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HSA_s AND THE STATES: LIFTING THE BARRIERS

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Introduction

Since late 2003 when the federal government cleared the way for health savings accounts coupled with high-deductible health plans, the market for such plans has blossomed. Recent surveys and media reports show that more and more businesses are or soon will be offering health savings account (HSA) plans. While this is excellent news for health care consumers, there are still many state government barriers that interfere with the efficient delivery of HSA plans. This study examines those barriers and offers suggestions for overcoming them.

Earlier this year, a survey by Aon Consulting found that 22% of U.S. companies offered consumer-driven health plans, including HSA

plans.¹ Nearly three-quarters of that group began offering them in either 2004 or 2005. The future looks even brighter. A recent poll conducted by Mellon Financial Corporation showed that the number of firms offering HSAs in 2006 could more than quadruple.²

This is good news for businesses and consumers trying to manage escalating health care costs. A recent report from the Kaiser Family Foundation found that health insurance premiums rose nationally by more than nine percent in 2005.³ While that is lower than the 11.2% increase in 2004, it is still well ahead of the rise in employee compensation and inflation. Preliminary data on HSA plans suggest that they buck the trend. Sales data from eHealthInsurance.com shows that during

the first half of 2005 premiums for individual HSA plans declined 19 percent relative to 2004.⁴ This amounted to an average monthly savings of over \$36.

This is particularly encouraging for the uninsured. A recent Congressional Budget Office study found that “a 10 percent reduction in insurance premiums is estimated to result in a 5.7 percent increase in health insurance coverage in the nongroup [individual] market.”⁵ For those in poverty, the incentive is even greater, with a 10 percent reduction in insurance premiums yielding an 8.4 percent increase in health insurance coverage.

Yet barriers to HSAs remain at the state level. Some states have still not conformed their tax codes so that deposits to HSAs are exempt from state income taxes. Still others have not eliminated “first-dollar coverage” mandates that violate IRS requirements for a high-deductible plan (they have until 2006 to do so.) Other state regulations that interfere with HSA plans are community rating, guaranteed issue, and insurance approval processes. Finally, most states have been slow to incorporate HSAs into state employee insurance coverage, high-risk pools, and Medicaid reform plans.

State Income Tax Relief

Overall, states have made considerable progress conforming their income tax codes to accommodate HSAs. Of the forty-one states with an income tax, only seven still tax contributions to HSAs: Alabama, California, Maine, Massachusetts, Mississippi, New Jersey, and Wisconsin.

There is little excuse for the delay. Conforming a state’s income tax code is relatively simple. A state legislature need merely pass a short law saying “Section 125 of the Internal Revenue

Code, as amended by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108 -173), relating to health savings accounts, shall apply” to the state income tax code.⁶ States should also consider making the deduction retroactive to January 1, 2004, when the federal law giving HSAs tax exemption took effect.

In 2004, Wisconsin Governor Jim Doyle vetoed a bill that would have conformed Wisconsin’s income tax code to exempt contributions to HSAs. One reason he gave was Wisconsin’s tight budget: “At a time of continuing fiscal challenges, it is irresponsible,” the governor said.⁷ That excuse no longer applies. Of the seven states that have yet to conform their income tax code, all increased expenditures in their General Fund budgets in fiscal year 2005. The increases ranged from 3.0% (Mississippi) to 11.5% (New Jersey).⁸ If states can now afford to increase spending, they can afford to exempt contributions to HSAs from state income tax.

Finally, one minor tax issue arises in the states of New Hampshire and Tennessee. Although neither state taxes regular income, both tax dividend and interest. Since HSA accounts can be invested, interest earned on HSAs could be taxed under those two states. New Hampshire and Tennessee should pass legislation exempting HSA contributions from taxes on interest and dividends.

First-Dollar Coverage Mandates

An HSA is intended to be used for smaller and routine health care expenses with a high-deductible health insurance policy purchased to cover major medical expenses. However, some states require insurance to cover various conditions and treatments at the “first dollar”, which means that the policy must cover the condition before any deductible is met. For

example, Arizona has a first-dollar insurance coverage mandate for metabolic conditions, New Jersey has one for lead poisoning screening, and Minnesota has one for hair prosthesis (wigs).

The IRS rules governing HSAs allow for some first-dollar exceptions, primarily for preventive care. However, IRS regulations state that “except for preventive care, a plan may not provide benefits for any year until the deductible for that year is met.”⁹ The 2003 Congressional legislation enabling HSAs gave states until January 1, 2006, to eliminate mandates that conflict with HSA rules.

