected, in all cases the main independent variable, *HSA*, is negative and significantly related to attitudes toward health care privatization. For example, in the models using the unmatched data in the first column, the −.82 coefficient indicates that individuals who are enrolled in a Health Savings Account are significantly ($p \leqslant .05$) less likely to think a privatized style of health care coverage is desirable. Moreover, these effects hold when controlling for education, race, and gender. The same patterns appear in the analyses of matched data. The HSA coefficient is negative and significant (−.97; $p < .10$) with the nearest-neighbor technique, and the coefficient becomes even bigger relative to the size of its standard error with the convex hull matching. Both models control for the same demographics, partisanship, and ideology, although none of these factors is significant given that the models appear to be matching respondents quite well. Moreover, the main coefficient of interest remains significant even in analyses that use fewer

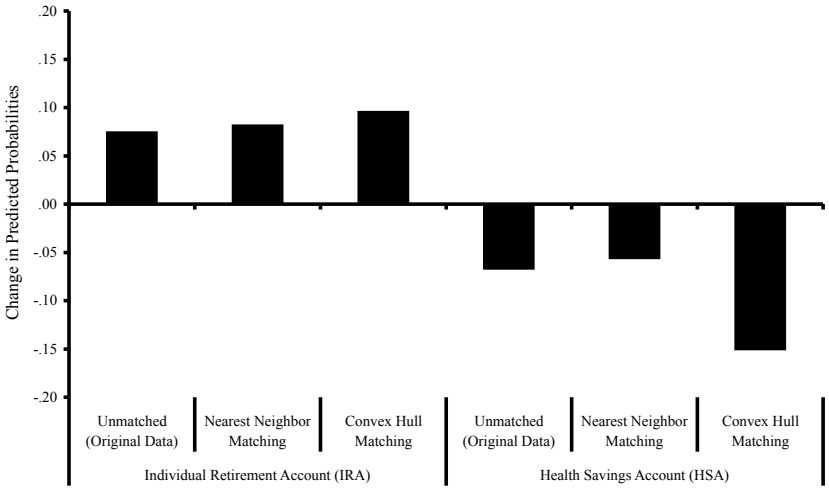

Figure 1 Change in Predicted Probabilities of Support for Privatized Social Security and Health Care Based on IRA and HSA Ownership

than 14 percent of the observations in the data set (n = 94 and 70 out of 668 possible unmatched observations for the HSA models).[19]

As is often helpful with maximum likelihood models, predicted probabilities are used to illustrate the substantive effects. In Figure 1, the first three columns show the effects of IRA participation on public support for Social Security privatization for each of the models in table 2. The effects of participation in IRA are associated with effect sizes of 7 to 10 percentage points (and associated standard errors of between 3 to 6). The remaining part of Figure 2 shows corresponding negative effects for HSA participation of −7 to −15 percentage points (standard errors of between 3 to 9) depending on which sample is used to generate the estimate. All of the patterns confirm the hypotheses presented earlier regarding the effects of participation in IRAs and HSAs on public support for Social Security and health care privatization. The feedback effects are also as large as or larger than what the model for the unmatched HSA sample generates in the case of education (+8 points), race (−8 points), and gender (+6 points).

19. The unmatched HSA analysis uses fewer responses than the entire sample (n = 688 vs. n = 1,396) because only respondents who said they received health care from a "private plan through your or your spouse's employer" were given the health care privatization question.

Before moving on, I will provide some helpful context for the results. These policy feedback effects are remarkable given the low statistical power (i.e., few observations should make attaining statistical significance difficult) and because support for privatized health care was already quite low. Ten percent of the non-HSA sample endorsed individualized health care for themselves; amazingly, *only one* HSA respondent out of more than fifty in the sample wanted self-directed health care. Similarly, about 18 percent of the non-HSA respondents thought most people would be better if they purchased health coverage on their own. Only four respondents (7 percent) who had HSAs felt the same way. Thus, support for privatized health care, already low, dropped even further for the respondents who experienced HSAs firsthand. The effects might have been even larger had the opinions not already been at a minimal level of support.

