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Who's Afraid of Personal Responsibility?
Health Savings Accounts and the Future of
American Health Care

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Abstract

This article examines the recent enactment of Health Savings Accounts (HSA) as they might affect how Americans obtain coverage for their health care expenses and the role that personal responsibility will play in that process. It explains the historical development of this country's tying health insurance to current employment status and especially the role of tax policy in that phenomenon. After considering the advantages and disadvantages of this approach, the article analyzes the key elements of the 2003 legislation that created HSAs. This part examines the "high deductible" insurance plan that must accompany an HSA, including its limit on out-of-pocket expenditures and the scope of additional insurance permitted. The operation of the HSA itself is then addressed, including the relationship of employer and employee contributions into such accounts, the tax treatment of distributions from these accounts, and what happens to unused balances. The article then assesses the likely impact of HSAs according to five C's: complexity of possible configurations, confusion over self-administration, choice of alternative arrangements, control, and cost of health care. The article concludes that HSAs represent a potentially paradigmatic shift in how Americans view health care costs and align a growing appetite for individual control over this critical employee benefit with today's workplace realities.

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I. INTRODUCTION

Five months ago, a major health maintenance organization (“HMO”) was notified by the State of Illinois that it would not be a health plan option for state employees in the upcoming plan year.¹ Affected by this decision were not only the doctors, nurses, support staff, and clerical workers of the HMO in question, but also some 90,000 state workers and retirees.² These current and former employees would need to switch to one of the other health plan options, in some cases ending doctor-patient relationships that had existed for two or three decades or longer.

What precipitated this dramatic turn of events was not some outpouring of dissatisfaction with this specific HMO. Rather, the State of Illinois, in its role as employer, had asked for bids from various health care provider organizations, and this particular bid came in higher than the State wanted to pay.³ The rejection of this bid, moreover, resulted in an essentially all-or-nothing situation. That is, the affected employees were not told that their employer (i.e., the State) would pay x dollars toward their existing coverage, or x percentage of the cost, and they would have to pay the additional cost if they wanted to remain with their current plan. Instead, this HMO would no longer be an available option, period.

1. Debra Pressey, *State Changing HMO Plan*, NEWS-GAZETTE, Apr. 27, 2004, at A-1.

2. *Id.*

3. Kate Clements, *Lawmakers Address Switch in Coverage*, NEWS-GAZETTE, Apr. 29, 2004, at A-1 (quoting the spokeswoman for the Governor’s Bureau of the Budget stating that the decision “was done 100 percent by the book and done so in a way to get the best . . . pricing for our taxpayers . . .”).

To be sure, employees could opt for a so-called indemnity plan instead of the HMO alternative.⁴ Under that arrangement, the affected employees would continue to use the same physicians and other health care providers as they had done so previously. But most employees would face higher out-of-pocket costs,⁵ in some cases substantially higher costs, by choosing this option. The only way to avoid such costs was to switch to a different HMO, thereby changing their doctors, hospitals, and pharmacies.

What is so scary about this situation is that it is playing out throughout the country every day, usually with less media attention, but with the same consequences for everyone involved. Indeed, what is scariest about this situation is that this scenario of contract review and possible nonrenewal is precisely how the system is *supposed* to work! That is, the employer uses the threat of nonrenewal to force health care providers to compete on the basis of cost and to seek competitive advantage by pricing their services below their competitors. Such threats, of course, can be effective only if they are occasionally carried out. The possibly horrific consequences for the affected employees are simply part of the process of controlling health care costs.

Why this is the case is the subject of this Article. The next Part explains where Americans get their health insurance and how unique the United States is among developed economies in its reliance on employers for this critical societal function. Then, the Article considers the advantages and disadvantages of an employment-based health care financing system. The Article then explains the impact of tax policy on this system and the problems that necessarily spring from its design. The Article then analyzes the health savings accounts that were created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.⁶ The final Part examines the planning and policy implications of these accounts and offers some observations about their likely impact on how Americans will finance their health care needs in the future.

