The Role of State Regulation in Consumer-Driven Health Care

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Timothy S. Jost† & Mark A. Hall††

I. INTRODUCTION

In December of 2003 the Medicare Modernization Act (MMA) added section 223 to the Internal Revenue Code, creating a federal tax subsidy for money contributed to (and earnings accumulated on) health savings accounts, or HSAs.1 Though public attention was largely focused at that time on the provisions of the MMA creating the new Medicare prescription drug benefit, the MMA was also a major victory for advocates of "consumer-driven health care" who believe that HSAs have the potential to control the cost and improve the quality of health care in the United States, and perhaps even to increase health care access.2

Consumer-driven health care advocates believe that the key reason health care costs are out of control in the United States is that most Americans are too generously insured.3 They believe the solution is to increase consumer sensitivity to cost and effectiveness by making people spend their own money for health care.4 People should make health care purchasing decisions just as they make purchasing decisions for everything else: by evaluating the costs and benefits of health care and balancing their preferences for it with their preferences for other goods and services.

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4 See GINGRICH, supra note 3, at 110-13.
If consumers are forced to do so, providers and professionals will lower their prices
to compete seriously for the consumer dollar. On the other hand, consumers will
buy only the services they really need (or want, or can afford) and thereby reduce
utilization to the correct level. Consumers will also be more sensitive to the
effectiveness of health care, since they are now spending their hard-earned dollars to
buy it. Finally, as costs come down health care will become more affordable to
those who currently consume too little of it.

Consumer-driven health care advocates believe that imposing higher deductibles
is the most effective way to turn patients into consumers. They argue that
individuals should be encouraged to buy high-deductible health plans (HDHPs) to
cover medical catastrophes, and spend their own money to cover routine medical
care. They encourage the establishment of HSAs to help assure that money is
available to cover routine costs and to equalize the tax treatment of insured and out-
of-pocket medical spending. The MMA does this by offering three tax benefits: tax
deductions for funds that HSA holders contribute to their HSAs (regardless of
whether the account holder files an itemized return), exclusion from income and
payroll taxation for funds employers contribute to HSAs for their employees, and
freedom from taxation for accumulated earnings of HSAs. The HSA must,
however, be coupled with a HDHP, which must have a deductible of $1,000-$5,000
a year for a single individual, or $2,000-$10,000 a year for family coverage. The
tax subsidies for contributions to the HSA, moreover, only apply to amounts limited
to the lesser of the deductible of the insurance plan or $2250 for individual coverage
and $4500 for family coverage (indexed for inflation), though people over 55 are
allowed to make additional “catch-up” contributions.

Money contributed to a HSA is not subject to income tax if it is spent on
“qualified medical expenses” but is subject to both income tax and to a 10% excise
tax if it is used for other purposes. “Qualified medical expenses” are broadly
defined, however, to include many things traditional health insurance does not cover
such as non-prescription drugs, transportation or lodging while away from home to

5 See John C. Goodman & Gerald L. Musgrave, Patient Power: The Free-Enterprise
Alternative to Clinton’s Health Plan, 18-27 (1994).
6 See Consumer-Driven Health Care, supra note 2, at 69, 98.
7 Goodman & Musgrave, supra note 5, at 83-88.
8 Id.
9 See id. at 88-92.
10 I.R.C. §§ 62(a)(19), 106(d), 223(a)-(b), 223(e), 3231(e)(11), 3306(b)(18) (West 2005). See
Bob Lyke, Chris Peterson & Neela Ranade, Health Savings Accounts, CONGRESSIONAL RESEARCH
SERVICE (March 23, 2005), at 3-11; Richard L Kaplan, Who’s Afraid of Personal Responsibility?
(explaining the provisions of the MMA).
11 I.R.C. §§ 223(e)(2)(A)(i) (West 2005). The insurer, however, may cover preventive
medical expenses, such as the cost of screenings or vaccinations, before the deductible is met. I.R.C.
§ 223(e)(2)(C) (West 2005); I.R.S. Notice 2004-23, 2004-1 C.B. 725. The policy must also limit out-
of-pocket expenses to no more than $5000 per year for single coverage, $10,000 per year for family
coverage. I.R.C. §§ 223(e)(2)(A)(ii) (West 2005). These amounts will be indexed for inflation. I.R.C.
§ 223(g) (West 2005).
12 I.R.C. § 223(b)(2)-(3) (West 2005). See also U.S. Treasury - HSA Frequently Asked
Oct. 4, 2005). Persons aged 55 to 65 may also make an additional “catch up” contribution. I.R.C. §
223(b)(3)(A) (West 2005).
receive medical care, or long term care insurance premiums. 15 If HSA funds are not spent for health care, they can be withdrawn for any purpose once the account holder dies, becomes disabled, or reaches the age of 65. 16

The consumer-driven health care vision and strategy is very controversial. Many health care policy experts believe that HSAs will do little to control health care costs or improve quality, and are likely to diminish access to health care by further fragmenting the insurance market. 17 The purpose of this article, however, is not to join this debate. Rather, our aim is to explore the regulatory issues that HSAs and HDHPs raise. Consumer-driven health care in general, and HSAs in particular, are major federal health policy initiatives, yet they raise a host of regulatory and health policy considerations that traditionally have been the province of the states. Therefore, understanding the interplay of federal and state oversight in this field is critical. For instance, some consumer-driven advocates complain that “state laws are getting in the way” of HSAs, 18 yet the sale of these products is increasing rapidly, 19 perhaps so rapidly that the states will not be able to fully think through the issues they raise before they capture a significant market share. There are legitimate concerns that state and federal regulatory policies may not be well-coordinated in this quickly developing new approach to health care finance and delivery.

To explore these issues, we begin by considering broadly the federalism issues raised by health insurance generally. We then focus more particularly on how these issues play out in the context of HSAs and HDHPs. We base our analysis in large part on twenty-two interviews we conducted in the spring of 2005 with a total of thirty-two regulators, insurance company and trade association representatives, independent experts, and HSA advocacy groups.

II. FEDERALISM IN HEALTH CARE REGULATION

Throughout the last half-century, both the federal and state governments have played a major role in regulating health insurance in the United States. Their respective jurisdictions have evolved over time, and a variety of approaches to sharing and allocating authority have emerged. 20 A dominant theme—arguably the dominant theme—has been federal deference to state regulation. From the Supreme Court’s 1868 decision in Paul v. Virginia that “[i]ssuing a policy of insurance is not a transaction in commerce,” 21 until the 1940s, insurance regulation was regarded as exclusively a state concern. In 1944 the Supreme Court reversed its position in

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19 From all accounts, the MMA strategy has been spectacularly successful. By March of 2005, an estimated 1,031,000 people had opened MMA compliant HSAs and purchased MMA compliant HDHP policies. AHIP, Number of HSA Plans Exceeded One Million in March 2005. See www.ahip.org for the most current statistics.
United States v. South-Eastern Underwriters Association,\textsuperscript{22} recognizing that insurance did involve interstate commerce. The following year, however, the McCarran-Ferguson Act\textsuperscript{23} rearticulated the position that insurance regulation is principally the domain of the states, and that Congress preempts state regulation only if it clearly and considerately expresses an intent to do so.