Why are the perceptions of self-directed health care so negative? After all, everything else held constant, one might assume that early enrollees would be the most enthusiastic. We can gain insight into their views thanks to a few additional questions in the survey. Respondents who answered the HSA item were also asked four questions on whether they thought buying health insurance on their own (even with an employer subsidy) would make it easier or harder to find a plan that suits their needs, keep insurance if they are sick, handle administrative issues such as filing a claim, or getting a good price.[20] The response patterns are depicted in Figure 2. Strikingly, *none* of the HSA enrollees thought it would be easier to handle administrative issues or keep their insurance if they become sick.[21] Moreover, HSA participants are no more likely to think it would be easy to find a plan that matches their needs. Only on the price dimension were HSA participants marginally more likely to think buying insurance on their own would make it easy to get a good price, although the effect was not significant at conventional levels.

Thus, the people who have HSAs overwhelming reject the privatized style of consumer-driven health care that they get with HSAs. They are

20. The question was worded this way: "What if the employer gave you the cash amount they would have contributed to your policy, and you had to buy health insurance on your own—Do you think purchasing your own coverage would make it easier or harder for you to [INSERT EACH OF THE FOLLOWING ITEMS SEPARATELY]: 1) Find a plan that matches your needs well . . . 2) Find or keep health insurance if you are sick . . . 3) Handle administrative issues, such as filing a claim or signing up for a policy . . . or 4) Get a good price for health care . . . ?"

21. It was not possible to estimate these relationships in a statistical model due to a lack of variation (i.e., not a single HSA participant thought it would be easier to keep insurance while sick or handle the administrative issues), but a binomial test for a difference in proportions indicates that the HSA and non-HSA respondents differ ($p < .01$).

more cognizant of the hassles of finding a plan and handling the paperwork. They recognize the risks inherent in keeping insurance if they are sick. Even when it comes to cutting costs, which dominates the policy debate (e.g., Cogan, Hubbard, and Kessler 2005; Herzlinger 2004; 1997), the early experiences with HSAs have not been positive according to reports from individuals who have them.

Finally, it seems worthwhile to note that the lack of support for individualized health care among HSA participants does not translate into higher support for national health insurance. That is, one might suspect that if HSA participants do not want individualized health care, perhaps they would favor nationalized health care instead (i.e., so the coefficient would be negative for privatization but positive for nationalization). Fortunately, it was possible to investigate this further. The Kaiser/Harvard/ICR survey included an item that asked respondents if they would favor or oppose "a national health plan, financed by taxpayers, in which all Americans would get their insurance from a single government plan."

A statistical analysis revealed that HSA participants are no more likely to favor nationalized health care than non-HSA participants (matched or unmatched, the coefficients are always negative and insignificant). The lack of a finding here might be due to the introduction to the question, which explicitly references solutions to the problem of the uninsured in America.[22] It is also the case that nationalization is a very different policy option than individualized health care; unless they had lived abroad, most respondents would not have had direct experience with such a plan, which is part of the theoretical argument in this article. Thus, discontent is confined to the individualized health care domain; HSA participants dislike individualized coverage, but that does not translate into more support for nationalized health insurance to cover the uninsured in America. Other respondents concurred; support for national health care coverage for the uninsured was less than 40 percent for HSA and non-HSA participants alike.

Other Evidence on Consumer-Driven Health Plans

The ICR/Harvard/Kaiser survey in 2004 provides an early and unflattering picture of self-directed health care. HSAs appear to have policy

22. The question began with the statement "I'm going to read you some different ways to increase the number of Americans covered by health insurance. As I read each one, please tell me whether you would favor it or oppose it."

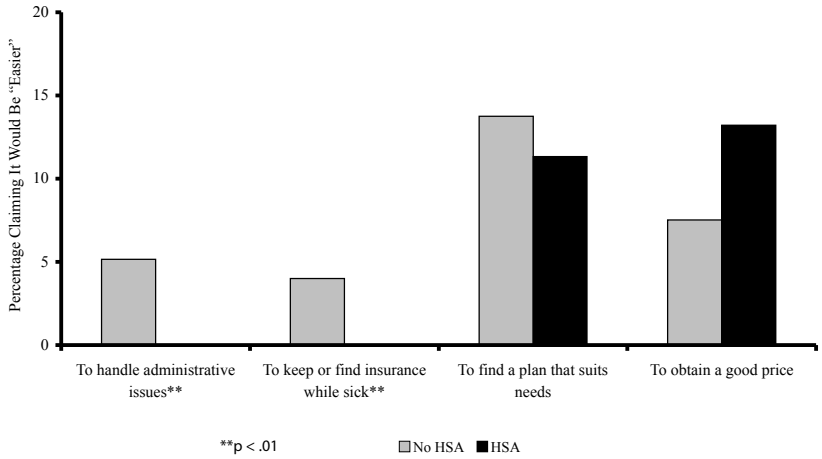

Figure 2 Perceptions of What Aspects of Health Care Would Be "Easier" with Health Care Based on IRA and HSA Ownership

feedback effects, but in a manner that none of their supporters probably imagine. It could be the case, however, that these patterns are an aberration, something that might not hold in other surveys or once companies and HSAs enrollees gain more experience with these plans. While few surveys on HSAs have been conducted since their inception, the Employee Benefit Research Institute (EBRI) and the Commonwealth Fund fielded a survey in the fall of 2005 in which they asked a detailed set of questions about high-deductible health plans and HSAs.[23]