States should repeal first-dollar coverage mandates. Barring that, they should exempt HSA qualifying insurance from such mandates. Arizona offers some lessons for other states on removing these mandates. The Arizona House of Representatives considered a bill (HB 2063) that stated “that no law shall prevent a health insurance policy intended to qualify as a [high deductible health plan] from requiring the application of deductibles, co-payments or co-insurance to benefits provided under the policy.”¹⁰ The bill failed to even make it out of committee because it included an amendment exempting all health care policies from all state mandates, not just first-dollar ones. While this is surely a desirable goal, this approach creates opposition from special interest groups that favor mandates. States should consider a narrowly tailored approach, one that only exempts HSA qualifying insurance from any mandates that would result in such plans being disqualified under IRS regulations. Finally, states should also make such legislation retroactive to January 1, 2006, if necessary, so that HSA plans do not run afoul of the federal deadline.

Community Rating and Guaranteed Issue

Twenty-seven states currently have community-rating regulations and five have guaranteed issue regulations in effect. Community rating is a process by which the health insurance premiums individuals pay are an average of all premiums (for sick and healthy, young and old, etc.) in a given region. Everyone in that region is charged the same price—the average—for health insurance, with some age and sex bands. Guaranteed issue means that an individual can purchase health insurance at any time, i.e., an insurance company cannot deny him a policy even if he waits until he is sick to buy.

Community rating has a history of increasing the number of uninsured. Since healthy people are charged more than they otherwise would be in a free market, many decide not to purchase health insurance. One reason high-deductible policies are attractive is that they lower the cost of premiums. In a state with community rating, a healthy consumer with an HSA policy will pay more for the premium than he would without community rating. Preliminary data on HSAs show that about 40% of those choosing an HSA policy were uninsured in the previous six months.¹¹ States with community rating will make HSAs less attractive to those without insurance since the premiums will be more expensive.

Guaranteed issue has had the effect of reducing competition in the health care industry. For example, guaranteed issue often forces smaller health insurance companies to provide insurance to patients with higher health care costs. Such companies often leave states with guaranteed issue, finding it too difficult to make

a profit. This reduction in competition results in fewer options for health care consumers. It seems particularly harmful to the development of HSAs. Of the five states that still have guaranteed issue—Maine, Massachusetts, New Jersey, New York, and Vermont—none of them has a health insurance company that offers HSA policies for individuals, according to *HSA Insider*.¹² Again, a narrowly tailored approach may be best when removing the barriers of community rating and guaranteed issue. Ideally states should remove these free-market impeding regulations from all health insurance policies, but they could begin by creating exceptions for HSA policies.

Insurance Approval Process

Most states require health insurance companies to seek approval of the state department of insurance prior to selling a new policy in the state. While some of these processes are rather simple, others are quite burdensome. Since many companies are still developing HSA policies, the insurance approval process can delay the delivery to market of high deductible plans.

Consider the state of New York. There are three ways to receive approval for an insurance product from the New York State Insurance Department: Traditional prior approval, alternative prior approval, and the “new” prior approval with certifications.¹³ If a company chooses prior approval with certifications, it has three more options: submission based on a checklist, submission based on a template, and submission based on a previously approved policy form. If a company chooses the first option, it must see if the appropriate checklist is available on the New York State Insurance Department’s website. If so, it can then proceed to the standard transmittal form, which includes the primary form and various subsidiary forms. Once those are completed, a company must also file the appropriate certification of compliance.

And, a company must note that this new process is subject “to the Department’s prior Circular Letters No. 14 (1997) and No. 18 (1999).”¹⁴ The Department’s website offers the helpful tip that “If you have any questions about the new process, please be sure to contact the Health Bureau prior to making your submission,” although that particular portion of the website does not list a phone number. According to Circular Letter No. 4 (2003), this is “part of the Insurance Department’s initiative to improve the ‘speed to market’ objective for insurance products.”¹⁵

States should streamline this procedure by turning it into a simple two-part process that insurance companies can complete online. The first part will require a company to state all of its relevant information, such as name, contact information, address, etc. The second part contains a description of the new policy that includes its structure (deductible, HSA, etc.), what it covers, and whom it will be offered to. The states should also require solvency certification for applicants.

State legislatures should also pass legislation stating that the department of insurance has 60 days to approve or deny a new policy. If it fails to do so within 60 days, the insurance company can begin selling the new policy, provided that the insurance company has met necessary solvency requirements.

State Employee Health Plans

States have been very slow to introduce HSAs into their state employee health plans. Thus far, only Arkansas and Florida have taken steps toward this end.

This inaction is odd, given the ever-rising cost to states for state employee health care. In Georgia, for instance, state officials projected a \$446 million deficit this year for the state employee health plan.¹⁶ State employees were

not pleased when that gap was closed by increased premiums. And it may only get worse. In Minnesota, premiums for employees with dependents are set to rise 10% in 2007.¹⁷ Getting the ball rolling is not particularly difficult. Earlier this year, Florida passed legislation that directed the Department of Management Services to “establish within the State Group Insurance Program...a State Group Health Insurance High Deductible Health Plan.”¹⁸ The legislation also mandated that the high deductible plan “shall include a health savings account feature.”