Federal deference to state law is also evident in the Employee Retirement Income Security Act of 1974 (ERISA).\textsuperscript{24} In general ERISA, which was intended to bring national uniformity to employee pension and benefit law, preempts state laws that "relate to" an employee benefit plan.\textsuperscript{25} At the same time, however, ERISA explicitly "saves" from preemption state laws that regulate insurance,\textsuperscript{26} assuring that most issues affecting insured employee benefit plans are governed by state rather than federal law. Recent Supreme Court decisions interpreting ERISA have emphasized the expansive state regulatory authority over insured ERISA plans.\textsuperscript{27}

ERISA’s complex preemption provisions also demonstrate other Congressional approaches to health insurance regulation. The Supreme Court has interpreted ERISA’s "deemer" clause, which provides that ERISA plans "shall not be deemed to be an insurance company or any other insurer," as preempting all state laws that relate to self-insured employee benefit plans.\textsuperscript{28} ERISA also preempts ordinary contract law of the states that duplicate its exclusive remedies.\textsuperscript{29} Section 502 of ERISA provides a cause of action exclusively in federal court and under federal law, "to recover benefits due . . . under the terms of [the ERISA] plan, to enforce . . . rights under the plan, or to clarify . . . rights to future benefits under the terms of the plan,"\textsuperscript{30} and preempts all state law to the contrary. ERISA regulations issued by the Department of Labor further provide a detailed federal scheme for claims determination and internal review by ERISA plans.\textsuperscript{31} In these respects, ERISA has replaced state insurance law with federal.

With regard to other issues, however, federal law simply preempts state law without replacing it with federal regulation, essentially leaving a regulatory vacuum. The most notable example is ERISA’s approach to common law or statutory claims against managed care plans for extra-contractual damages.\textsuperscript{32} Here ERISA preempts

\textsuperscript{22} United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).
\textsuperscript{26} 29 U.S.C. § 1144(b)(2)(B).
\textsuperscript{31} 29 C.F.R. § 2560.503-1 (2004). ERISA is not the only statute through which Congress has preempted state insurance law and replaced it with federal law. The 1997 Balanced Budget Act, for example, preempts state regulation of provider-sponsored Medicare managed care organizations, placing them instead under federal regulation. 42 U.S.C. § 1395w-25(a)(2) (2000). See also 42 C.F.R. § 422.402(a) (2004) (generally preempting state law regulating Medicare managed care organizations when it is inconsistent with federal regulation).
\textsuperscript{32} See Aetna, 124 S.Ct. at 2503.(Ginsburg & Breyer, JJ., concurring). Another example is the 1974 federal HMO statutes, which preempts some state laws governing federally-qualified HMOs that were viewed as obstructive to the development of this desirable form of health care finance and
all state claims but offers no federal remedy. More broadly, self-insured ERISA plans are exempt from state regulation and only subject to limited federal regulation.\textsuperscript{33} With respect to many issues where states see regulation as appropriate, self-insured plans are simply unregulated. Congress is currently considering legislation for preempting state regulation of association health plans that reflects this same approach.\textsuperscript{34}

State law preemption with and without replacement federal regulation does not exhaust the possibilities for dividing federal/state authority in health insurance regulation. The Health Insurance Portability and Accountability Act (HIPAA) represents yet another approach.\textsuperscript{35} Several provisions of HIPAA impose direct federal regulatory control over insurers themselves, but allow the states to supplement federal regulation as long as the state regulation is not less restrictive than the federal law.\textsuperscript{36} HIPAA’s provisions limiting preexisting conditions clauses, for example, establish a federal floor for regulation but allow the states to impose more restrictive requirements.\textsuperscript{37} Several states have done so.\textsuperscript{38} HIPAA’s privacy requirements for health information also are subject to more restrictive state regulation.\textsuperscript{39}

Finally, in at least one instance the federal government has attempted to encourage the states themselves to regulate insurance, imposing federal regulation only if the states fail to take up the challenge. HIPAA requires insurers that sell in the individual market to offer insurance to individuals who lose group insurance coverage unless the state in which they are doing business provides an alternative approach to insuring individuals.\textsuperscript{40} Most states have taken an alternative approach by covering individuals through high-risk pools.\textsuperscript{41}

Despite the variety of these approaches to federalism, the general trend is toward greater federal involvement in health insurance regulation. Health care finance and delivery raises issues of national importance that are frequently viewed as calling for uniform or consistent national solutions. Rarely are these issues considered purely local concerns, and only a minority of policy advocates see the virtue in pursuing a “laboratory” of state experimentation with widely different delivery. 42 U.S.C. § 300e-10 (2000). The federal HMO Act, however, does not directly regulate HMOs, other than to specify the terms for federal qualification and hence protection from obstructive state laws. 42 U.S.C. § 300e (2000).

\textsuperscript{33} See 29 U.S.C. § 1144(b)(2)(B). Their internal claims practices are subject to 29 C.F.R. § 2560.503-1, 42 U.S.C. § 1395w-25(a)(2), and 42 C.F.R. § 422.402(a), but they are otherwise largely unregulated.

\textsuperscript{34} See, e.g., Mark A. Hall, Elliot K. Wicks, & Janice S. Lawlor, HealthMarts, HIPCs, MEWAs, and Association Health Plans: A Guide for the Perplexed, 20(1) HEALTH AFFAIRS 142, 142-143 (Jan./Feb. 2001).


\textsuperscript{36} See generally Colleen Medill, HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?, 65 TENN. L. REV. 485 (1998); Jack Rovner, Federal Regulation Comes to Private Health Care Financing, 7 ANN. HEALTH L. 183 (1998); Symposium, Making a Federal Case out of Health Care, 22(1) CATO J. 1 (Spr./Sum. 2002).

\textsuperscript{37} 29 U.S.C. § 1181(a); 42 U.S.C. § 300g-41(a), 44.


\textsuperscript{40} 42 U.S.C. § 300g-41(b).

\textsuperscript{41} See U.S. GEN. ACCOUNTING OFFICE, supra note 38.
approaches or non-approaches to possible solutions. Increasingly, there is a shared sense that the most effective path toward reform is through federal leadership and oversight. This was the path taken for promoting HMOs, for ensuring portability and accessibility of group health insurance coverage, and for protecting medical privacy. At first glance, this also appears to be the path for consumer-driven health care.

Closer inspection reveals, however, that Congress has taken a quite different approach in the MMA. The remarkable aspect of the MMA’s provisions regulating HSA/HDHPs is the indirectness of its regulatory strategy. The MMA does not require anything of health insurers or the states; however, it also does not explicitly free insurers from any state requirements. Rather the MMA simply offers federal tax subsidies for contributions individuals or employers make to an HSA that is coupled with a HDHP, and for the earnings of those accounts. The MMA does not require insurers to offer such policies. It does not compel states to require insurers to offer such policies. It does not even require the states to allow conforming high deductible insurance policies to be sold. It simply makes it clear that states that prohibit such policies will deprive their residents of access to a generous federal tax subsidy. The Department of the Treasury has issued a notice that allows states until the end of 2005 to eliminate state statutes that block such high-deductible policies. The law does not compel the states to eliminate these barriers, however. Therefore, although HSAs are one of the major federal health policy initiatives of our time, states may completely block or fail to implement them if they desire.

The use of tax subsidies to effect health insurance regulation is not original to the MMA. Arguably the single most important federal intervention in the health insurance market is the government’s provision of tax subsidies for employment-related health insurance found in the 1954 federal income tax amendments. More recently, federal tax subsidies have also been extended to subsidize health care flexible spending accounts, the purchase of health insurance by the self-employed, and most recently health reimbursement accounts. Tax incentives were also available for Archer Medical Savings Accounts (MSAs), which preceded the HSA. However, with the exception of the MSA statute, which was adopted for a limited time and applied to only very limited circumstances, these tax subsidies are not linked to particular forms of insurance and do not affect state attempts to regulate insurance. The MMA represents, therefore, an innovative approach to federalism health policy: regulation (and deregulation) through tax subsidies rather than through preemption.