The individual-level EBRI/Commonwealth data are unavailable for analyses with statistical models, but the marginal frequencies were released publicly, and they paint a portrait of frustration. As Paul Fronstin and Sarah Collins (2005) report in an issue brief devoted to the survey, individuals with more comprehensive health insurance were more satisfied with their health plan than individuals in high-deductible plans, with or without health savings accounts.[24] Specifically, 63 percent of individuals with comprehensive health insurance were extremely or very satisfied with their health plan, compared with 42 percent of those with consumer-

23. The study was conducted from September 28 to October 19, 2005, by Harris Interactive and included more than 600 respondents with consumer-driven (i.e., HSA-style) plans or high-deductible health plans without investing accounts, in addition to more than a thousand respondents with traditional employer-provided health care plans.

24. The report is available at www.commonwealthfund.org/index.htm.

driven health plans (CDHPs) and 33 percent of high-deductible health plan (HDHP) participants (ibid.: 1).[25] Moreover, CDHP respondents reported higher out-of-pocket costs, more missed health care, and a lack of information. While the survey did not include political variables, so there is no way to formally evaluate the hypotheses presented earlier, there were very few bright spots in the report other than elevated levels of price sensitivity.[26] Cost consciousness is often touted as a goal by economists (Cogan, Kessler, and Hubbard 2005) and some leaders in Washington (White House 2006), but early experiences with consumer-directed health care appear to be associated with high levels of dissatisfaction.

All of this might come as a surprise, especially to proponents of consumer-driven health plans, yet the patterns were confirmed in a second EBRI/Commonwealth Fund study in 2006 (Fronstin and Collins 2006) as well as a more recent study by a different organization that same year. Specifically, the National Survey of Enrollees in Consumer Directed Health Plans by the Kaiser Family Foundation in 2006 found a similar pattern of discontent for participants in CDHPs (i.e., HSAs and Health Reimbursement Arrangements, or HRAs) relative to what they refer to as a nonrandomly assigned "control" group sample of respondents with employer-sponsored health insurance.[27]

In the survey, only 15 percent of CDHP individuals would give their health plan an "A," compared with 24 percent for the control sample; they were much more likely to grade their plan as a "C" (33 vs. 25 percent),

25. CDHPs include HSAs and the similar Health Reimbursement Arrangements (HRAs), which are employer-funded accounts in which the funds roll over from year to year. HDHPs have no account.

26. CDHP respondents were more likely to be cost conscious (e.g., they considered costs when deciding to see a doctor or fill a prescription, checked to see if their health plan would cover their costs as well as the price of service before receiving care, and discussed treatment costs with a doctor). However, individuals with CDHPs were also more likely to go without care (Fronstin and Collins 2005: 1).

27. The survey was designed by the Kaiser Family Foundation and fielded by Knowledge Networks from their online panel. Knowledge Networks maintains a large, randomly drawn, representative national panel of households. Every participating household receives free computer hardware (WebTV), free Internet access, free e-mail, and technical support. The initial sample consisted of 22,560 people ages eighteen to sixty-four. Of these, 272 (1.2 percent) met the criteria of belonging to a consumer-directed plan with an accompanying savings account (e.g., currently covered by private insurance purchased through an employer or individually, a deductible of at least $1,050 for individuals or $2,100 for families, coverage coupled with a personal savings account that does not have to be used by the end of the year, etc.). For comparison purposes, a comparison "control" group of 715 individuals with employer-sponsored health insurance who do not have a high-deductible plan coupled with a savings account, although they might have one or the other. All data were weighted to more accurately mirror national census estimates. The margin of error is plus or minus 7 points for the CDHP group and 5 points for the control group. The survey was fielded from June 21 to July 10, 2006.

