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Policy Recommendation

February 2021

What States Can Do to Improve Health Savings Account Incentives - Summary*

Health Savings Accounts (HSAs) are savings accounts wherein:

- Income diverted by an individual to an HSA is not taxed (currently limited to $3,600 for an individual and $7,200 for a family).
- Interest or other earnings that accrue to an HSA are not taxed.
- Withdrawals to pay for medical expenses defined under federal law are not taxed.
- HSA contributions may be made by HSA owners or by employers on behalf of individual employees and/or their families.
- HSA contributions can only be made if an individual is covered by a high deductible health insurance plan.
- Balances may accumulate.
- On retirement, an HSA owner may make withdrawals to spend for non-healthcare purposes without tax penalty, but must pay tax on such withdrawals as income.

By the end of January 2020, HSA assets had grown to almost $72 billion, but this is paltry (less than two percent) when compared to the $3.8 trillion spent on health care in 2019 alone.

Americans regularly spend nearly all of their yearly contributions, possibly because an individual with a high deductible health plan (HDHP) who pays cash to a provider without recourse to insurance will not see that purchase counted toward their deductible.

HSA account holders pay out of their HSAs as insured customers and lose out on substantial cash-pay discounts since they are charged the price agreed to by their insurance company.

Origin of Health Savings Accounts

HSAs were enacted in 2003 partly to help counteract the "third-party-payer" problem in health care.

- There are two major third-party payers in health care – government and employer-paid health insurers.
- Only 10 percent of health care expenditures are paid directly from patients' pockets.
- Due to third-party payments, patients are mostly insulated from what their health care actually costs and do not question costly recommended procedures that might not be necessary.
- Health care providers respond by suggesting procedures that are of, at best, marginal value.
- Providers also charge excessively high prices for procedures when providers do not feel as morally constrained as they do in dealing directly with individuals, but see bills as being paid by anonymous monolithic institutions.

One Way HSA Incentives Are Undermined by Insurance Companies

High deductible health plans (HDHPs) *should work* significantly differently from traditional employer-provided health plans.

- Cash-pay health service prices are often lower than those negotiated by insurance companies.
- HDHP patients should be considered cash payers who pay the entire charge for services rendered during a year until the relatively high deductible is reached.
- *Except for circumstances where the insured is traveling or in cases of true emergency, insurance companies do not accept cash-pay receipts for out-of-network or in-network purchases to be counted toward the deductible.*
- When an individual with an HDHP presents an insurance card to a provider, that provider is bound by the pricing contracted with insurance and is prohibited from offering a price lower than the contracted price.
- If there is a chance that the deductible will be reached, and insurance companies do not accept cash-pay receipts to be counted toward the deductible, then it makes little financial sense for an HDHP-covered individual to act as a cash-pay customer.
- A cash-paying individual with an HDHP risks paying much more out-of-pocket by paying cash without presenting an insurance card than if he pays insurance-negotiated prices having presented the insurance card, pushing those with HDHPs to always present an insurance card and likely get charged more than if they acted as cash payers without insurance.

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One can only speculate, but it appears that the main reason insurance companies do not accept cash-pay receipts toward HDHP deductibles is that patients might become less dependent on insurance companies.

Solutions

What States Should Do

- **Require insurance companies to count self-pay claims for covered services toward a consumer's deductible, whether the service is performed by an in-network provider or not.**
- **Require insurance companies to inform HDHP participants that cash-pay prices might be lower than insurance-negotiated prices and of procedures to make cash-pay claims.**
- **Require insurance companies to immediately give any policyholder who asks real-time and meaningful pricing information.**
- **If service prices are not disclosed by medical service providers prior to services being rendered, prohibit them from civil litigation over unpaid bills in excess of the lowest transparent price(s) for the same service(s) in an area, and prohibit referrals to collections agencies and credit ratings services when prices exceed the same.**

What the Federal Government Should Do

- **Increase limits on yearly HSA savings, divorced from minimum or maximum health insurance deductibles, to at least $10,000 per person or $20,000 for a family.**
- **Allow employers to make tax-free contributions to employee HSAs subject to no limit other than the maximum just mentioned.** (Employers could make HSA contributions in lieu of paying insurance premiums.)
- **Allow HSA owners to pay for health insurance premiums from their HSA without tax penalty.** (This would allow for portability from one employer to the next.)
- **Allow HSA owners to donate HSA balances above a minimum balance (say, $75,000 or a sliding scale that increases with age) to others' HSAs without tax penalty for either the donor or recipient.**
- **Allow HSAs to be inherited without tax penalty as long as they are maintained as HSAs by heirs.**

Conclusion

The bulk of the responsibility for poor policy that results in high and fast-rising medical service prices lies with the federal government. However, states can and should do their part.