II. SOURCES OF HEALTH CARE COVERAGE

In most other developed countries, citizens receive health care as a matter of right,⁷ financed through some combination of user fees, such as co-payments and premiums, and universal charges, typically payroll taxes. For certain portions of the U.S. population, that description holds true as well. For example, Americans aged sixty-five years and older or who are disabled receive most of their health

4. Pressey, *supra* note 1, at A-1.

5. *Id.*

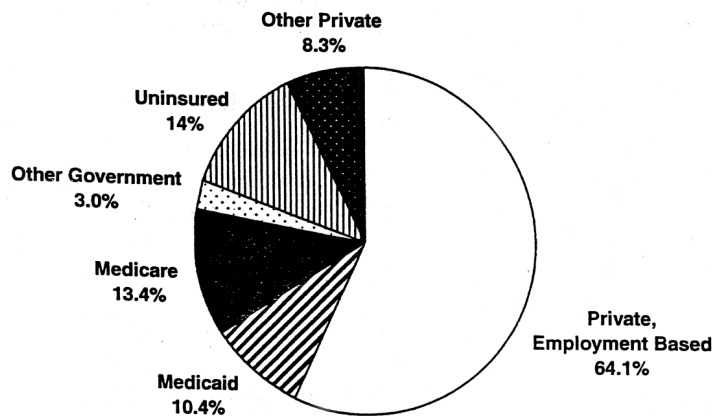
6. Pub. L. No. 108-173, § 1201(a), 117 Stat. 2066, 2469-76.

7. See, e.g., Charles Fleming, *Europeans Face Health Cuts*, WALL ST. J., Nov. 17, 2003, at A18 (stating that “the tenet underpinning most European systems is that, no matter the cost, health coverage is a public right and key to a cohesive society”).

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insurance from Medicare, a program of the federal government.⁸ Medicare is financed by a 2.9% tax on all earned income that is received throughout a person's work life,⁹ in addition to monthly premiums of \$66.60 (in 2004)¹⁰ paid by enrollees, and general income tax revenues. Moreover, persons of any age who satisfy certain poverty criteria receive their health insurance from Medicaid, a joint undertaking of the federal and state governments. This program is financed from general tax revenues of the contributing governments.

But as this graph shows, nearly two out of three Americans receive their health insurance through their employers as a feature, or benefit, of their employment.¹¹



If one disregards those Americans who have no health insurance and those Americans who are covered by Medicare, employment-based insurance accounts for 88% of all Americans with health insurance.¹² Moreover, a recent Value of Benefit Survey revealed that 60% of workers rate health insurance as the single most important employee benefit,¹³ easily outdistancing the next most popular

8. See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 57-102 (3d ed. 2003).

9. This tax is collected half (i.e., 1.45%) from the employee and half from the employer. I.R.C. §§ 3101(b)(6), 3111(b)(6) (2000).

10. Medicare, The Official U.S. Government Site for Medicare Information, at http://medicare.custhelp.com/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=144 (last visited Nov. 11, 2004) (copy on file with the *McGeorge Law Review*).

11. Kathleen McGarry, *Public Policy and the U.S. Health Insurance Market: Direct and Indirect Provision of Insurance*, 55 NAT'L TAX J. 789, 791 (2002). This percentage varies by ethnic group, from a low of 44.6% for Hispanics to a high of 69.5% for Caucasians. *Id.* at 793.

12. Computed by author using data in previous footnote.

13. Rachel Christensen, *Value of Benefits Constant in a Changing World: Findings from the 2001 EBRI/MGA Value of Benefits Survey*, EMP. BEN. RES. INST. NOTES, Mar. 2002, at 1-2.

choice, a retirement savings plan.¹⁴ This survey was conducted *before* the Enron implosion and other corporate debacles diminished the allure of stock market oriented retirement programs. In other words, most Americans look to their jobs for health insurance and regard this feature of their employment as extremely important.

A. *Variation by Employer Size*

Notwithstanding these realities, employment in America increasingly does not assure an employee of having health insurance. Smaller employers in particular tend to offer health insurance to their employees less frequently than do their larger counterparts.¹⁵ The following chart¹⁶ depicts the percentage of workers in firms of specified sizes with no health insurance:

<u>Number of Employees</u>	<u>Percentage</u>
1,000 or more	9.8
500-999	11.9
100-499	13.0
25-99	18.7
10-24	25.6
Fewer than 10	31.4

An important survey of small employers found that “[f]irms that do not offer health benefits also tend to have larger proportions of females, workers under age 30, and minority employees.”¹⁷ Perhaps even more significant is the finding that worker compensation at firms without health benefits is “considerably lower” than compensation at firms that offer such benefits.¹⁸

Small employers that provide health benefits typically cite the same sound business reasons that larger employers give for doing so: providing health benefits aids employee recruitment, increases employee loyalty, decreases turnover, and increases productivity.¹⁹ Fully 77% of employers in the survey said that offering health insurance “is the right thing to do.”²⁰ Most smaller employers that do not provide health benefits believe that the absence of these benefits has no effect on their business,²¹ but these same employers report higher turnover of

14. *Id.* at 2 (selected by 23%).

15. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*, EMP. BEN. RES. INST. BRIEF NO. 264 (Dec. 2003), at 9.

