Expanding and Incentivizing Health Savings Accounts:

A Critical Reform For Broadly Available, High Quality Health Care

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The overall goal of US health care reform is to broaden access for Americans to high quality medical care. Over decades, the improper expectation has developed that health insurance will subsidize the entire gamut of medical services, including routine care, with little out-of-pocket payment. Through a series of regulations, including coverage mandates, copayment limits, and restrictions on medical savings accounts, the Affordable Care Act (ACA) counterproductively doubled down on that longstanding misapplication of health insurance and pushed health care reform in the wrong direction. Fundamentally, insurance is about reducing risk, and in health care, the risk is incurring large and unanticipated medical expenses. Instead, the ACA's broad coverage requirements and misguided subsidies encouraged more widespread adoption of bloated insurance and furthered the inappropriate construct that insurance should minimize out-of-pocket payment for all medical care. Patients in such plans do not perceive themselves as paying for these services, and neither do physicians and other providers. With patients having little incentive to consider value, prices and doctor qualifications remain invisible, and providers don't need to compete on price. The natural results are overuse of health care services and unrestrained costs.

It is in the context of overall health care reform that I will discuss the importance of health savings accounts (HSAs), including the rationale for incentivizing their use and for strategically reforming them to leverage their impact on broadening access to quality medical care, increasing patient choice, and improving health for all Americans.

The critical concept is that *reducing the cost of medical care itself* is the most effective pathway to broader access to quality care, lower insurance premiums, and ultimately better health. Instead, most post-ACA ideas continue to stress making *insurance* more affordable, mainly through cash to consumers in refundable tax credits or other subsidies. Insurance premiums are secondary, though, and historically chiefly reflect two factors: 1) the cost of medical care, accounting for about 80 percent of insurance premiums; and 2) the regulatory environment, accounting for most of the rest. Prior and anticipated payouts for medical services are by far the single largest component of health insurance premiums. When the cost of health care services increases, insurance premiums rise. Other factors do have some impact on private insurance premiums, including government regulations, in particular mandated coverage; characteristics of the insured individual (for example, age and certain behaviors); and cost shifting caused by underpayment by public insurance. By overlooking the main factor – the cost of medical care itself - strategies to subsidize premiums artificially prop up insurance coverage that typically minimizes out-of-pocket payment. This is directly counterproductive, because it shields medical

care providers from competing on price. While a number of recent proposals rightfully strip back some of the ACA's harmful regulations and taxes that directly increased insurance premiums, more emphasis is urgently needed on reducing medical care prices, the core cause of high insurance costs and the chief barrier to wide access to care.

Lowering the cost of medical care itself, though, is fraught with peril. It must be achieved without harming patient care. That means without jeopardizing quality, restricting access, or inhibiting critical innovation of American medical care that - based on peer-reviewed data throughout the leading medical journals - is the standard of excellence for the world. Cost reduction can be accomplished *without* restricting health care use or creating obstacles to future innovation, i.e., avoiding the way that other governments regulate costs in their centralized, single-payer systems. Decreasing the cost of care for everyone requires creating conditions long proven to bring down prices while improving quality: incentivizing empowered consumers to seek value, increasing the supply of medical care, and stimulating competition for consumers.

Two key points are essential to clarify from the start, in order to fully understand the role and importance of HSAs in US health care reform:

1) the HSA is a vital and highly effective tool to broaden access to affordable, high quality health care for all Americans, even those without HSAs. It does so by putting consumers directly in charge of buying their own health care. The fundamental purpose of an HSA is NOT simply to provide a tax-sheltered benefit for individuals, in order to cushion the blow of high health care expenses for account holders;

2) the HSA is NOT an isolated, independent component of the health care system. Rather, it is intimately related to other aspects of the health care system, including insurance structure and regulation and tax policy. Reforms to maximize the positive impact of HSAs for consumers are therefore tied to other regulations and reforms.

To broaden access to affordable, high quality health care for all Americans, three fundamental steps must occur, and all directly relate to HSA reforms:

1) Patients must be strongly incentivized to consider medical care prices *and* simultaneously equipped with the tools optimized to do so. This is accomplished through universally available, large, liberalized, and transferable HSAs, in conjunction with lower cost, higher deductible insurance coverage.

For consumers to incorporate price into decisions to buy health care and then leverage that consideration to pressure prices downward for everyone, they must have clear personal gain from paying less, and they must pay directly for more of their own care. Conscious value-seeking by incentivized consumers is the essential lever to force competition among sellers, in this case the health care providers, which translates into lower prices and better value.

But is it realistic to suggest that patients could seriously consider price and value? Critics often claim this is unworkable: how can you shop around from the back of the ambulance? But emergency care

represents only six percent of health spending[1]. Among privately insured adults under age 65[2], almost 60 percent of all health expenditures is for elective outpatient care; only 20 percent is spent on inpatient care and 21 percent on medications. Of the top one percent of spenders[3], the group responsible for more than one quarter of all health spending at an average of $100,000 per person per year, a full 45 percent of spending is also outpatient. Likewise, 60 percent of Medicaid money is spent for outpatient care. Even in the elderly, almost 40 percent of expenses are for outpatient care[4]. Outpatient services dominate America's health spending, and these are amenable to price-conscious purchasing.