A key policy question, therefore, is how the states have responded and will respond to this federal invitation to allow an innovative form of insurance. Has the

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44 See supra notes 10-16 and accompanying text.
46 See JOST, supra note 43, at 77-80; See generally MARK V. PAULY, HEALTH BENEFITS AT WORK (University of Michigan Press 1998).
47 See Paul Fronstin, Health Savings Accounts and Other Account-Based Health Plans, EBRI ISSUE BRIEF NO. 273 (Employee Benefit Research Institute, D.C.) (Sept. 2004).
48 Id. at 6.
possibility of a tax subsidy for their residents been sufficient to entice the states to remove regulatory barriers to HSAs and high-deductible insurance policies? Alternatively, do the states have their own concerns about HSAs or HDHPs that have produced regulation limiting their availability? Can the carrot of federal tax interventions alone effectively lead state health insurance regulatory policy? This article addresses these questions.

III. OPPORTUNITIES FOR STATE REGULATION

Health insurance is one of the most heavily regulated industries in the United States. One would expect, therefore, that a major innovation such as consumer-driven health care would encounter state regulatory issues on a number of fronts. We outline the possibilities by focusing separately on HSAs and HDHPs.

HSAs raise a number of state law and policy issues. The most direct issue of public policy that states face in dealing with HSAs is whether to confer a state tax break on funds deposited in HSAs similar to that conferred by federal law. This is obviously a legislative and revenue issue rather than a question of insurance regulation. HSAs also raise regulatory issues. HSAs are not insurance, they are financial accounts, and so their regulation depends on the nature of the institution that administers the account. If a financial institution, such as a bank or credit union, administers the account, then HSAs present no especially unique issues. However, the MMA HSA provisions also allow insurers (as well as “other persons”) to serve as trustees or custodians of HSAs. Some insurers may want to administer their own HSAs, devoting some of their capital reserves to developing this new expertise and product line, and perhaps putting some of their capital at risk in managing investments. If so, this may raise concerns for regulatory oversight of insurer solvency and financial accounting.

Another regulatory issue raised by HSAs is the treatment of provider networks with whom insurers may contract in order to offer their HSA holders access to health care items or services at a discount. These can come in two forms. We learned through our interviews that, for qualified medical expenses the HDHP does not cover, such as eye glasses or massage therapy, some HSA marketers offer “discount only” plans or cards that give account holders access to a discounted network of service providers. Discount arrangements may also apply to medical services that are covered by the HDHP but are subject to the high deductible. Health plans negotiate discounted payment rates with networks of providers that not only decrease the direct cost to the health plan for insured services but also obligate these providers to charge lower rates for services paid by the patient that are subject to the deductible. Both types of discount arrangements raise regulatory questions. For

50 See generally Mila Kofman, Health Savings Accounts: Issues and Implementation Decisions for States, ISSUE BRIEF, (AcademyHealth State Coverage Initiatives, D.C.), Sept. 2004 (explaining “the key issues that state officials need to know about HSAs—including what they are, how they compare to other types of tax-preferred accounts, and what public policy implications and implementation issues need to be considered”), available at http://www.statecoverage.net/pdf/issuebrief904.pdf.
instance, are "discount only" plans subject to insurance regulation at all? If not, they might cause consumer confusion and therefore be subject to other non-insurance consumer protection laws. And do rules that govern managed care provider networks—such as network adequacy, any-willing provider, and provider due process rights—apply to HDHP provider networks when they are being used for services paid for from the HSA?

A final HSA issue arises from a Department of Labor ruling that HSAs are not considered employee benefit plans subject to ERISA, even if they are partly funded by employers and are tied to an employer-sponsored HDHP because employees personally own these accounts. Professor Jacobi first noted that this ruling may surprisingly open a door to state policy initiatives that were previously considered preempted by ERISA. If employer-funded HSAs are not subject to regulation under ERISA, then logically they are also not subject to ERISA preemption. This could mean that states have the power to mandate that employers offer or fund HSAs—a radical change from the traditional understanding that states may never impose direct benefit mandates on employers.

Turning next to the high deductible health plan, a state contemplating regulation encounters the full range of regulatory issues presented by any health plan. The most obvious state regulatory obstacle HDHPs face is whether state law permits the size of deductibles that federal law requires in order to obtain favorable tax treatment of HSA funds. Two sources of possible noncompliance exist. First, when states mandate inclusion of particular benefits, they frequently require that those benefits be subject to low or no patient cost-sharing, in order to prevent insurers from circumventing the benefit mandate. Second, HMOs as originally conceived typically provide virtually "first-dollar" prepaid coverage for a comprehensive range of health care services, and therefore state enabling acts or regulations may prevent HMOs from offering high-deductible policies.

Less obvious regulatory issues spring from rules that govern how health insurance is priced and underwritten in the individual and small group markets. Especially for the small group market, most states restrict in some fashion (ranging from community rating to rating bands) the extent to which an insurer may vary its rates among subscribers based on their individual health status. At the same time, states require that rates be actuarially fair. Because high-deductible plans are

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54 Id. at 112-15.
55 See generally Mark A. Hall, Managed Care Patient Protection or Provider Protection? A Qualitative Assessment, 117 AM. J. MED. 932 (2004).
57 Jacobi, supra note 17, at 579.

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known to attract healthier subscribers, and they also are meant to discourage excess utilization, these plans raise the issue of whether subscribers should be fully credited with their lower health expenditures or instead should be charged rates based on an insurer's overall risk pool in a given market.

Another set of issues relate to states' efforts to standardize benefit plans in order to promote comparison shopping. A few states allow only standardized benefits to be sold in some market segments, while many others require insurers to offer standardized plans alongside their more tailored options. States must decide whether to include HSA-qualifying high-deductible plans in this mix of standardized benefits. Also, states that have subsidized high-risk pools for people who are uninsurable at standard rates must decide whether to include an HDHP in the set of plans offered through these programs.

In order to understand these issues, we conducted a series of interviews over a three month period in the spring of 2005. We interviewed fourteen state insurance regulators from nine states. We attempted to canvass states from different regions of the country, including states that have a reputation for "heavy insurance regulation" (e.g., Maryland, New Jersey and New York) or "light insurance regulation" (e.g., Arizona, Pennsylvania and Virginia). We conducted extended interviews with representatives of three insurers, including two of the largest participants in the industry and one smaller boutique HSA/HDHP company. We interviewed knowledgeable persons at America's Health Insurance Plans, the Blue Cross/Blue Shield national association, the National Association of Insurance Commissioners, and Communicating for Agriculture and the Self Insured, Inc., an entity that follows closely developments in state high-risk plans. We also interviewed persons connected with the Galen Institute and the National Center for Policy Analysis, HSA advocacy groups, and an independent expert on state insurance regulation. All totaled we spoke with thirty-three individuals representing nineteen different entities. The interviews were conducted on a confidential basis. While we draw on them throughout this article, we do not cite to specific interviews in the footnotes.