16. Derived from data in Paul Fronstin, *Uninsured Up in 2001, Number With Job-Based Health Benefits Declines*, EMP. BEN. RES. INST. NOTES, Nov. 2002, at 1, 3.

17. Paul Fronstin & Ruth Helman, *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey*, EMP. BEN. RES. INST. BRIEF NO. 253 (Jan. 2003), at 10-11.

18. *Id.* at 10.

19. *Id.* at 6-7.

20. *Id.* at 7.

21. *Id.*

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workers.²² In any case, as more Americans work for smaller employers, the likelihood that they will have health insurance diminishes. The ill-fated Health Security Act²³ that was promoted by the Clinton Administration would have mandated that employers provide health insurance for their employees, but the disastrous experience of that proposal makes another attempt in that direction unlikely.²⁴

B. Variation by Employment Sector

Furthermore, the likelihood of having employer-provided health insurance varies by the general sector of the economy in which an employee works. The following chart²⁵ depicts the percentage of workers with employment health benefits in 2002, the most recent year for which data is available:

<u>Employment Sector</u>	<u>Percentage</u>
Government	73.2
Manufacturing	69.4
Wholesale and retail	52.7
Personal services	43.2
Agricultural, fishing, mining	41.7

The U.S. economy continues to evolve with fewer jobs in manufacturing and more jobs in personal services. This structural shift necessarily diminishes the likelihood that an employee will have access to employer-provided health insurance.

III. EMPLOYER-SPONSORED HEALTH INSURANCE

As the preceding section has shown, most Americans of pre-retirement age receive whatever health insurance they have through their employer. Such employment-based arrangements have several important advantages and disadvantages, as highlighted in this Part.

22. *Id.* at 8.

23. H.R. 3600, S. 1757, 103d Cong. (1993).

24. See Michael J. Graetz, *Mandating Employer Health Coverage: The Big Mistake*, 60 TAX NOTES 1765 (1993). But see Michael Selz, *Small Firms' Argument on Health Mandates Questioned*, WALL ST. J., Aug. 29, 1994, at B2. See generally THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* 158-59 (1995).

25. Derived from Paul Fronstin, *The Impact on Employment-Based Health Benefits of the Shift from a Manufacturing Economy to a Service Economy*, EMP. BEN. RES. INST. NOTES, June 2004, at 1-5.

A. *Advantages of Employer-Sponsored Health Plans*

There are three major advantages of obtaining health insurance through one's employment: guaranteed acceptance, convenience of enrollment, and lower distribution and administration costs. Income tax advantages will be considered in the next Part of this Article.²⁶

1. *Guaranteed Acceptance*

Most employer-based health plans are group insurance policies that cover all workers without regard to their individual medical profile. Dependent coverage for family members is frequently available as well, though these dependents may be subject to medical underwriting or coverage limitations that are determined by their pre-existing medical conditions.

2. *Convenience of Enrollment*

The convenience of payroll deduction enables workers to pay this important expense automatically, without any affirmative effort on their part. The risk that health insurance might lapse because of nonpayment of premiums, therefore, is virtually nil—an extremely important consideration for such vital coverage. Employer-sponsored health insurance, in other words, employs the power of inertia in *support* of an employee's best interests.

3. *Costs of Distribution and Administration*

Economies of scale translate into lower overall costs compared to individually obtained insurance policies. Lower costs of educating prospective purchasers and ensuring collection of premiums are just two aspects of this enhanced distribution mechanism. Although overhead costs for employer-sponsored health insurance plans vary by size of employer, they are generally lower than for individually purchased health insurance policies.²⁷

B. *Disadvantages of Employer-Sponsored Health Plans*

Employment-based health insurance has two major disadvantages: employer control of plan design, and loss of coverage when employment ceases.

26. See *infra* Part IV.

27. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 31 (2001).

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1. Employer Control of Plan Design

As the episode that began this Article demonstrated, employer-sponsored health insurance puts the employer in control of many critical plan decisions—from whether to have a plan at all, to the scope of the plan's coverage, the health care provider networks to use, the level of premiums to be paid by employees, and the deductibles and co-payments that the plan will have. In other words, many extremely important features of health insurance are determined by the employer that pays the bills rather than the employees who receive the services. It would be extremely unusual for the decisions made by an employer to accord with the choices that a diverse workforce would make if the individual employees could make their own selections and trade-offs. Indeed, that was the most poignant aspect of the vignette that began this Article: many—perhaps most—of the affected employees would have been willing to pay some additional amount to maintain the health plan they currently had, but that was not a choice that was offered. In point of fact, half of all employees with employer-sponsored health insurance are not offered a choice of health insurance arrangements.²⁸ They get what the *employer* selects.