Better than tax deductions or income exclusions for health expenses, health savings accounts (HSAs) introduce something unique and powerful into health care decisions. Instead of simply introducing incentives that subsidize health care spending relative to other spending, they also incentivize saving. HSAs allow individuals to set aside money tax-free for uncovered health expenses, including routine care. These tax-sheltered accounts grow by contribution or investment. Note that widespread HSAs, when paired with high deductible plans, could pay for the bulk of medical care events, since most health care experiences involve smaller, non-catastrophic expenses. Since they reward saving, HSAs are highly effective in motivating patients to consider price and value.

To fully leverage the impact of HSAs, it is important to position more patients as direct payers for health care. One key vehicle to position patients as direct payers for a higher proportion of their medical care is widely available, higher deductible insurance plans (HDHPs) with fewer coverage mandates and cheaper premiums. Higher deductibles force direct patient payment for care up to the deductible. Such catastrophic coverage would restore the essential purpose of insurance - to reduce the risk of incurring large, unanticipated medical expenses. Because patients would pay for most medical care directly at the point-of-care, they would be newly exposed to most health care prices and, consequently, newly concerned with value. Provider prices would become more visible and align with what consumers value, rather than being set artificially or generated via obscure, complex third-party payer arrangements. While the visibility of information that patients require for assessing value must be radically improved, we may not even need legislation to force price transparency. The most compelling motivation for doctors and hospitals to post prices and signals of quality would be their understanding that they are suddenly competing for price-conscious patients who control the money.

Despite the ACA's attempt to shift consumers to bloated coverage, a shift toward high deductible plans with HSAs has continued. In the decade-and-a-half since the tracking of this type of coverage, employers have increasingly offered such plans, and consumers have increasingly selected high-deductible plans. Among those enrollees, a shift toward higher deductibles has continued.[5] Since the introduction of HSAs in 2004, the number of accounts has skyrocketed to over 22 million as of the end of 2017 (see Figs. 1, 2

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[1] Owning the Cost of Emergency Medicine: Beyond 2%; Lee MH, Schuur JD, Zink BJ; Annals Emerg Med 2013;62:498

[2] IMS Institute for Healthcare Informatics. Healthcare spending among privately insured individuals under age 65. February 2012

[3] ibid

[4] What Contributes Most to High Health Care Costs? Health Care Spending in High Resource Patients. D Pritchard, A Petrilla, S Hallinan, DH Taylor Jr., VF Schabert, and RW Dubois; *Journal of Managed Care & Specialty Pharmacy* 2016 22:102-109

[5] Kaiser Family Foundation, "Employee Health Benefits Annual Surveys, 2007–2014," http://kff.org/health-costs/report/employer-health-benefits-annual-survey-archives.

below). Indeed, by increasingly choosing HSAs when given the opportunity, American consumers are approving their value.