"D" (7 percent vs. 3 percent), or "F" (3 percent vs. 1 percent). Among the reasons given, CDHP individuals were more likely to feel vulnerable to high medical bills (41 percent vs. 31 percent), more apt to disagree with the statement that understanding their health plan is easy (35 percent in any disagreement category vs. 20 percent for the control sample), and more likely to have chosen to not fill a prescription due to the costs (26 percent vs. 15 percent) or to skip a recommended medical test or treatment (25 percent vs. 15 percent).

The responses to the survey are helpful because they help rule out some possible explanations for why HSA enrollees are disappointed. One might think the high deductibles could be a source of disenchantment, but participants in HSA-style accounts are healthier and wealthier than others. In particular, by a 64 percent to 52 percent margin, the CHDP group reported being in very good or excellent health, compared with slightly more than half (52 percent) of the control sample. Similarly, only 37 percent of the CDHP group reported taking a prescription medication on a daily basis, compared with 49 percent of the control group with traditional employer-based coverage. They are less likely to go to a doctor or clinic for a specific medical problem (64 percent for CDHP vs. 76 percent for the controls), less likely to go to the emergency room (17 percent vs. 23 percent), and less likely to report going without care because of cost (77 percent vs. 88 percent). Perhaps some of this is due to preventative behaviors: CDHP enrollees are more likely to exercise at least three or more times a week (39 percent vs. 30 percent). Thus, even though the CDHP deductibles are higher, the typical respondent with one of these plans is less likely to invoke the deductible because they appear to be marginally healthier.

Moreover, even if CDHP enrollees need health care and must pay their high deductibles, they are more prepared to pay it given their higher socioeconomic status. Roughly 45 percent of the CDHP sample reported income over $75,000, compared with 30 percent for those with traditional employer-based coverage. They are also more highly educated (57 percent with a college degree or higher vs. 35 percent for the control sample) and more likely to own their own homes (80 percent vs. 71 percent).[28] On top of that, for any HSA funds unspent on the deductible or medical care, the savings account allows them to save money in tax deferred, much like

28. There were no dramatic differences with respect to partisanship affiliation. On ideology, the CDHP sample appeared to be more polarized (i.e., more likely to say they were liberal or conservative) compared with the relatively moderate control sample. The CDHP sample was also no more concerned with losing weight and only slightly less stressed than the control sample.

IRAs. If anything, one might guess that this group would be disproportionately likely to favor individualized care.[29]

Thus, the findings in the empirical analyses reported here do not seem to be an aberration. The patterns in the empirical analyses conducted earlier continued in subsequent surveys, especially with respect to dissatisfaction. If anything, there were reasons to suspect that individuals who hold savings accounts in health might be happier. Most CDHP enrollees with plans from their work said their employers made contributions toward their premiums (82 percent vs. 86 percent). Also, by and large they are early adopters for a relatively new program who self-selected into these arrangements. That is, the 2006 survey from Kaiser also indicates that they were not forced to take the CDHP. Before they enrolled in their current health plan, 86 percent of the CDHP sample was covered by another health plan (compared with 74 percent for the control group), and of the 14 percent who were previously uninsured, only 3 percent were uninsured for more than a year. Also, 56 percent of those covered by an employer-sponsored CDHP (n = 204) had a choice of different health plans, and 62 percent of those (n = 184) considered a plan without a savings account. Thus, the modal experience is one of choosing the CDHP rather than being forced into it. Nevertheless, and quite revealingly, CDHP participants were twice as likely to say they would try to switch to another health plan if they were to develop a chronic medical condition (30 percent compare to 15 percent for the controls). Even without the prospect of illness, 50 percent of the CDHP sample indicated they would be very or somewhat likely to switch health plans, compared with 33 percent for the controls.

Conclusions

This study has documented policy feedback effects of a personal nature. The central finding is that policy feedback effects occur, but they can be domain-specific (also see Gusmano, Schlesinger, and Thomas 2002: 761). That is, participation in investment accounts for retirement or health do not lead to uniformly conservative or liberal policy opinions. As expected, IRA owners tend to favor Social Security privatization, but that does not

29. The climate might have been conducive as well. There is research suggesting that stock market movement affects attitudes toward Social Security privatization (Barabas 2006). Based upon that study, and given the stock market downturns of the 2000–2003 and 2007–2008 time periods, one might guess that accounts would be more popular during the 2004–2006 period than in the years before or after. While there is no definitive research and not yet enough survey evidence on HSAs to construct a time series, it seems possible that support for accounts-based programs would be even lower when the stock market goes down.

meant that investing always or unequivocally engenders support for investment account–based policy solutions (e.g., Butler and Germanis 1983; Butler 1983). Participation in HSAs reduces public support for health care privatization. In particular, HSA owners, owing to their wildly different programmatic experiences, are much less likely to endorse individualized health care coverage. Thus, HSAs and related forms of consumer-driven health plans are not automatically destined to become "the next IRA." The irony is that dissatisfaction with HSAs is greatest among those who have them.