2. Loss of Coverage When Employment Ceases

A major drawback of employer-sponsored health insurance is the inevitable linkage of health coverage with employment. Lose the latter, and you lose the former as well. As a result, the economic setback that is caused when employment terminates can quickly degenerate into a financial catastrophe when the worker—and his or her family—lose health insurance. In other developed countries, the loss of one's employment does not produce this double whammy.

A federal statute does mandate the availability of continuation coverage,²⁹ but this protection has several significant caveats. Continuation coverage is limited to only eighteen months.³⁰ A terminated employee may have found new employment by that point, but there is no guarantee that the new employment will include employer-sponsored health insurance, or that the new coverage will be as comprehensive as the insurance that the previous employer provided.

In any case, the cost of continuation coverage is borne *entirely* by the terminated employee,³¹ without the subsidy that employers typically provide. The resulting cost to the ex-employee can be staggeringly high—as much as

28. *Id.* at 27.

29. 29 U.S.C.A. §§ 1161(a), 1162(1) (2003). See generally Paul Fronstin, *Health Insurance Portability: COBRA Expansions and Job Mobility*, EMP. BEN. RES. INST. BRIEF NO. 194 (Feb. 1998).

30. 29 U.S.C.A. §§ 1162(2)(A)(i), 1163(2). This eighteen-month limitation does not apply if the employer files for bankruptcy. *Id.* §§ 1162(2)(A)(iii), 1163(6).

31. *Id.* §§ 1162(3)(A), 1164(1).

ten times the pre-termination cost or more.³² Given the context of a person who is not employed, paying the increased cost of this insurance can be prohibitive. Little wonder, then, that only one in five individuals who are eligible for continuation coverage actually obtains it.³³

Individually purchased health insurance is usually not much of an option either. Such policies can be more expensive than continuation coverage, and these policies may even be completely unavailable because of the former employee's medical conditions.³⁴ In other words, loss of the guaranteed-acceptance feature of employer-based health insurance can be a significant problem. The bottom line is that in an employment-based health insurance system, the loss of one's job seriously jeopardizes a person's access to health insurance.

IV. TAX POLICY AND HEALTH INSURANCE

The preceding Part analyzed some of the positive and negative features of a system wherein most employees obtain coverage of health care costs through their employers. This Part examines an independent factor that substantially undergirds this system—namely, tax policy. This Part first explains the history and context of tax policy's role in employer-provided health insurance and then considers some of the unintended consequences of this role.

A. Tax Exclusion of Health Insurance Benefits

Section 106 of the Internal Revenue Code provides that “gross income of an employee does not include employer-provided coverage under an accident or health plan.”³⁵ Unlike many other sections of the tax code, this exclusion is remarkably free of limitations, caps, and phase-outs that are based on an employee's total income or other factors.³⁶ As a result, an employer can provide whatever health insurance it chooses without including *any* of the attendant costs of that insurance in the employee's income. A similar exclusion applies to the employee's payroll tax obligation for Social Security and Medicare contributions.³⁷ Indeed, the exclusion of health benefits from the payroll tax is an

32. See INSURE.COM, KNOW YOUR COBRA RIGHTS, available at <http://www.insure.com/health/cobra.html> (last modified Nov. 29, 2001) (copy on file with the *McGeorge Law Review*).

33. KAISER COMM'N ON MEDICAID & THE UNINSURED: COBRA COVERAGE FOR LOW-INCOME UNEMPLOYED WORKERS I (2001), available at <http://www.kff.org/content/2001/10252001/4021.pdf> (last visited Feb. 11, 2002) (copy on file with the *McGeorge Law Review*).

34. See COUNCIL OF ECON. ADVISORS, REACHING THE UNINSURED: ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS 2-3 (2000).

35. I.R.C. § 106(a) (West 2000).

36. Cf. *id.* § 221(b)(1), (2) (fixed dollar limit and income-based phase-out for deductions of student loan interest expense).

37. *Id.* §§ 3101(a)-(b), 3121(a)(2).

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even bigger benefit than the exclusion from the income tax for the two out of three workers who typically owe more in payroll taxes than in income taxes.³⁸

These employee-level exclusions are then bolstered by an income tax deduction at the employer level. That is, employers may deduct the cost of the health insurance that they provide from their own federal income tax base³⁹ and from the computation of their own payroll tax obligations.⁴⁰ As a result, the tax code provides an enormous subsidy for employer-sponsored health insurance: employers deduct the premiums, but employees do not report the benefit of these premiums as income.