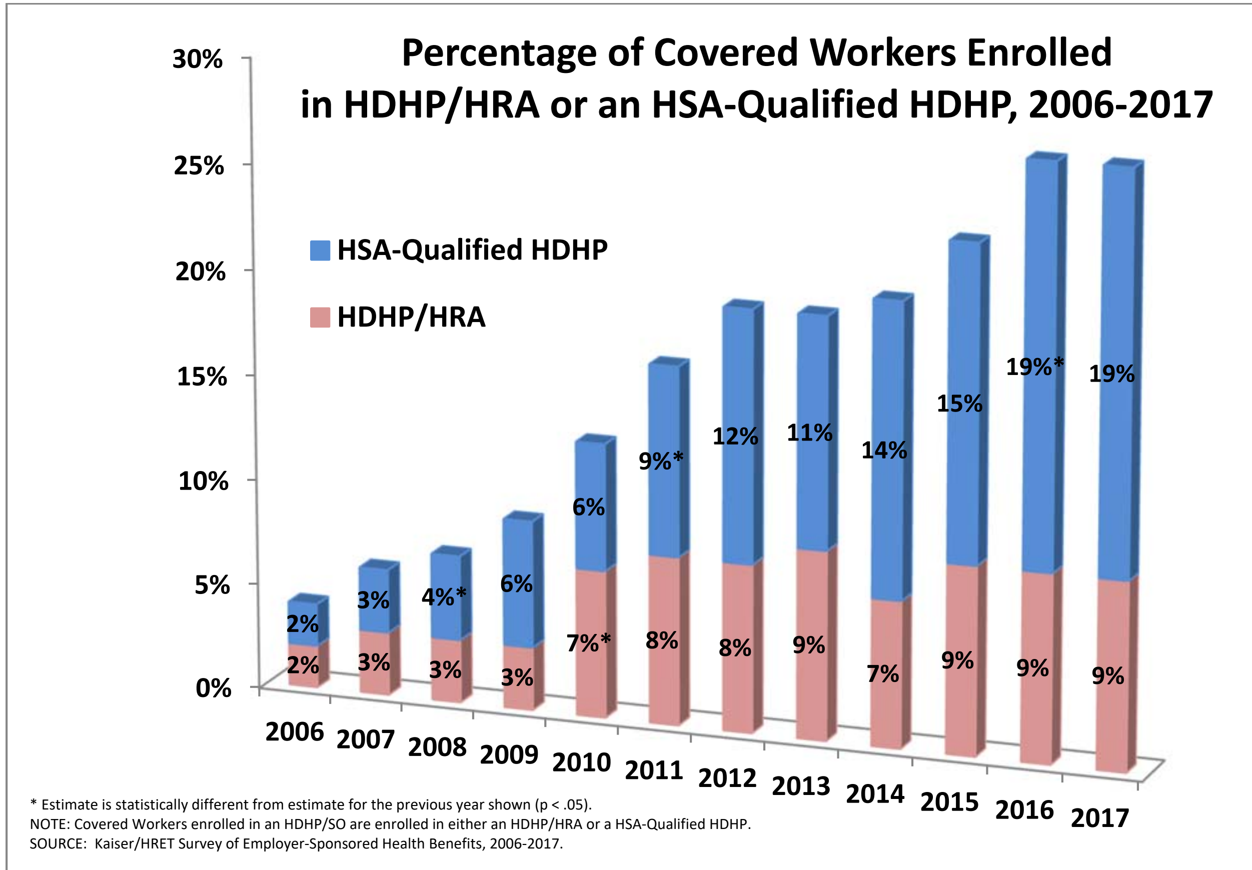

Fig. 1. Percentage of covered employees into HSA-qualified coverage has steadily increased since their introduction.

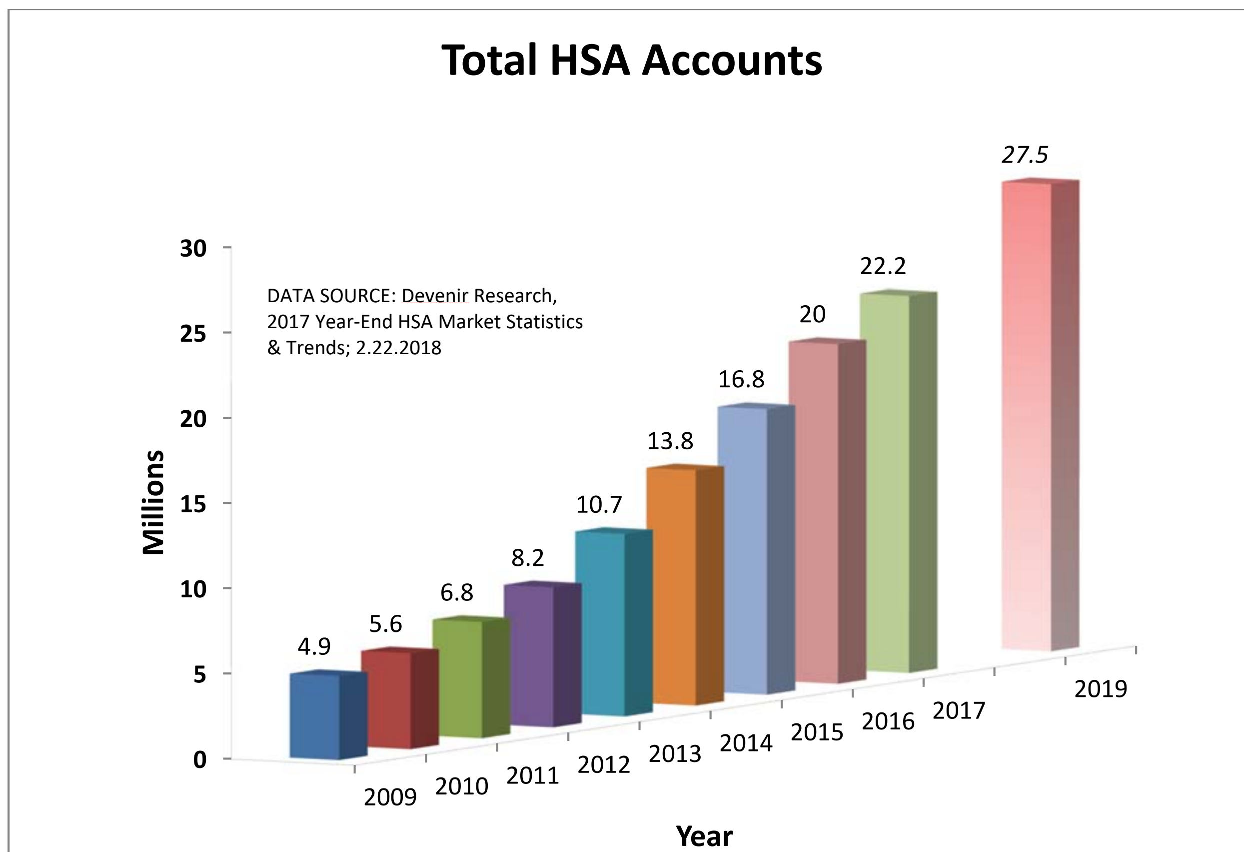

Fig. 2. Enrollment into HSAs has steadily increased since their introduction (2019 is Devenir projection).