IV. STATE REGULATION OF HEALTH SAVINGS ACCOUNTS AND HIGH DEDUCTIBLE HEALTH PLANS

A. THE THREE BIGGEST BARRIERS: NO (OR LOW) DEDUCTIBLE MANDATES, HMO DEDUCTIBLES, AND STATE TAX SUBSIDIES

Most public discussion of state regulatory issues affecting HSAs and HDHPs to date has centered around three issues, and all three came up frequently in our interviews. The first of these is the one issue specifically addressed by the federal

64 Under the terms of our research involving human subjects protection protocol these interviews were confidential. This is also important for protecting the commercial interests of the private sector representatives we interviewed. For this reason we do not cite to individual interviews.
65 Arizona, California, Colorado, Maryland, New Jersey, New York, Pennsylvania, Virginia, and Vermont. Several of these states followed up our interview by sending us additional information.
66 See, e.g., Geisel, supra note 18; Kofman, supra note 50; and Lueck, supra note 18.
government—the problem of state mandates that bar high deductibles for particular services. As noted above, HSAs only qualify for tax subsidies under the MMA if they are coupled with HDHPs that have minimum deductibles of at least $1000 for individuals, $2000 for families.67 The statute allows (but does not compel) HDHPs to have no deductibles or lower deductibles for “preventive” health services, as defined in the Medicare statute,68 but does not otherwise allow particular services to be exempt from the high deductible requirement. The Treasury Department defines what is meant by “preventive care” and does not defer to state definitions.69

At the time the MMA was adopted, a number of states mandated coverage of specific non-preventive health services (as defined by federal law) either without a deductible or with a low deductible. Examples include a Florida law that prohibits insurers from charging insurance deductibles or copayments to victims of violent crime,70 laws in Maryland and Pennsylvania that prohibit the application of a deductible for certain home health visits for recently delivered mothers and newborns,71 and a Pennsylvania statute requiring coverage without a deductible for medical foods for certain conditions.72 The Department of the Treasury, which administers the HSA program, quickly realized the implementation problem this created. Consequently, the Department provided an opinion that HSAs coupled with HDHPs could qualify for the tax subsidy, even if state law compelled the HDHP to offer low deductibles for specific services that did not qualify as preventive, but only through December 31, 2005.73 The states effectively had a reprieve until that date to revoke or amend their conflicting requirements. HSA tax subsidies will not be available after this date in states that fail to do so.

Most states quickly followed suit.74 According to a survey conducted by America’s Health Plans (AHIP), by May of 2005 the legislatures of all but four states with impediments (New Jersey, New York, Ohio, and Rhode Island) had passed laws removing the impediments, though at that point the governors in three states had not yet signed the legislation into law (Florida, Pennsylvania, and Texas).75 The states saw it as their responsibility to fix problems of nonconformity so that they would not be a barrier to marketplace innovations spurred by the federal initiative. The states’ responses were remarkably rapid and widespread. Without any specific federal requirement or threatened penalty, most were willing to set aside the particular public health or provider protection considerations that caused them to enact various benefits mandates in order to facilitate the federally-led consumer-driven market initiative.

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Several states, however, continue to impose nonconforming mandates. In at least one state, New Jersey, this delay in amending mandates seems to be due at least in part to political opposition to HSAs. Failing to revoke or amend a mandate is a relatively low profile approach to banning HSAs from a state without necessarily joining a high profile political debate on whether they are good public policy. In other states, however, this noncompliance seems to be temporary, due simply to legislative lassitude or to idiosyncratic legislative cycles. Still, this delay troubles the industry because new insurance policy forms must be approved before they are marketed, which causes an additional period of delay following any conforming enactments. Also, contracts for large group insurance policies are negotiated months in advance of their effective date, and employers are reluctant to consider HSA plans unless they are certain they will be legally available. This combination of factors is likely to delay the market's adoption of HSAs for some states even beyond the January 1, 2006 deadline for states to conform their laws to federal requirements.

A second widely-recognized issue is whether HMOs can offer an HDHP. Most insurers are structuring HDHPs as PPOs. Some insurers, however, also want to make HDHPs available as HMOs. Some see this possibility as combining the virtues of managed and consumer-driven health care, others are licensed only as an HMO, and yet others would like to offer consumers all options possible. The traditional understanding of an HMO, however, is that it offers comprehensive health care in exchange for a fixed premium. An HMO with a $1000 deductible, or to stretch things further, a $5000 or $10,000 deductible, seems, therefore, to raise definitional problems.

This turns out not to be a pressing problem in many states. Many either explicitly allow HMOs to have deductibles or have been willing to stretch their state law definitions of HMOs to allow HDHPs. Some, like Virginia have explicitly amended their HMO statutes to allow HDHPs coupled with HSAs. Others, like Connecticut, have interpreted their insurance rules to permit high deductibles for HSA-related plans.

In a number of states, however, including Illinois, Ohio, Maine, Missouri and New York, state law prohibits or limits HMO deductibles. This is particularly problematic in New York, where only HMOs are permitted in the non-group market. Therefore, the New York bar on high-deductible HMOs effectively keeps HSAs entirely out of the individual market. In most states, this market segment has had the largest initial growth of HSAs.

In a number of other states, moreover, regulators expressed to us some concern about how high HMO deductibles can go. This is Arizona's position, which has allowed a $5,000 deductible policy, but has concerns about higher deductibles. Vermont also believes that it could perhaps prohibit very high deductible HMOs, and is researching this question. Regulatory policy in California is still uncertain and emergent, with concerns expressed that a high deductible might at some point make HMO coverage "illusory." Maryland law prohibits cost-sharing that is so high that it creates a barrier to care, but regulators support HSAs as a matter of policy and

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77 Id.
80 AHIP, supra note 75.
81 AMERICA'S HEALTH INSURANCE PLANS, HEALTH SAVINGS ACCOUNTS OFF TO A FAST START IN THE INDIVIDUAL MARKET (2005), http://www.ahip.org/content/default.aspx?docid=7418.
would allow high deductible plans up to the federal maximum as long as preventive care is subject to no or low deductibles. In sum, most states are trying to permit MMA compliant HDHP HMOs, but there might be limits to how far they are willing to go.

The third major issue is state tax subsidies for HSAs. Twenty-seven of the states (and the District of Columbia) simply use the federal definition of taxable income and, therefore, automatically recognize all deductions and exclusions available under federal law for state income tax filers, including HSA related deductions.\(^\text{82}\) Another nine states do not have a state income tax, and thus are not in a position to offer income tax incentives.\(^\text{83}\) The remaining states, however, need a specific law singling out HSAs for favorable treatment. Many states have for some time provided state tax deductions and exclusions for Archer MSAs; indeed some did so even before HIPAA introduced the MSA into federal law.\(^\text{84}\) In the wake of the MMA, many states have amended their state tax laws to conform to the new federal provisions.\(^\text{85}\)

Not all have done so, however.\(^\text{86}\) The failure to provide parallel state tax subsidies in some states may be explained again by legislative inertia. The lack of a state tax subsidy does not bar the use of HSAs within the state, it merely makes them a little less attractive, so states no doubt feel less urgency here than they do about removing low or no deductible mandates. Some states never offered state tax subsidies for the old Archer MSAs, and are not tempted to do so by the MMA HSA provisions. In a number of states, moreover, the refusal to extend tax subsidies is probably based on budgetary concerns, since many states currently experience continuing fiscal difficulties.\(^\text{87}\) Those states that have decoupled state tax deductions and exclusions from those found under the federal law have become grudging about offering new state tax subsidies. Governor Jim Doyle of Wisconsin vetoed a tax subsidy for HSAs in 2004, stating that it would cause Wisconsin to lose $39 million in revenue over eight years.\(^\text{88}\) Finally, some states are also using this approach because they question HSAs as a matter of public policy. Wisconsin's Governor Doyle also expressed concern that a tax subsidy for HSAs would encourage employers to reduce the generosity of health benefits.\(^\text{89}\) The bottom line, however, is that most states currently offer state tax subsidies for contributions to HSAs that conform to federal requirements.

Beyond these three main issues, few of the sources we interviewed believed there are other major state-law barriers to HSAs. One advocacy group representative and one insurance company representative asserted that states were slow to issue necessary approvals and rulings on new HDHP policies because of their general hostility to consumer-driven health care, but the other insurers whom we interviewed did not raise this as an independent issue (indeed one stated that it had not experienced unexpected delays). Another state insurance regulation expert we

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\(^{82}\) AHIP, supra note 75, at 2.

\(^{83}\) See generally id.

\(^{84}\) See Blue Cross and Blue Shield Association, State Legislative Health Care and Insurance Issues, 2003 SURVEY OF PLANS, 80-82 (2003).

\(^{85}\) AHIP, supra note 75.

\(^{86}\) See id. at 2 (according to AHIP's survey, eight had failed to do so).