The size of this subsidy is truly gargantuan. The most careful estimate of the foregone tax revenue in 2004 reveals the following figures:⁴¹

<u>Exclusion</u>	<u>Billions(\$)</u>
Federal income tax	114.7
Social Security taxes	52.2
Medicare taxes	14.2
State income taxes	<u>21.4</u>
Total	<u>\$202.5</u>

Indeed, the revenue cost relating to health insurance provided by employers is the single largest tax exclusion, deduction, or credit in the federal government's compilation of such provisions, usually called the "tax expenditure budget."⁴² This single item outranks the revenue cost of employer-provided pensions, the special treatment of long-term capital gains, or home mortgage interest.⁴³ Because most of the states that impose an income tax use the federal tax code's definition of "income," this exclusion for employer-provided health insurance reduces state tax receipts as well.⁴⁴

38. JOEL SLEMROD & JON BAKIJA, *TAXING OURSELVES: A CITIZEN'S GUIDE TO THE DEBATE OVER TAXES* 51 (3d ed. 2004).

39. I.R.C. § 162(a)(1) (West 2000).

40. *Id.* §§ 3111(a), (b), 3121(a)(2).

41. See John Shells & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, HEALTH AFFAIRS, Feb. 25, 2004, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1>, at W4-109 (copy on file with the *McGeorge Law Review*).

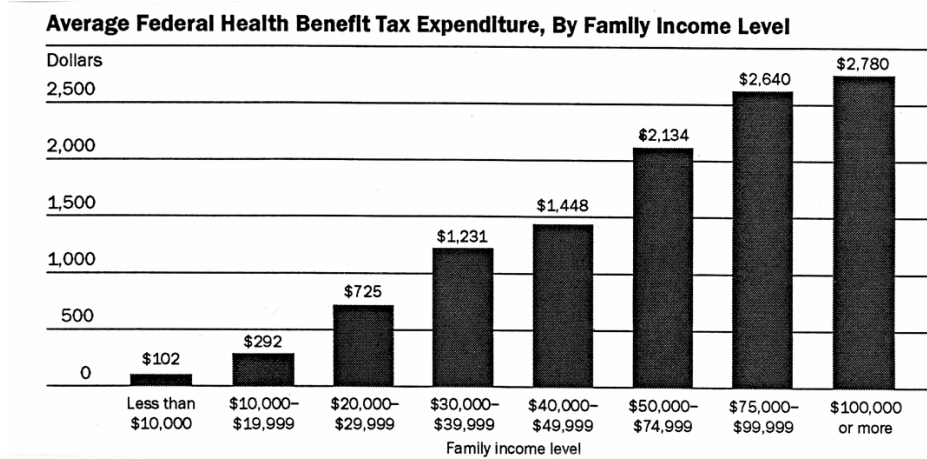
42. See JOINT COMM. ON TAX'N, *ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2004-2008* (JCS-8-03, 27 (2003)).

43. *Id.* at 22-23, 27-28.

44. See 2 JEROME R. HELLERSTEIN & WALTER HELLERSTEIN, *STATE TAXATION* ¶ 20.02, at 20-4 (3d ed. 2002) ("The overwhelming majority of . . . states with broad-based income taxes employ federal adjusted gross income as the computational starting point . . ."); see also 2 ALL STATES TAX GUIDE (RIA) ¶ 3112, at 3057 (Dec. 14, 1993) (listing states that use federal income in determining their tax base).

The distribution of the benefits from this highly favorable tax treatment, moreover, is a function of the individual employee's income. That is, excluding a \$6,000 annual premium for employer-provided health insurance from the income of an executive in the 35% tax bracket reduces that person's income tax liability by \$2,100, while the same exclusion for an office worker in the 15% tax bracket saves only \$900 in taxes. This simple example does not consider the additional savings from excluding the premium from the employee's payroll taxes or from that person's state income taxes, but the point remains the same: a tax-based exclusion necessarily benefits upper-income recipients more than lower-income recipients.

The following chart⁴⁵ displays the relationship of family income to the federal tax benefit that is obtained by excluding health insurance premiums from a recipient's taxable income:



In fact, 26.7% of the federal tax benefit pertains to the 14% of the population with annual family incomes of \$100,000 or more.⁴⁶ As a result, a peculiar federal policy has resulted—subsidize health insurance generally but provide the greatest subsidy to the most economically advantaged.

45. Shells & Haught, *supra* note 41, at W4-109.

46. *Id.* at W4-110.