HSAs with high deductible coverage have already proven to be a highly effective instrument to reduce health care prices and help individuals buy affordable insurance. A March, 2015 study confirmed previous strong evidence that health spending is significantly reduced for those in such plans. Spending reductions averaged 15% annually[6] and increased with the level of the deductible and when paired with HSAs. In Haviland's 2011 study, adding HSAs to high-deductible plans correlated to an increased savings of from 5.5 percent to 14.1 percent, or 50 percent to more than double the savings of high-deductible plans alone. More than one-third of the savings by enrollees in that study reflected lower costs per health care event, i.e. value-based decision-making by consumers[7]. In other words, prices mattered. These reductions in health care spending occurred without harmful impacts, like increases in emergency room visits or hospitalizations, and without any greater impact on economically vulnerable families[8].

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[6] Do "Consumer-Directed" Health Plans Bend the Cost Curve Over Time?; A Haviland et al, NBER Working Paper No. 21031, March 2015; http://www.nber.org/papers/w21031

[7] Haviland AM, Sood N, McDevitt RD, and Marquis MS. The effects of consumer-directed health plans on episodes of health care. Forum for Health Economics and Policy, 2011;14(2):1-27; http://www.rand.org/pubs/external_publications/EP201100208.html

[8] Haviland, A., N. Sood, R. McDevitt, and S.M. Marquis 2011. "How Do Consumer Directed Health Plans Affect Vulnerable Populations." Forum for Health Economics & Policy. 2011;14(2) (Online): 1558-9544.

When people have savings to protect in HSAs, the cost of care comes down without harmful impact on health.

Consumer-empowering shifts toward widespread HSAs and higher deductible coverage reduce prices and broaden access to quality care - the main goal of health system reforms in the first place – and these shifts should be accelerated. Downward pressure on health care prices from competing for patients who pay directly for care has been clearly demonstrated by medical procedures originally not covered by insurance. For instance, prices rapidly and dramatically decreased when patients paid out-of-pocket for LASIK corrective vision surgery and MRI or CT screening. Published evidence from MRI[9] and outpatient surgery[10] confirms that when patients are motivated to compare prices, prices come down by almost twenty percent. While price reductions are particularly visible to high deductible plan holders with HSAs, the downward pressure on prices from these instruments *reduces prices for all health care consumers*. Annual health expenditures would fall by an estimated $57 billion if only half of those Americans with employer-sponsored insurance enrolled in such consumer-directed plans[11]. Savings would increase further if deductibles were truly high, rather than simply meeting the outdated definition of $1,000 used in those estimates, and if high deductible plans were freed from excessive, costly mandates. Total annual savings from these reforms could approach $200 billion.

Note that premiums of high-deductible catastrophic coverage are lower than premiums of so-called comprehensive coverage because of the anticipated lower costs of covering the medical care under the plan. However, my analysis of Employer Health Benefits Annual Survey data[12] (see Fig. 2 below) shows that premiums for HDHPs rose from two to five times faster than premium increases of any other type of coverage after ACA passage.

[9] S-J Wu, G Sylwestrzak, C Shah and A DeVries; Price transparency for MRIs increased use of less costly providers and triggered provider competition; Health Affairs 2014;33:1391-1398; http://content.healthaffairs.org/content/33/8/1391.abstract
[10] JC Robinson, T Brown and C Whaley; Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery; Health Affairs 2015;34:415-422, http://content.healthaffairs.org/content/34/3/415.abstract
[11] Haviland, A., M.S. Marquis, R.D. McDevitt, and N. Sood. 2012. "Growth of Consumer Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 billion Annually." Health Affairs 31(5): 1009-15 (http://content.healthaffairs.org/content/31/5/1009.full)
[12] Kaiser Family Foundation Employer Health Benefits Annual Survey Archives; https://www.kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/