\(^{88}\) Lueck, supra note 18, at R4.

\(^{89}\) Id.
interviewed suggested that any delay was probably due to the innate conservatism of state insurance regulators faced with a new and unfamiliar product, and not to any particular hostility toward HSA/HDHPs. In sum, most persons we interviewed agreed that the vast majority of states do not currently impose significant barriers for insurers who want to offer MMA-compliant policies. The most significant problems are that not all states allow HMO high-deductible policies, and not all offer state tax benefits that parallel the federal deduction.

V. OTHER STATE REGULATORY ISSUES RAISED BY MMA COMPLIANT HSAS AND HDHPs

The current issues raised by insurers and regulators do not exhaust the range of potential regulatory issues. As the states gain more experience with HSAs and HDHPs, they may well encounter a range of additional regulatory issues. Early recognition of these issues is important because it enables states to deal with them responsibly rather than waiting for a crisis to provoke precipitous or over-reactive action. Experiences from managed care regulation in the 1990s reveal that case-specific or crisis-driven regulation is often neither efficient nor effective.  

A. STATE REGULATORY ISSUES RAISED BY HSAS.

First, how the health savings accounts are administered may raise several state regulatory issues. A number of the large insurers with whom we spoke, including Aetna, United, and the Blues plans, do not administer these accounts themselves. United, for example, has acquired a bank (Exante) which manages its HSAs, while Aetna has partnered with J.P. Morgan for this purpose. The Blue Cross and Blue Shield Plans have approved debit cards featuring the Blue Cross and Blue Shield Logo for use with HSAs, but banks will administer the HSAs. This approach offers a number of advantages, including access to banking experience and FDIC insurance. Other insurers, however, including Destiny Health, one of the largest boutique HDHP insurers, administer their own HSAs.

One of the essential functions of insurance regulation is to assure that insurers have sufficient capital and reserves to meet their obligations as those obligations become due. Because funds in HSAs can be carried over from year to year, insurers that administer HSAs could potentially accumulate large sums of money for which they are responsible. Most insurers, however, have little experience functioning as banks. The process of managing and investing assets, receiving deposits, processing checks and debit card transactions, and providing account statements may be new to them.

Under the MMA, HSA's may be administered by banks, insurance companies or "another person who demonstrates to the satisfaction of the Secretary [of the Treasury] that the manner in which such person will administer the trust will be consistent with the requirements of this section." Banks are regulated by the

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92 FURROW, supra note 49, at § 9-1.
FDIC, Comptroller of the Currency, or state banking regulators. Administrators other than banks or insurers are regulated by the federal government in the same way 401(k) administrators are, and as such are subject to a reasonably thorough regulatory process. Most states, however, do not appear to have a regulatory mechanism that oversees insurers offering financial services. None of our interview sources could point to any actual regulatory requirements or consequences for insurers that administer their own HSAs, other than that the funds must be maintained in a separate account and must not be commingled with insurer funds that are at risk. If these funds are kept separate from the insurer's other funds, then they are not subject to, and do not affect, the insurer's solvency and reserve requirements.

The financial institutions, other than insurers, that the MMA authorizes to administer HSAs are familiar types of heavily regulated financial entities. Consumers who choose insurers to administer their HSAs will likely assume there is some similar oversight of financial services from insurers. Questions will undoubtedly surface about state regulatory oversight the first time HSA holders (or providers who expect to be paid by HSAs) encounter major problems in getting an insurance administrator to honor checks or debit card transactions. Why did insurance regulators allow the problem to arise? Will state insurance guaranty funds cover the obligations of insolvent insurers under their HSAs, or only under their HDHPs? Do unfair claims practice laws cover HSA claims? We found little evidence in our interviews that insurers or insurance regulators were considering these issues.

A second issue HSAs raise is how state statutes and regulations that regulate managed care will apply to HSA transactions. As noted above, managed care uses a number of tools to control health care utilization and prices, including provider networks, utilization review, and provider payment incentives. Perceived excesses in the application of these tools have in turn resulted in extensive state regulation of managed care. Although these laws clearly apply to the portion of services the HDHP insures, whether they apply to covered services below the deductible or to other services paid from HSAs but not covered by the HDHP is unclear.

All of the HDHP insurers with whom we spoke make their negotiated network discounts available to HSA holders. This is a great advantage to HSA owners, as it gives them the benefit of the considerable market power that insurers command for extracting discounts from providers. Insurers also use their standard claims processing systems, including medical necessity review, to determine when the policy deductible (and, ultimately, the out-of-pocket maximum) has been met for any particular subscriber. In general, only insured expenses can be counted against a deductible. If a subscriber with a $3,000 deductible receives an outpatient surgery costing $2,500, insurers are unlikely to credit the cost of the surgery fully against the

95 This may well be because most insurers we spoke with have decided to avoid these concerns altogether by using banks to administer HSAs, and the one insurer we spoke with who is administering its own accounts has considerable experience with consumer-driven health care. But it was surprisingly difficult to locate anyone who had thought through this problem.
97 See Furrow, supra note 52, at 625-633.
98 Hall & Havighurst, supra note 76.
deductible without determining whether the surgery was a covered expense, whether $2,500 was a reasonable charge, and whether the subscriber received pre-approval for the surgery if required under the policy. In short, even while spending their own money from HSAs, subscribers will be subject to some managed care controls to the extent that they attempt to claim these expenses against their insurance deductibles. The MMA explicitly recognizes the HDHPs' use of networks, allowing them to impose higher out-of-pocket limits for services provided outside of the network. The Treasury's interpretation of the MMA also permits HDHPs to impose penalties for the failure of insureds to seek precertification of services and these penalties do not count against the HDHP out-of-pocket maximum, or, presumably, against the deductible.

This raises a host of questions, however. If an insurer refuses to credit the cost of the surgery fully against the deductible because it was not medically necessary, can the HSA holder appeal the decision under the state's claims review laws? If a network provider is treating an HSA holder and that provider's contract with the HDHP is terminated, must the provider continue to offer the HSA holder the HDHP negotiated discount for the period of time that a state's continuity of care statute requires the HDHP to cover services? Do state any-willing-provider statutes apply to HDHP networks for HSA-covered services as well as for HDHP funded services once the deductible is met? In sum, does the whole panoply of managed care regulatory statutes also apply to HSA expenditures, at least insofar as they are applied against HDHP deductibles?

The answer to these questions in general is yes. Virtually all regulators and insurers we talked to assumed this to be the case, but this assumption has not yet been challenged or tested, as it might be if, for instance, a particular provider insisted it was not bound by the restraints in its managed care contract for services paid directly by patients through their HSAs. Even if the current understanding holds, it means that HDHPs will face no less of a restrictive regulatory environment than do conventional managed care plans. Because many people believe that regulation mortally wounded managed care, this realization might cause states to consider whether some aspects of existing regulation will deter appropriate development or operation of HSAs/HDHPs.

The interplay between the HSA and HDHP does not just raise questions as to how state managed care regulations apply; it also presents the very real potential for consumer misunderstanding and confusion. To understand clearly how MMA HSAs work when coupled with HDHPs, consumers first need to realize that HSAs are savings accounts, not insurance. Not all consumers will understand this, especially since, as one regulator noted, some HSAs and HDHPs are being misleadingly marketed as providing seamless coverage. Next, consumers must appreciate that HSAs can pay for a broader range of qualified medical services than

102 See Margaret Ann Cross, Will Providers Seek New Contracts as Consumer-Directed Plans Grow?, MANNED CARE (May 2004).
103 See Mark A. Hall, The Death of Managed Care: A Regulatory Autopsy, 30 J. HEALTH POL., 427, 427 (2005).
those covered by the HDHP. It is easy to imagine some consumers exhausting their HSA s on miscellaneous expenses that do not count toward the deductible at all and then facing the rude surprise of "catastrophic" medical expenses once a serious accident or illness strikes and learning that insurance coverage is still a long way off. Insurance regulators will undoubtedly be drawn into these controversies from time to time. Even in more routine circumstances, keeping track of two different categories of medical expenses—those the HSA covers and those the HDHP covers—is bound to cause confusion and consternation. Added to this consumer burden are the already confusing distinctions between billed versus allowable charges, and in-network versus out-of-network providers, which bedevil all but the most expert readers of insurers' "explanation of benefits" forms. All of this is to say that HSA/HDHPs raise significant issues for consumer education and dispute resolution, and that these issues will likely reach the attention of state insurance regulators.