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The combination of an employer-level deduction and an employee-level exclusion makes employer-provided health insurance even *more* attractive than compensation in the form of wages and salaries. Such compensation is also deductible by the employer paying these funds,⁴⁷ but wages and salaries are included in the recipient's income for purposes of the federal income tax,⁴⁸ the Social Security and Medicare payroll tax,⁴⁹ and for most state income taxes as well. Thus, tax policy actually creates a situation wherein many employees will prefer expanded health benefits in lieu of additional wage compensation, and the employer is basically indifferent between these two alternatives because both expenditures are tax-deductible.

This wages-vs.-health-benefits trade-off was the source of employer-provided health insurance originally. As described in a history of health insurance benefits, “[w]hen wages were frozen by the National War Labor Board [during World War II] and a shortage of workers occurred, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option.”⁵⁰ An important ruling by the Internal Revenue Service in 1943 bolstered this strategy by stating that employees were not required to pay tax on the value of health insurance premiums that their employers paid on their behalf.⁵¹ This ruling was then codified by Congress in 1954 when it enacted the code section quoted at the beginning of this Part ⁵². Thus, tax policy has not only subsidized employer-sponsored health insurance, but it has also *avored* such insurance over direct compensation of employees.

B. Consequences of the Tax Treatment of Health Insurance

The preferential tax treatment of employer-sponsored health insurance that was described above has produced two important consequences: over-insurance and over-utilization of health services.

1. Over-Insurance

As long as an employee anticipates having medical expenses, that person is better off with less wage compensation and more comprehensive health insurance. For example, assume that Janet has a choice of two employer-provided health insurance plans: Plan A covers all health costs after Janet pays for \$500 of medical expenses in a given year; Plan B has no annual deductible.

47. I.R.C. § 162(a)(1) (West 2000).

48. *Id.* § 61(a)(1).

49. *Id.* § 3121(a).

50. *History of Health Insurance Benefits*, FACTS FROM EBRI (Employment Benefit Research Institute, Washington D.C.), Mar. 2002, at 1.

51. Special Rule, 433 STANDARD FED. TAX SERV. (CCH), ¶ 6587.

52. I.R.C. § 106 (West 2000).

Further assume that Janet’s employer will increase her salary by \$500 per year if she chooses Plan A. Finally, assume that the employer’s cost for the two health insurance plans differs by the amount of annual deductible—say \$4,500 for Plan A and \$5,000 for Plan B.

Under these facts, the employer’s pre-tax costs are the same regardless of Janet’s choice. If Janet chooses Plan A, the employer will increase her salary by \$500 and will pay \$4,500 for Janet’s health insurance - a total of \$5,000. This is the same cost to the employer as the Plan B insurance policy. Moreover, the employer can deduct the entire \$5,000 in either case.⁵³

For Janet, however, there is a major difference in these two alternatives. If Janet is in the 25% federal income tax bracket and lives in a state with a 5% income tax, she will owe the following taxes on her additional compensation of \$500:

Federal income tax	\$125.00
Payroll taxes ⁵⁴	76.50
State income tax ⁵⁵	<u>25.00</u>
	<u>\$226.50</u>

Thus, Janet will have an after-tax income of only \$273.50 and will still be obligated to pay the first \$500 of medical expenses that she incurs, a potential net loss of \$226.50. In contrast, if Janet chooses Plan B, she will owe no taxes on the additional \$500 of value that is represented by the no-deductible health insurance policy,⁵⁶ and she will not be obligated for any of her medical expenses.

Given this situation, Janet has every incentive to choose the most comprehensive medical insurance policy that is offered, even preferring first-dollar coverage to a comparable increase in her salary. As a result, Janet will opt to over-insure in order to use insurance to cover routine and readily predictable expenses, not just unusual or unanticipated medical costs. In an automotive context, this situation is comparable to buying insurance for the cost of oil changes and tire rotations, as well as the cost of serious accidents. This misuse of insurance artificially inflates the cost of health insurance itself, as deductibles and co-payments are disfavored and more comprehensive policies are preferred.

53. *Id.* § 162(a)(1).

54. This amount includes the employer portion of the Social Security and Medicare payroll taxes, because economists generally treat these costs as being paid ultimately by the employee through lower wages. *See* C. EUGENE STEUERLE & JON M. BAKIJA, *RETOOLING SOCIAL SECURITY FOR THE 21ST CENTURY* 74-75 (1994).

55. For this purpose, the deductibility of state income taxes is ignored because nearly two-thirds of American taxpayers do not “itemize” their deductions and therefore do not receive any federal tax benefit from their state income tax payments. *See* Brian Balkovic, *Individual Income Tax Returns, Preliminary Data, 2002*, STAT. INCOME BULL., Winter 2003-04, 6 (63.7% in 2002).