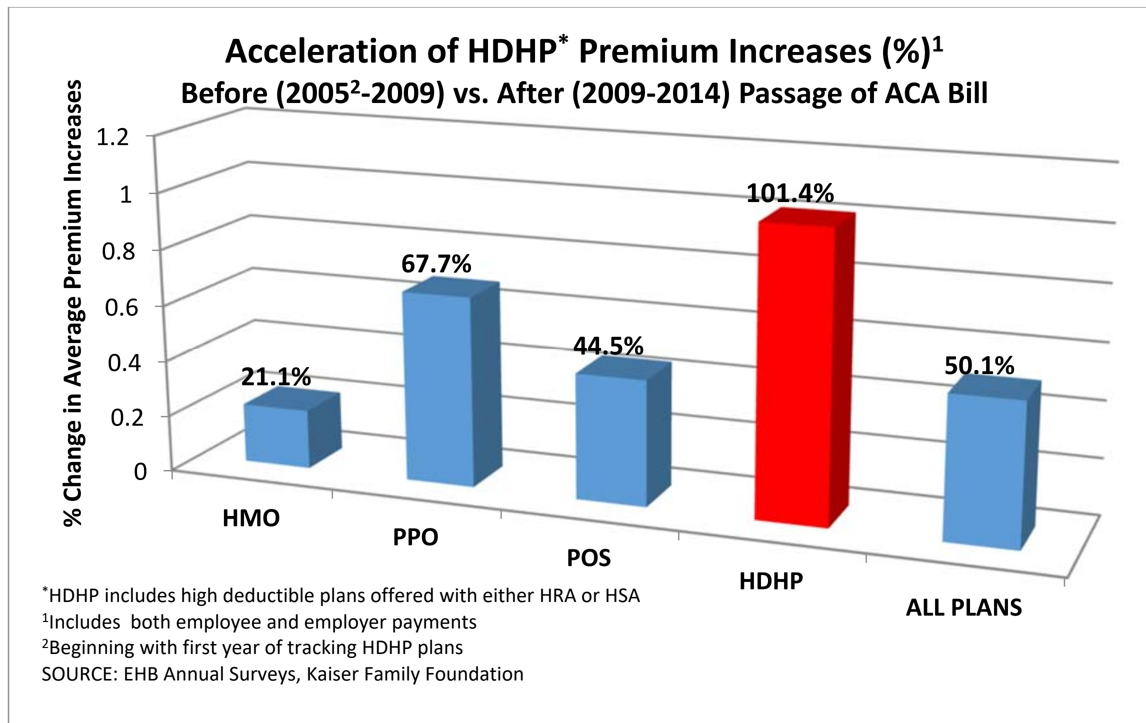

Fig. 2. ACA regulations have accelerated the increase in premiums of high deductible plans more than any other type of coverage.

The factors by which the ACA contributed to rising premiums in high deductible plans must be eliminated. Excess mandated coverage that made HDHP insurance more expensive should be rolled back, including the ACA's "essential benefits" that increased premiums by 10 percent[13] and the 2,270 state coverage mandates for everything from acupuncture to marriage therapy. To make HDHPs even more affordable, we should remove the ACA's 3:1 age rating that raised premiums for younger enrollees by 19 percent to 35 percent,[14] many of whom would buy lower premium coverage.

The issue is not whether HSAs are effective in making health care more affordable for everyone; it is how to maximize their adoption and fully leverage their power.

It is essential that HSAs are made available to all Americans, perhaps even automatically opened for every citizen with a social security number or at birth. All HSAs should be fully owned and controlled by individuals, eliminating more restrictive variants that are tied to specific employers. To maximize

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[13] EF Haislmaier and D Gonshorowski, "Responding to *King v. Burwell*: Congress's First Step Should Be to Remove Costly Mandates Driving Up Premiums" (Heritage Foundation Issue Brief 4400, May 2015), http://www.heritage.org/research/reports/2015/05/responding-to-king-v-burwell-congresss-first-step-should-be-to-remove-costly-mandates-driving-up-premiums.

[14] JT O'Connor, "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," *Milliman Reports*, April 25, 2013, http://ahip.org/MillimanReportACA2013/.

consumer leverage on prices and thereby broaden access to affordable, quality care for everyone, the current ban on full HSA participation by all seniors on Medicare should be abolished. Given that seniors are the biggest users of health care, motivating them to seek value is a crucial part of exerting downward pressure on health care prices. Nearly 4 million Americans reach age 65 every year and live 25% longer now than in 1972[15]. Today's seniors need to save money for decades, not years, of future health care. The expected tripling of health expenses for a 65-year-old by 2030 makes HSAs even more important[16]. Presently, HSA participation is quite restricted for seniors. Seniors who have applied for or accepted Social Security cannot contribute to an HSA. Restricted accounts called "Medicare Advantage MSAs" are currently available but require enrollment in a high-deductible MA health plan. Among other restrictions, deposits into these MSAs are prohibited except from Medicare itself and are limited in amount to typically less than half of the required deductible of the accompanying coverage.

HSA limits should be expanded by liberalizing maximum allowable contributions (and catch-up contributions for persons in their 50s) to, for example, equal those of total annual out-of-pocket limits for ACA Marketplace plans (for 2018, $7,350 for individuals and $14,700 for families). Restrictions on HSA uses should be eased, most importantly for the expenses of the HSA holder's elderly parents. And the list of allowable health care services and products that can be purchased with HSA funds should be expanded to include, for instance, over-the-counter drugs without need for doctor's prescription, and home health care devices.