Consumer confusion and misunderstanding is particularly possible where HSAs offer "discount only" plans to their account holders alongside HDHPs. A number of insurers offer their HSA account holders negotiated discounts with providers of noninsured qualified medical services, such as optical services or massage therapy. Regulators we spoke with acknowledged that such discount plans could raise a number of issues, such as consumer misunderstanding of the terms, plan marketers' misrepresentation of the scope or nature of benefits, or provider misunderstanding of participation arrangements. Both consumers and providers may not understand, for example, that services covered through the discount arrangement are not covered services, and therefore are not insured even if the deductible is exceeded. In non-HSA contexts, there are reports that consumers who buy into such arrangements sometimes believe they are buying true insurance rather than merely access to a network of discounted providers. In non-HSA contexts, moreover, discount plans have involved "rented" preexisting PPO networks assembled for other purposes, and serious misunderstandings have resulted when providers have found themselves obligated to provide discounted services to consumers outside of the context in which they had agreed to serve.

Insurance regulators generally do not address problems that arise from discount-only plans because they do not consider discount only plans to be insurance. Rather, these products and practices are overseen by state attorneys general or consumer protection agencies, if at all. Consumers who believe, however, that discount plans are insurance products might come first to the insurance regulator for assistance if they encounter problems. As a result, the NAIC is considering, how these products should be regulated, and several states have adopted legislation specifically addressing them.

The problems that result from the high deductible feature of HDHPs and from the insurance companies' efforts to extend benefits to their members whose

108 Britton, supra note 53, at 111-12.
109 Id. at 112.
expenditures are still below the deductible are not unique to HDHPs coupled with HSAs. These problems currently exist, even without HSAs, under normal high deductible policies, which are already fairly widespread. The problems may become more pressing under HSAs for a couple of reasons. First, if MMA compliant policies truly become as common as their advocates claim they will, these policies will reach many people who have had no previous experience with high deductible policies. Many of the problems with managed care arose from consumer unfamiliarity with this new type of insurance. People new to consumer-driven plans will face a similar learning curve. Second, the MMA HSA provisions, which provide tax subsidies for HSAs coupled with policies with deductibles of up to $5,000 for individuals and $10,000 for families, may lead to even higher deductibles than are now common. This in turn will make the existing issues apply to an even greater range of medical expenses, even for people who are already covered by high deductible plans. A recent survey found that 90% of single policies offered to HSA enrollees exceeded the minimum of $1,000, and 17% exceeded twice that amount. The states may therefore have to deal with these problems to a greater extent than they have had to so far.

B. STATE REGULATIONS INTENDED TO IMPROVE ACCESS TO HEALTH INSURANCE AND HIGH DEDUCTIBLE HEALTH PLANS

One traditional focus of state insurance regulation has been improving access to health insurance for the uninsured by controlling insurer underwriting and rating practices primarily in the small group market, but also in the individual market in some states. The goal of these laws is to open the insurance market to higher risk insurance applicants or small groups who might otherwise be excluded. This goal is manifest in laws requiring forms of community rating, establishing high-risk pools, and requiring the offer of standardized policies.

A number of commentators have expressed a concern that HDHPs might further fragment insurers’ risk pools by attracting mainly low-risk subscribers, leaving high-risk subscribers in separate risk pools with ever increasing premiums for

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111 See James Maxwell, et al., Are California’s Large Employers Moving to Catastrophic Health Insurance Coverage?, HEALTH AFFAIRS (Web Exclusive), http://content.healthaffairs.org/cgi/reprint/hlthaw.w5.233v1?jikey=VflpznJFN.6Lo&keytype=ref&siteid=healthaff, May 2005 (reporting that 12% of large private and 5% of large public employers in California offer high deductible PPOs, with 15% of private employees and 18% of public employees taking up high deductible policies when offered). High deductible policies are even more common in the individual and small group market. One recent study of adults aged 50 to 70 with individual insurance coverage found that 42% had deductibles of $1000 or higher and 24% had deductibles of $2000 or higher. Sara R. Collins, Paying More for Less, Older Adults in the Individual Insurance Market, COMMONWEALTH FUND, June 2005, available at http://www.cmwf.org/usr_docs/841_collins_olderaadults_ib_06-30-2005.pdf.

112 See Hall, supra note 103, at 448.


114 Reden & Anders, supra note 107.

conventional insurance. HSAs and HDHPs are thought to be more attractive to low-risk subscribers because they are less likely to exhaust their high deductibles and therefore more likely to build up substantial savings in their accounts. Also, high-risk people are less likely in general to make any change in their health insurance, so at least initially any new type of policy, whatever kind it is, will tend to attract people who are healthier than average. HSA/HDHP advocates, on the other hand, argue that the flexibility available to HSA holders will be attractive to the chronically ill, as will be the absolute caps the MMA imposes on out-of-pocket expenses and lower premiums. They also argue that the cost control incentives and greater freedom of choice under HSA/HDHPs will make insurance more affordable to all. Even if the price of HDHPs initially is artificially low due to favorable risk selection, this advantage will tend to be neutralized over time as sicker people in higher-priced plans decide it is to their advantage to switch.

Experience to date does not conclusively settle this dispute. Preliminary reports are based on only a few employers or insurers, using forms of spending accounts and high-deductible plans that predate the MMA and differ significantly from HSA/HDHPs. This limited evidence shows no strong signs of risk selection measured by the age or chronic illness of employees who choose different plans, but does show some indication of risk selection based on the health care utilization in the year prior to choosing a plan. There is also some evidence that wealthier and better educated people are disproportionately choosing HSA/HDHPs. It makes sense that wealthier people would choose MMA compliant HSA/HDHPs because the wealthy benefit more from the MMA tax deductions and are better able to cover high deductibles out of their income and assets. Insofar as there is a connection between socio-economic status and health status, this may presage further segmenting of the risk pool. Still, it is easy to overestimate or exaggerate the extent of possible adverse selection, and so far large price advantages have not yet emerged for HSA/HDHPs. In fact, one initial study found that utilization of


117 See, e.g., Herzlinger, supra note 2, at 119-120, 157-9.

118 See Consumer-Driven Plans Can Reduce Number of Uninsured, Panelists Say, BNA HEALTH CARE DAILY (May 4, 2005).


expensive hospital services increased much more in a consumer-driven health plan than in a conventional plan chosen by other employees at the same firm.\textsuperscript{125}

Still, states must be prepared for the possibility that HDHPs will attract a substantially healthier-than-average population. Insurers and employers consider this a real possibility and take steps to counteract it within larger employer pools,\textsuperscript{126} either by offering consumer-driven plans only as the sole option to a workforce, or by increasing rates the same average amount for all plan types rather than charging employees based on the actual rates of utilization for the particular plan type they choose. These self-help measures work well enough in larger employer groups, but for small employer and individual purchasers, insurance market reforms attempt to accomplish the same general results. In particular, rating rules, such as community rating or rating bands, limit the extent to which an insurer may vary its rates among subscribers based on their individual health status.\textsuperscript{127} If HDHPs cover mainly low-risk people, however, insurance premiums will more directly reflect individuals’ underlying medical risk because higher risk subscribers will remain in conventional types of policies. Therefore, if HDHPs end up segmenting low versus high-risks into different types of policies, then the goals of rating reforms will be eroded even if insurers charge each person the same rate for the type of policy they purchase. Accordingly, states concerned about access to coverage by sicker people might choose to regulate HDHP premiums to assure that lower prices for these policies reflect only their leaner benefits and not the better inherent health of the people who choose to purchase these policies.