56. I.R.C. § 106(a) (West 2000).

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2. *Over-Utilization of Health Care*

Having opted for the most comprehensive health insurance policy available, many employees will feel duty-bound to make sure that they get their money's worth by seeking health care for every possible malady and mishap. After all, Janet in the preceding example accepted a lower wage in lieu of more comprehensive health insurance. She therefore wants this trade-off to work out for her benefit. In effect, she has no incentive to economize on health care expenditures. To the contrary, Janet has every incentive to run to the doctor for every minor scrape—a form of “moral hazard” wherein the presence of insurance alters the insured's behavior toward incurring the very expenses that are covered by that insurance. As explained in a 2003 report prepared for the Joint Economic Committee of Congress, “[i]ndividuals with more comprehensive health insurance coverage tend to spend more money on health care. Insurance lowers the net cost of health services at the time a patient decides to purchase care.”⁵⁷

More recently, the Comptroller General of the United States indicated that the tax exclusion of health insurance has “desensitized” workers to the cost of their health care.⁵⁸ He further contended that the tax exclusion has induced demand for health services, thereby raising the cost of health care generally.⁵⁹ An open question remains whether employees might undertake more seriously lifestyle changes that affect their health—for example, stopping smoking, monitoring food intake, exercising more regularly, and avoiding alcohol abuse—if they saw the impact of these behaviors on their health insurance costs. Under present circumstances, the failure to make these changes may increase their medical expenses, but individual employees do not pay these costs in any way that they can see.

V. HEALTH SAVINGS ACCOUNTS

As part of the 2003 Medicare legislation, Congress authorized the creation of health savings accounts (“HSA”)⁶⁰ in an effort to try a different approach. This Part examines these accounts, which became effective for the first time in 2004.⁶¹

57. TOM MILLER, HOW THE TAX EXCLUSION SHAPED TODAY'S PRIVATE HEALTH INSURANCE MARKET (Joint Econ. Comm.), Dec. 17, 2003, at 4.

58. Elizabeth White, *GAO Head Urges New Look at Exclusion From Tax of Job-Related Health Coverage*, DAILY TAX REP. (BNA), Apr. 19, 2004 (reporting remarks of David M. Walker).

59. *Id.* See also Jonas Schreyogg, *Demographic Development and Moral Hazard: Health Insurance with Medical Savings Accounts*, 29 GENEVA PAPERS ON RISK AND INS. 689, 691 (2004).

60. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201(a), 117 Stat. 2066, 2469-76 (adding I.R.C. § 223 (West Supp. 2004)).

61. *Id.* § 1201(k).

A. Background and Overview

HSAs did not spring forth out of thin air. The Health Insurance Portability and Accountability Act of 1996⁶² created very similar accounts, called Medical Savings Accounts⁶³ (“MSAs,” later renamed “Archer MSAs”⁶⁴). Both types of accounts combine a tax-favored savings account that is controlled by the employee/account-holder⁶⁵ and a high-deductible health insurance policy.⁶⁶ The operative concept of HSAs and MSAs is the same: the high-deductible insurance plan covers major health expenditures, and the associated savings account can be used to pay for care that is not covered by the insurance plan, including the plan’s annual deductible.⁶⁷ These savings accounts, moreover, are the property of the account-holder, and any funds remaining in the account at the end of the taxable year stay in the account for that person’s use in future years.⁶⁸ The premise behind these accounts is that the account-holder will see that medical expenses paid out of that person’s account reduce his or her economic resources. As a consequence, it is expected, holders of these accounts will be more cautious in purchasing discretionary health care services and will seek out the best price available.⁶⁹ They are, after all, spending their *own* money, not the funds of some impersonal insurance company.

Despite these structural similarities, HSAs and MSAs are not equivalent. Most of the differences are of no concern here, but three major differences should be noted. First, MSAs were established under a statutory provision that had a stipulated termination date.⁷⁰ This termination date was later extended by subsequent legislation, but only for very short periods of time—an additional year or two.⁷¹ More importantly, the concept of a specified termination date was retained. That feature indisputably hampered the acceptance of MSAs, because employers, employees, and insurance companies were understandably reluctant to adopt a radically different approach to health care financing when it appeared

62. Pub. L. No. 104-191, § 301(a), 110 Stat. 1936, 2037-48 (adding I.R.C. § 220 (West 2000)).

63. See I.R.C. § 220 (West 2000).

64. Community Renewal Tax Relief Act of 2000, Pub. L. No. 106-554, Appx. G., § 202, 114 Stat. 2763A-587, 2763A-628 to 2763A-629.

65. I.R.C. §§ 220(d)(1), 223(d)(1) (West 2000).

66. *Id.* §§ 220(c)(2), 223(c)(2).