Beyond broadening their maximums and their uses, several other reforms are important in order to achieve the desired impact of HSAs on health care availability and quality for everyone. This means ensuring stronger incentives are in place to motivate value-seeking by patients. HSAs should never expire or be forfeited due to an arbitrary "use it or lose it" deadline. On the death of the owner, HSAs are currently deemed taxable unless the beneficiary is the spouse. This should change, so that tax-sheltered rollovers would be allowed to all surviving family members, not just spouses.

HSAs should be de-linked from specific insurance deductible requirements (i.e., in defining "HSA-qualified plans"). The requirement of owning coverage with government-specified deductibles in order to open an HSA is counterproductive, as it limits the use, and therefore the power, of HSAs. It also eliminates the possibility of HSAs with other, more tailored plans that could cover necessary care subject to a lower deductible, especially for chronically ill people. We should modify the insurance exchange regulations to allow everyone, regardless of age or employer, the option of high deductible plans with the same liberalized rules on HSAs. The only requirement for making contributions to the reformed HSA should be that the enrollee at least has active catastrophic insurance coverage, without any specified deductible. Eliminating those requirements would help more families save for out-of-pocket expenses and broaden consumer power.

HSAs have also been a valuable vehicle through which a growing number of employers offer wellness programs and medical screenings, including such tests as blood pressure, body mass index, and

[15] JM Ortman, VA Velkoff, and H Hogan; An Aging Nation: The Older Population in the United States: Population Estimates and Projection; Current Population Reports; May 2014 P25-1140

[16] Actuarial data from HealthView using historical claim data and projections, June 2011

cholesterol. In 2015, 96.7 percent of employers offered lifestyle programs,[17] increasing from 73 percent in 2011 and 57 percent in 2009. More than one-third of firms offering wellness programs include financial incentives to participants, including lower insurance premiums, reduced cost sharing, and higher employer contributions to individual HSAs.[18] Consumers have demonstrated the efficacy of smoking cessation and obesity interventions, including cash financial incentives. Significant gains in productivity, marked reductions in health claims, improvement of chronic illnesses, and major cost savings have resulted and have benefited both participant employees and their employers.[19] Medical costs and absentee day costs fall by about three to six dollars for every dollar spent on wellness programs.[20] The ACA limits the financial incentives from employers, including cash deposits into employee HSAs, to 30 percent of the cost of that employee's health coverage. Abolishing that limit would expand these powerful motivators for employees, encouraging employees to participate in more wellness programs already proven to improve health and reduce health costs.

HSAs could also transform Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance, with equal access to doctors, specialists, treatments, and medical technology as the general population, instead of shunting poor Americans into a parallel second-class system with worse health outcomes and far less access to care. A reformed Medicaid would establish and seed fund HSAs and provide an option for limited-mandate, high deductible private insurance with currently budgeted federal dollars. States should not only be encouraged to allow Medicaid enrollees to opt for HSA contributions; federal funding could be contingent on states meeting certain enrollment thresholds into limited-mandate coverage and HSAs. It would give control of the health care dollar to low-income families to foster provider competition for that money. HSAs would provide new incentives for lower-income families to seek good health through wellness programs and healthy behavior in order to save and protect their new, growing financial assets. These reforms would change the purpose and culture of Medicaid agency offices from running special government-administered Medicaid plans to establishing HSAs and finding private, low cost health plans for beneficiaries.

Below is a summary table comparing the proposed expanded, liberalized HSA to current HSAs:

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[17] National Business Group on Health, "Taking Action to Improve Employee Health: Results from the Sixth Annual Employer-Sponsored Health and Well-being Survey," March 25, 2015, https://www.businessgrouphealth.org/pub/29d50202-782b-cb6e-2763-a29a9426f589.
[18] Kaiser Foundation and Heath Research and Educational Trust, "2014 Employer Health Benefits Survey, Section 12: Wellness Programs and Risk Assessments," September 2014, http://kff.org/report-section/ehbs-2014-section-twelve-wellness-programs-and-health-risk-assessments/.
[19] L. L. Berry et al., "What's the Hard Return on Employee Wellness Programs?" *Harvard Business Review*, December 2010, https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs.
[20] K. Baicker et al., "Workplace Wellness Programs Can Generate Savings," *Health Affairs* 29 (2010): 304–11.