Most of the regulators we interviewed felt that risk segmentation was not a pressing problem and that the rating issue just identified had not proven to be problematic. Several regulators were not certain how exactly the state’s rating rules apply to HDHPs since they left this issue to the expert judgment of trained actuaries. Those we spoke to who had actuarial expertise said, however, that so far their rating rules have not required insurers to spread risk between HDHPs and more conventional health plans. Instead, most felt it was appropriate, and actuarially fair, to base the premiums for each policy type on the health care costs and utilization generated by each policy’s benefit structure and risk pool. Several regulators acknowledged that problems might develop under this approach if substantial risk segmentation were to emerge, and one regulator in New Jersey was very concerned about this based on the risk segmentation that had already occurred in the individual (non-group) market between plans with $250 and $1000 deductibles. Most other regulators, however, noted that high-deductible plans of some form have been in the market for a number of years without any serious problems, and MMA qualified plans are too new to know whether they will produce any greater concern. A Pennsylvania regulator felt that, if problems arose, there is only a limited amount under that state’s fairly loose rating laws that could be done to counteract risk segmentation.

One reason this issue may not have emerged as a regulatory problem is that the major insurers may not be attempting to take advantage of any favorable risk


\textsuperscript{127} Hall, supra note 63.
selection. Several insurer representatives we spoke to said that PPO products are rated as a single risk pool in each market, adjusting only for deductible levels and other benefit differences, rather than pricing HSA plans as an entirely separate risk pool from other offerings. This appears to be sound actuarial practice, especially when new products are first offered without enough experience and size to provide “actuarial credibility” for a separate rating structure. It remains to be seen, however, whether major insurers will continue rating PPO products as a single risk pool once HSA-qualified plans grow in size and popularity. Past experience with other forms of community rating predicts that rating practices can change quickly in response to pressure from competitors who decide to seize on lower risk pools as a pricing advantage in the marketplace, and at least one insurer we spoke to already rates its HSA/HDHPs separately from other PPO products.

Another reason regulators may have refrained from scrutinizing rating practices for HDHPs is the growing disillusionment with traditional approaches to expanding access to coverage, which we detected in several quarters. Regulators seemed very sensitized to the “zero-sum” logic that, for every high-risk subscriber whose rates are lowered by regulation, several lower risk subscribers must pay higher rates, which at the margin may deter some of them from purchasing any insurance. The insurance market reforms of the 1990s have not succeeded in greatly expanding access overall, and coverage levels continue to erode. Therefore, regulators appear willing to try approaches such as HSA/HDHPs that might make insurance dramatically more affordable for average purchasers. They are, therefore, reluctant to regulate access to these policies too closely.

High-risk pools, currently offered in about two thirds of the states, represent another effort to make health insurance available to all. High-risk pools offer health insurance coverage to persons who are not otherwise insurable at a premium that is usually set at some multiple of average premiums in the state, typically ranging from 125% to 150%. These premiums will not usually cover the cost of insurance for high-risk subscribers, and are supplemented by surcharges on insurers or through tax revenues.

A number of states are currently offering or are considering HSA-qualified plans in their high-risk pools. Virtually all states with risk pools currently offer plans with deductibles high enough to qualify for HDHP status. Indeed, many offer plans with deductibles up to $5,000 or $10,000. Two issues, however, keep people insured by these plans from qualifying for HSA tax subsidies under the MMA. First, a number of high-risk plans have lower deductibles for drugs, since

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132 Communicating for Agriculture, supra note 130, at 12.
133 Communicating for Agriculture and the Self-Employed’s report for 2004-2005, lists nine states that reported that they were in the process of establishing HSA-qualified plans or already had one, two additional states with legislation pending to authorize HSA plans, and ten additional states that reported researching or considering HSA plans. See id. at 7.
134 Id. at 28.
many people in these pools have a chronic illness that requires expensive medication. Second, the HDHPs offered by several state high-risk pools are also "bare bones" policies that have higher out-of-pocket maximums than those allowed by the MMA.

States that offer MMA compliant policies, however, need to consider how the cost of HSA contributions should be weighed, if at all, in setting the amount the risk-pool participant pays for coverage. As noted above, premiums for high-risk pool policies are usually set at some multiple of average premiums for a policy offering comparable coverage in the non-group market; thus a judgment needs to be made as to how to fit HSA contributions into this formula. To date, all of the states seem to be setting the price for the HDHP either by reference to the cost of other non-HSA HDHPs in the market (adjusted for the different benefit structure of HSA-linked HDHPs) or with reference to other MMA-compliant HSA-linked HDHPs. In either case, the cost of the HSA is not taken into account, but is simply treated as one optional way through which the purchaser of the high-risk pool policy can meet the deductible. An alternative approach would be to add the cost of the HSA contribution to the HDHP premium to reach a total cost of the combined HSA and HDHP, and to subsidize this total expense to the extent it exceeds a certain cost (for example 125% of the average combined cost of HSA contributions and HDHP premiums in the non-group market). This approach might yield a greater subsidy for HSAs, and might prove attractive to a state that strongly supports HSAs as a matter of public policy, but apparently no state has done this yet. Rather, they are content to subsidize the high deductible policy, and let the policy holder worry about funding the HSA.

A final way states might, in theory, promote access using HSAs is to mandate that employers offer them or fund them at certain levels. Ordinarily, the possibility of an employer insurance mandate must be rejected out of hand because it seems to fly so directly in the face of ERISA preemption, which prevents states from mandating employer-funded benefits. This possibility has theoretical plausibility, however, because of a Department of Labor ruling, noted above, that HSAs are not employee benefits subject to ERISA jurisdiction even when employers fund them. Therefore, logically, ERISA would not preempt state mandates of employers relating to HSAs. We queried regulators, insurers, and others about whether this possibility had occurred to them or had come up in discussions, and consistently were told that it had not. Several people commented that this was an interesting and plausible idea, but, as one insurer representative joked, "please don’t tell anyone else," for fear that it might open up entirely new avenues for state regulation in an area that currently is seen as blissfully below the states’ radar screens. Another, however, observed that if any state tried to do this the Department of Labor would rapidly reconsider its non-preemption position.

135 Id. The Department of the Treasury does not permit tax subsidies for HSAs where the HSA owner has a low deductible pharmacy plan, Rev. Rul. 2004-38, but does allow transition relief to allow persons with low deductible pharmacy plans to qualify for HSAs until January 1, 2006.
136 See id. at 7.
137 See id. at 17.
VI. FEDERALISM REVISITED: THE STATE REGULATORY RESPONSE TO THE MMA HSA/HDHP PROVISIONS

Overall, the states’ initial response to the MMA has been quite remarkable. Most states have responded affirmatively to the latest federal legislation, despite its lack of explicit compulsion, by removing any regulatory barriers to qualified HDHPs. Many states have gone further, adopting or modifying state income tax laws to supplement the federal incentives with state incentives for the purchase of HSAs and HDHPs. Given the dismal fiscal environment that most states have been dealing with in the recent past, and the reluctance of the states to otherwise commit funds to expand health care access, these tax subsidies are quite significant. With a few notable exceptions—in particular California, New York and New Jersey—the states seem generally supportive of consumer-directed health care and reluctant to impose regulatory burdens on its progress.