Hence, for scholars and policy makers alike, it is important to recognize that policies can generate attitudinal effects and that they can increase or reduce support. It is still early in the implementation of HSAs, however, and the policy feedback literature is particularly concerned with long-term effects. The trends held over the course of a few years, but it remains to be seen whether these patterns of dissatisfaction persist across decades. As more health care insurance organizations and banks get into the health accounts business, they might be able to ease some of the worrisome aspects. Advances in technology and marketing might help solve some of the problems. Finally, as more people sign up, participants might be able to delegate the responsibility of choosing and managing HSAs to trusted family members or experts, as they already do with many aspects of retirement investing.

Nevertheless, HSAs and IRAs differ in some key respects — most notably the amount of risk citizens endure and how soon they must endure it. These are some of the immutable features of accounts-based solutions in health that will make them unlike voluntary retirement investing accounts. Also, despite my efforts to make matched comparisons, IRAs and HSA service different populations. Perhaps the most telling statistic is that only 10 percent of Americans with health insurance had HSAs as of the mid-2000s (Feldman et al. 2005; Fronstin and Collins 2005), while more than half of U.S. households have stocks, and a sizable percentage hold them as IRAs or 401(k)s (Darlin 2006). IRAs probably would not have proliferated had they not been well received. There is not a lot of evidence, but what there is suggests that IRAs and related retirement accounts were supported by large segments of the American population even during the years following their enactment.[30]

30. A search of the Roper Center for Public Opinion Research archives from the 1970s and early 1980s for questions about IRA or 401(k) accounts did not turn up any surveys with Social Security privatization preference items. However, several studies reveal that IRAs were popular

Assuming these trends hold, what political effects will HSAs and other CDHPs have in the long run if leaders continue to push them? For all the politicians' talk of giving consumers choices, increasing options is not always a good thing (Schwartz 2003), especially if people must revisit their choices each year and their health depends, at least in part, on getting it right. Values are important too. Citizens are more concerned than elites about distributional issues and fairness when it comes to managed care (Schlesinger 2002). If early privatization efforts fare poorly, citizens might be more willing to endorse collective solutions to problems (Schlesinger 2004).

This is not to say that IRAs and related accounts will be revoked anytime soon. But assuming policy makers move ahead with HSAs, there are several important questions concerning HSAs that Americans, as a society, should confront. Can people, already managing their own health problems, become sophisticated health care consumers? Many policy makers justify their support for HSAs by citing economic reasons (i.e., to cut medical costs), but few have thought through the social consequences of rewarding some health consumers who are wealthy enough to afford HSAs or healthy enough to risk high-deductible plans (Shearer 2004).

Given that a small minority accounts for a disproportionate share of medical costs (Berk and Monheit 2001), HSAs may exacerbate existing inequalities because unhealthy individuals will exhaust their contributions (Fronstin 2004; Swartz 2003; 2005). Thus, it is important to continue to study who enrolls in HSAs, their experiences with them, and their attitudes toward this style of privatized, consumer-directed health care versus traditional forms of employer-provided coverage. One worry is that HSAs may unravel employer-based insurance and contribute to health problems via increased economic inequality. Since public preferences often shape public policies in the United States, whether HSAs work as proponents contend will likely influence which future policy reform initiatives are pursued and who receives health care in America.

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early on. In a Roper Organization poll from August 11 – 18, 1984, 52 percent of a 2,000-person national sample thought that IRAs or Keogh retirement accounts represented "good" or "excellent" values. The same question was repeated in August 1985, and support rose to 56 percent. Similarly, two national surveys conducted by Louis Harris & Associates in 1985 found that 50 percent to 55 percent of respondents thought IRAs, 401(k)s, and Keogh plans should be major parts of an individual's retirement income; fewer than 11 percent thought that they should play no role at all, with the balance unsure or feeling that they should at least play a minor role. Finally, from May 30 to June 2, 1985, Louis Harris & Associates found that 81 percent of a national adult sample favored increasing the maximum IRA contribution level for married couples from $2,000 to $4,000. An earlier Louis Harris poll, in March 1981, found 75 percent supporting an increase of the IRA deduction from $1,500 to $10,000.

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