Criterion	Current HSA	New HSA
General eligibility	Must meet specific requirements	Universal for all citizens; automatically opened at birth
Insurance requirement to contribute to HSA	High deductible coverage (deductible level specified by federal government)	Catastrophic coverage (no other specific requirement; no specified deductible range)
Limits on maximum contribution per year (e.g., 2018)	$3,450 (individual) $6,900 (family)	$7,350 (individual) $14,700 (family)
Uses of HSA funds	Not for non-prescription drugs other than insulin	• OTC drugs, home health products are eligible without need for MD Rx • Usable for elderly parents
Tax deductibility	Contributions and withdrawals deductible	Contributions and withdrawals deductible
Eligibility if enrolled in Medicaid	Not eligible without exemption	Eligible
Eligibility if enrolled in Medicare	Not eligible	Eligible
Eligibility if receiving Social Security?	Not eligible	Eligible
Special Medicare Advantage MSAs	List of restrictions limiting contribution levels, contribution sources, others	Full conversion to standard HSA; no special limits or restrictions
Penalty for ineligible withdrawals	20% penalty (plus taxation)	50% penalty (plus taxation)
Uses for insurance premiums (seniors only)	Can reimburse for money withheld from SS to pay Medicare Part B (e.g. $104.90/mo for 2015); Can make tax-free HSA withdrawals for Medicare Part D, MA premiums (not medigap).	Allowed for all premiums
Seniors and ineligible withdrawals	After age 65, taxation	After age 70, 20% penalty
Transfers into HSAs from retirement accounts	Not allowed	Allowed without penalty for seniors
Tax treatment to beneficiary on death of HSA holder	If spouse, tax-free rollover into HSA; otherwise, taxable income	If any family member, tax-free rollover into HSA

2) Introduce the right incentives into the tax code to maximize the use and benefit of HSAs.

The tax code plays an important role in realigning consumer incentives to fund HSAs and leverage downward pressure on health care prices. Beyond the numbers ($275 billion in 2016, according to CBO[21]), the unlimited income exclusion for health expenses created harmful, counterproductive incentives. It encouraged higher demand for care, regardless of cost, while distorting insurance into

[21] From Options for Reducing the Deficit: Reduce Tax Preferences for Employment-Based Health Insurance; Congressional Budget Office. https://www.cbo.gov/budget-options/2016/52246

covering almost all services. Similarly, insurance premium subsidies in the ACA and the tax credits proposed by the GOP artificially prop up high insurance premiums for bloated coverage that minimizes out-of-pocket payment. This prevents patients from caring about price, eliminating the incentives for doctors and hospitals to compete on price.

Presuming that health care deductions or income exclusions are maintained, the tax code should cap amounts, and it should also limit eligibility for deductions or exclusions to two categories of health-related expenses: 1) HSA contributions, and 2) catastrophic coverage premiums (*note*: the definition of "high deductible, catastrophic coverage" is based on 75 percent of the new maximum allowable HSA contribution. For example, to qualify as a high deductible plan for 2018, during which the allowable HSA contribution will be $7,350, the definition of high deductible would equal $5,512.50. This linkage ensures that the HSA contribution maximum will always be higher than covering just the deductible). It would be counterproductive to allow a tax preference for "comprehensive" insurance, because low deductible, heavily mandated plans hide the costs of covered care—that is a fundamental cause of lack of access and rising costs for everyone. Tax deductions for all health care spending are also counterproductive, because they give an incentive to spend more money on health care; in other words, there is an opportunity cost if you spend money on something other than health care because the money is worth more when spent on health care. This tax reform would eliminate that misincentive. Instead, the new incentive is to put money into an HSA and then seek value when buying health care; the opportunity cost is when it is spent, because it could be saved and then grow by investment (or later be bequeathed to the account owner's survivors). The tax revenue decrease from the anticipated HSA expansion would be offset by the new limits on income exclusions.

Note that the tax exclusion or deduction for significantly expanded HSA contributions will increase everyone's savings, including the middle class and the poor, by lower priced medical care and more affordable insurance coverage. And while limiting the health expense exclusion/deduction would reduce the employer benefit, the truth is that to a large extent employees pay for their benefits by receiving lower wages than they would have otherwise been paid. Employment benefits, including health care benefits, replace wages. Over time, employees will instead receive higher wages and more take-home pay as employers are forced to compete with higher wages to attract labor. Ultimately, the cost of insurance premiums and medical care will be reduced by this plan more than the tax benefit for health spending that has distorted the market for health care.

3) Strategically increase the supply of medical care to stimulate competition and increase choices for value-seeking patients.

The supply of medical care must be significantly yet strategically increased, so patients have more options to seek out the best value for their money. In large part, this means removing archaic anti-consumer barriers to competition among medical care providers, health care technology, and drugs.

To improve access to affordable, quality primary care, we need to simplify the credentialing requirements and remove outmoded scope-of-practice limits on qualified nurse practitioners and physician assistants. Private clinics staffed by NPs and PAs can provide cheaper primary care, including

vaccinations, blood pressure monitoring, treating simple infections, and dispensing common drugs. In a 2011 review, 88% of visits to retail clinics involved simple care[22]; care was 30–40% cheaper[23] than at physician offices and about 80% cheaper than at emergency departments; and patients reported high levels of satisfaction[24].

Medical school graduation numbers have stagnated for almost 40 years, despite widely recognized doctor shortages. Increasing specialist supply is also critical, since almost two-thirds of the 2025 projected doctor shortage of 124,000 will be in specialists[25]. We should eliminate archaic non-reciprocal licensing by states in favor of national MD licensing. This unnecessarily limits specialist competition, especially as telemedicine proliferates. Severe specialist and subspecialist training program restrictions have been in place for decades. These anti-consumer practices need to be open to public scrutiny and abolished.