Perhaps the experience with managed care regulation has caused most states to lose their taste for insurance regulation; or perhaps the receptive regulatory response is explained by the newness of the HSA/HDHP product and thus the lack of experience with problems it might cause. Whatever the explanation, the new approach to federalism in insurance regulation evidenced by the MMA appears to have been very successful. At least for the moment, the lure of tax incentives has been sufficient to launch HSA/HDHPs successfully in most states without the need for either direct preemption of state law or the imposition of direct federal regulation of insurance, thus avoiding all of the friction and controversies that have accompanied these strategies under ERISA or HIPAA. The few states that have refused so far to jump on the bandwagon have principled reservations about consumer-directed health care that are appropriately respected by this more passive federal approach. Thus in the end, the MMA seems a very promising model of incentive-based federalism in health insurance regulation.

It is too early, however, to know for sure what the full regulatory impact of HSAs/HDHPs will be. We may be at much the same place we were in the late 1980s with respect to managed care, when we were still quite innocent of the problems it posed. A few years later, the managed care backlash hit and state legislatures responded with a host of new regulatory statutes. A decade from now, if HSAs/HDHPs take off with the speed and force that their advocates predict we may see a very different regulatory environment.

Advocates of consumer-driven health care will argue that state or federal regulation of HSA/HDHPs is not necessary because the problems that afflict other types of insurance are either nonexistent or greatly reduced in their salience with respect to HSA/HDHPs. We have outlined a variety of areas, however, in which traditional regulatory concerns may still emerge. Solvency concerns are still relevant to the extent that insurers will be managing HSA accounts. Health policy concerns are raised by fears that HSAs will attract mainly healthier people and will work to the disadvantage of those with chronic illness. Also, HSA compliance requires that states undo benefit mandates that were adopted with public health goals in mind. Finally, concerns about consumer protection and managed care are still

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140 See Furrow, supra note 52, at 614-33 (describing these laws); Hall, supra note 103 (same).
relevant because of the complexity of HSA/HDHPs and because most of them still employ a range of established managed care controls.\textsuperscript{141}

There is at least one important difference between managed care and HSA/HDHPs that suggests consumer-driven health care may be less heavily regulated than managed care. Professionals and providers—most notably doctors—saw managed care as a threat, but they see HSAs/HDHPs as an opportunity. There is a long history of organized medicine opposing managed care in the United States because it subjects the professional autonomy of physicians to external control.\textsuperscript{142} Organized medicine also opposed managed care because it limits patients' free choice of providers. By contrast, organized medicine has long supported HSAs and HDHPs.\textsuperscript{143} On their face, HSAs would seem to guarantee absolute freedom in choosing providers. They impose no constraints on physician practice. No utilization reviewers need be looking over the doctor's shoulder while the patient spends his or her HSA funds. No claims reviewers will second-guess doctors' charges. Patients will have ear-marked funds from which to pay physicians directly and without delay at the time of service. In short, physician autonomy—both clinical and economic—will be absolute. Doctors will answer only to patients' demands and willingness to pay, and surely patients with money set aside for health care will not refuse services recommended by their trusted physicians.

Physicians may end up being unpleasantly surprised. Collecting from HSAs may prove more difficult than they might expect. Some patients will not pay their bills on time, even from their HSAs. Moreover, once HSAs are exhausted but deductibles have not yet been reached, patients are on their own. Most bankruptcies are currently driven in part by medical debt, and most persons bankrupted by medical debt are insured.\textsuperscript{144} One can predict that the incidence of medical bankruptcy will increase as deductibles get larger, and that physicians and providers will often end up being unsecured creditors.

Further, relationships between providers and HDHP companies are likely to be as complicated as are their current relationships with managed care companies. HDHPs still need to conduct some form of claims review to determine when the deductible has been met. Plans are also still concerned that deductibles not be exhausted too quickly, and they continue to impose pre-approval or other utilization

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\textsuperscript{141} Advocates of consumer-driven health care believe that it greatly reduces insurers' need to manage the costs of care because, as long as subscribers are under the HDHP deductible, they are spending their own money. This argument is contestable for several reasons, however. See Hall & Havighurst, supra note 76. First, even high deductibles cover only a moderate portion of total health care spending, due to the concentration of spending among those with chronic illness or catastrophic expenses. For instance, people who spend more than $5000 a year on health services account for more than 70% of total medical costs. See Marc L. Berk & Alan C. Monheit, The Concentration of Health Care Expenditures, Revisited, 20 HEALTH AFF. 9 (Mar./Apr. 2001). Moreover, the problem of provider-induced demand may be only slightly ameliorated by high deductibles, since patients are still largely dependent on their physicians in making health care spending decisions. See Joseph P. Newhouse, Consumer-Directed Health Plans and the RAND Health Insurance Experiment, 23 HEALTH AFF. 107 (Nov./Dec. 2004). This is why most insurers still continue to use traditional managed care tools such as networks and utilization review to control costs even with HDHPs.


\textsuperscript{144} David U. Himmelstein et. al., MarketWatch: Illness And Injury As Contributors To Bankruptcy, HEALTH AFF. (Feb. 2, 2005), http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1.
review requirements in determining whether expenses are covered and count against the deductible and the out-of-pocket maximum. Therefore, providers still need to ensure that patients receive needed approvals before services are rendered.145 Network providers who have a discount arrangement with an HDHP insurer may also find themselves obligated to refund to the patient money collected from the HSA in excess of the discount. Even out-of-network providers whose charges are payable in full from the HSA may need to inform their patients that only part of the charges count against the HDHP deductible. In short, life may not be as rosy for providers under HSAs and HDHPs as they have hoped.

Some consumers are also likely to eventually have bad experiences with HSA/HDHPs. Some consumers who spend their HSAs quickly on “qualified medical expenses” that do not count against their deductible will be shocked and surprised when they encounter serious and unexpected medical problems and realize that they still have far to go to meet their deductible. Consumers who go out-of-network or who fail to get utilization review approval are also in for similar surprises. The first time that an insurer who administers HSAs becomes insolvent, subscribers will be shocked to learn that they have nowhere to turn to recover the loss of their personal funds, and that no regulator was there to make certain this did not happen. Finally, persons with high-cost medical care who prefer low-deductible health insurance policies may find those policies increasingly unaffordable if low-risk subscribers move to HSA/HDHP policies.

If providers and consumers become upset, the media is likely to get involved as well. If problems become sufficiently widespread, we may end up with nightly new stories, newspaper exposés, movies, and New Yorker cartoons about consumer-directed health care, similar to those directed at managed care in the mid-1990s.146 Congressional and state legislative hearings and new legislation may follow.

Perhaps. Perhaps not. But it would probably be best for everyone concerned—consumers, providers, insurers, state regulators, consumer-driven health care advocates and skeptics—if we think through the potential issues raised by HSAs and HDHPs ahead of time instead of making policy in the midst of a media frenzy.147 Many believe in retrospect that managed care could have been better regulated had managed care policy not been made this way.148 The “light touch” approach to federalism found in the MMA HSA legislation leaves regulatory responsibility squarely with the states. For consumer-driven health care to avoid the problems that attended managed care regulation, it is essential that the states think through all of the regulatory issues it presents sooner rather than later. We hope that this paper will serve as an initial contribution toward reasoned dialogue about how the states should appropriately regulate HSAs and HDHPs.

145 Providers who are contractually obligated to notify insurers or get preapproval before providing certain products or services and who fail to do so may find themselves barred from billing the patient’s HSA under their contract with the HDHP insurer.
147 It is also important that insurers and state and national regulators and policy-makers do whatever they can to educate consumers, providers, employers, and the public about how HSAs and HDHPs operate and their advantages and disadvantages, so that those who purchase these products do not have unrealistic expectations about them and cannot later justifiably claim unfair surprise.
148 See sources cited supra note 90 and accompanying text.