Arkansas began offering state employees an HSA option in mid-2004. Yet less than one percent of state employees switched to the HSA plan when it was offered. Arkansas’ experience offers some lessons for other states. John Hardnetty, the former Deputy Insurance Commissioner of Arkansas and strong proponent of adopting HSAs in the Arkansas state employee health plan, identified three strategies that would increase the number of state employees choosing the HSA option.

- First, the state must educate state employees about the HSA option. That sounds easier than it is. With thousands of employees spread out across the state, it is difficult to ensure that they get adequate information about HSAs. A mailing from the state employee benefits office explaining the HSA concept would be one option worth considering.
- Second, and closely related to the first, is overcoming state employees’ aversion to the concept of “high deductible.” If HSAs are to become popular among state employees, they must be informed that a high deductible plan means lower premiums, a savings account, and more control over their health care dollars.

- Finally, states should consider adding a “sweetener” to HSAs in the form of matching funds. If states agree to match a certain amount of the money the employee puts in the HSA, then state employees are far more likely to opt for HSA policies.

High-Risk Pools

High-risk pools are special safety net programs created by state governments for the one to two percent of the population that is uninsurable. Giving this population access to HSAs would give those with chronic conditions an option that is showing success in the private sector.

Critics often dismiss HSAs as primarily for the “healthy and the wealthy.” Such criticism overlooks the flexibility permitted by an HSA. An individual with a chronic condition who has constant interaction with the health-care bureaucracy may prefer a policy that gives him more ability to decide for himself which health-care services to buy.

Thus far, eleven states have added HSAs to their high-risk pools: Alabama, Arkansas, Colorado, Louisiana, Kentucky, Maryland, Minnesota, Missouri, Nebraska, South Dakota, and Wyoming.¹⁹ That means that there are twenty-one other states with high-risk pools that have yet to do so.²⁰ The policies offered by many of the high-risk pools in these states are high-deductible plans, and so would be ideal for HSAs. In the next legislative sessions, states that have not yet added HSAs to their high-risk pools should do so.

Medicaid Reform

States have been equally slow in using HSAs as a model for reforming their Medicaid

programs. Medicaid, which covers health expenses for low-income people, continues to eat up an ever larger share of state budgets. State spending on Medicaid was estimated to grow by more than 21% in fiscal year 2005; it is now the largest portion of many state budgets, surpassing the amount spent on education.²¹

States that have experimented with Medicaid pilot programs based on consumer-directed care have found them to be successful. In 2002, Colorado launched the Consumer-Directed Attendant Support program that gives severely disabled Medicaid recipients control over where some of their Medicaid dollars are spent. The program yielded high satisfaction among participants, and average monthly costs were 21% under budget. It has been so successful that Colorado is working to expand the system statewide.²²

Florida is another state that is moving its Medicaid program in the direction of HSAs. In his “Florida Medicaid Modernization Proposal,” Governor Jeb Bush gives Medicaid recipients more control over their health insurance options.²³ It gives all Medicaid recipients a “premium” based on their health risk that can be used to purchase a basic private health insurance plan. Part of the premium is also put into a flexible spending account. These accounts can be used for dental and vision care; expanding the coverage of the basic plan purchased with the premium; for rehabilitative and home-based services not covered by the basic plan; or saved for use in purchasing employment-based insurance after Medicaid eligibility expires. Florida should also consider allowing money remaining in flexible spending accounts at the end of the year to be used for job training and child care services. The reform will also put government in the role of providing information and counseling to participants to help them choose the plan that best fits their needs.

The Florida proposal embodies three principles that all state Medicaid reform efforts should follow:

- **Choice:** Give Medicaid recipients options in spending their Medicaid dollars. This will empower recipients to make their own health-care choices and give them a role in managing some of their health-care costs. It will also introduce more competition into the health-care market.
- **Information:** Consumers must have adequate information to make good choices. State governments must play a role in providing Medicaid participants with the tools necessary to choose from among competing options. State governments should also consider playing a role in providing recipients with pricing information on various health-care services. This would empower recipients to make better choices when using their HSA-style accounts.
- **Responsibility:** Recipients must be responsible for the choices they make. Reform must include incentives for recipients to use their Medicaid dollars wisely, such as being able to use dollars saved in an HSA-style account for other purposes, such as purchasing employer-based care or helping defray child-care costs.

Conclusion

Health savings accounts offer the promise of empowering consumers, expanding competition, and lowering health-care costs. Unfortunately, barriers remain on the state level that could slow this coming change. States can remove these barriers by conforming their

income tax codes, removing first-dollar coverage mandates, community rating and guaranteed issues, and streamlining the insurance approval process.

Yet states can do more than merely remove obstacles. They can actively accelerate the move toward consumer-directed care by offering HSA plans in state employee health plans, high-risk pools, and Medicaid reform plans. By taking these actions, states can do their part to move our society closer to a health care system with lower prices, better quality, and more choice.

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ENDNOTES

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