We should also eradicate archaic barriers to medical technology and prescription drugs that impede competition and raise prices. Although originally intended to "restrain health care facility costs", the certificate-of-need (CON) requirements[26] are another example of overregulation with unintended consequences, and are still in place in 34 states, Puerto Rico, and the District of Columbia. High drug prices are a conundrum: the same policies that are associated with the lower prices seen in other countries—price regulation and weaker patent rights—are also those that are generally associated with delayed launches and reduced access to drugs[27]. But we also see an extraordinary lack of price transparency for drugs, fueled by complex behind-the-scenes rebates[28] totaling $179 billion in 2016 from companies to pharmacy benefit managers (PBM), the government, and insurance that prevents any possible price consideration by patients. Worse, many PBMs contractually prohibit pharmacists from volunteering that a medication may be less expensive if purchased at the cash price with contractual gag clauses, according to a 2016 survey[29] of over 600 community pharmacies. And newly published data[30] revealed that well over 20% of patient co-pays (while using insurance) exceeded actual total drug costs if patients paid by cash without insurance. The hidden truth is that prices vary tremendously between drug stores for the same exact drug, yet patients are not sufficiently incentivized

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[22] Ashwood JS, Reid RO, Setodji CM, Weber E, Gaynor M, Mehrotra A. Trends in Retail Clinic Use Among The Commercially Insured. *The American journal of managed care*. 2011;17(11):e443-e448.
[23] Mehrotra A, Liu H, Adams J, et al. The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings. *Annals of internal medicine*. 2009;151(5):321-328.
[24] Weinick, Robin M., Craig Pollack, Michael P. Fisher, Emily M. Gillen, and Ateev Mehrotra, Policy Implications of the Use of Retail Clinics. Santa Monica, CA: RAND Corporation, 2010. https://www.rand.org/pubs/technical_reports/TR810.html.
[25] The Complexities of Physician Supply and Demand: Projections Through 2025 Michael J. Dill and Edward S. Salsberg Center for Workforce Studies November 2008; AAMC
[26] CON-Certificate of Need State Laws - 8/25/2016; National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx
[27] Cockburn I, Lanjouw JO and Schankerman M (2016) Patents and the global diffusion of new drugs. American Economic Review, 106 (01). pp. 136-164.
[28] Credit Suisse, 18 April 2017 Americas/United States/Europe Equity Research Pharmaceuticals & Biotechnology, "Global Pharma and Biotech"
[29] National Community Pharmacists Association News Release, Pharmacists Survey: Prescription Drug Costs Skewed by Fees on Pharmacies, Patients, Jun 28, 2016
[30] Van Nuys K, Joyce G, Ribero R, Goldman DP. Frequency and Magnitude of Co-payments Exceeding Prescription Drug Costs. *JAMA* 2018;319(10):1045–1047. doi:10.1001/jama.2018.0102

to alter buying patterns. In a December 2017 Consumer Reports study[31], the national average price for a one-month supply of five common generics ranged by a *factor of 20* between different retailers for a given drug. Even in a single city, the 30-day supply price showed a *10-fold to 17-fold* variation per drug. For the nearly 40 million seniors taking five or more medications daily, the savings from price comparison shopping could be many hundreds of dollars per month. Eliminating excess regulatory barriers to the supply of drugs, coupled with expanded HSAs empowering patients to compare prices, would reduce prices by competition. That pathway would help optimize value without hampering the unique access to drug treatment enjoyed by American patients.

Conclusions

From the evidence, we can conclude that expanded, liberalized, and transferable HSAs represent a key instrument in an overall strategy of broadening access to affordable, high quality health care for everyone. If appropriately designed, HSAs represent a strong incentive to consider price and value for those seeking medical care. HSAs offer more effective incentives than tax deductions for health expenses. HSAs have been proven to reduce the cost of medical care for individuals, and also to improve health by increasing the use of validated wellness programs. While expanded HSAs alone are not necessarily a panacea, they are a critically important and effective step.

In other countries, governments hold down health care costs mainly by limiting the use of medical care, drugs, and technology, through its power over patients and doctors as the single payer. And those countries get the expected results: long waits and worse medical outcomes, particularly for the poor, who are unable to circumvent those systems.

We should consider a different approach[32] – creating appropriate incentives and eliminating harmful regulations to reduce prices, so that high quality care is affordable for everyone. Broadly available options for cheaper, limited mandate, high deductible coverage; markedly expanded HSAs; and targeted tax incentives to leverage consumer power are keys to injecting price sensitivity for health care. Coupling those with strategic increases in the supply of medical care would generate competition and reduce the price of health care, expanding access to quality care for everyone.

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[31] "Shop Around for Lower Drug Prices", Consumer Reports, April 5, 2018; https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/

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