67. See Nancy Ann Jeffrey, *Medical Savings Accounts Offer Benefits, Risks*, WALL ST. J., May 1, 1996, at C1; Greg Scandlen, *A Guide to Medical Savings Accounts*, WALL ST. J., Sept. 15, 1997, at A22. See generally Joni L. Landy, *Preserving the Tax Advantages of Medical Savings Accounts*, 90 J. TAX’N 161 (1999).

68. I.R.C. §§ 220(d)(1)(E), 223(d)(1)(E) (West 2000); see also Landy, *supra* note 67, at 161.

69. See Scandlen, *supra* note 67, at A22.

70. I.R.C. § 220(i)(1)(A), (2)(A) (West 2000); Working Families Tax Relief Act of 2004, Pub. L. No. 108-311, § 322(a), 118 Stat. 1166, 1183 (two-year extension).

71. Community Renewal Tax Relief Act of 2000, Pub. L. No. 106-554, Appx. G, § 201(a), 114 Stat. 2763A-587, 2763A-628 (two-year extension); Job Creation and Worker Assistance Act of 2002, Pub. L. No. 107-147, § 612(a), 116 Stat. 21, 61 (one-year extension).

that the entire enterprise would vanish within a few short years.⁷² In contrast, HSAs are a *permanent* feature of the tax code, with no automatic termination or “sunset” provision in place. Congress can always change the tax law, of course, but barring such a change, HSAs will continue indefinitely.

Second, MSAs were subject to a national limit on the number of qualifying accounts that could be created.⁷³ This number—750,000—was not tiny, and an elaborate mechanism was created to keep a running tabulation.⁷⁴ In point of fact, the national limit was never exceeded or even approached: only about 80,000 MSAs were ever established.⁷⁵ But the very existence of a national limit, determined cumulatively, acted to depress interest in these accounts and cramped efforts to more broadly fashion payment mechanisms and the associated insurance policies.⁷⁶ In contrast, HSAs are not subject to any overall limit on the number of qualifying accounts that can be created.

Finally, MSAs could be created only for self-employed individuals⁷⁷ and persons who worked for employers with no more than fifty employees.⁷⁸ Ameliorative rules softened the full impact of the fifty-employees rule,⁷⁹ but the need to monitor this limitation and its exceptions further restricted the number of persons who might be interested in establishing an MSA. The HSA rules have no comparable restrictions on eligibility.

B. The “High Deductible” Insurance Plan

An essential component of the HSA arrangement is that the account-holder must be covered by a “high deductible health plan”⁸⁰ and by *only* such a plan.⁸¹ The precise parameters of such plans are not delineated, but certain key parameters are stipulated. They involve the plan’s annual deductible, its limit on out-of-pocket expenses, and the scope of covered services.

72. See also George Anders, *Medical Savings Accounts Are Proving a Tough Sell*, WALL ST. J., May 22, 1997, at A16 (noting that the sales commissions on high-deductible insurance policies associated with MSAs are lower than commissions on conventional health insurance policies because those policies are typically more expensive; as a result, insurance agents are less inclined to promote MSAs).

73. I.R.C. § 220(j)(2)(A)(ii) (West 2004).

74. See *id.* § 220(j); I.R.S. Notice 96-53, 1996-2 C.B. 219, 221-22 (Q&A 24 - QA 29).

75. Announcement 2002-90, 2002-2 C.B. 684 (78,913 MSAs).

76. See Gwen Moulton, *State Laws, Cap on Policies May Thwart Participation in MSA Demonstration Project*, DAILY TAX REP. (BNA), Sept. 13, 1996, at J-1.

77. I.R.C. §§ 220(c)(1)(A)(iii)(II), 401(c)(1)(B) (West 2000).

78. *Id.* § 220(c)(1)(A)(iii)(I), (4)(A).

79. *Id.* § 220(c)(4)(B), (C)(i), (C)(iii).

80. I.R.C. § 223(c)(1)(A)(i) (*enacted by Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Pub. L. No. 108-173, § 1201(a), 117 Stat. 2066, 2469-76) [hereinafter MPDIMA].

81. *Id.* § 223(c)(1)(A)(ii).

1. *Minimum Annual Deductible*

A qualifying “high deductible health plan” must have an annual deductible of *at least* \$1,000 for a single person (so-called “self-only coverage”)⁸² or \$2,000 for a family.⁸³ A plan’s deductible may be much higher than these minimums, subject to the out-of-pocket limits that will be discussed below. But the point is that the insurance plan that is associated with a HSA must have a deductible that is no less than \$1,000 for self-only coverage or \$2,000 for family coverage.

This deductible need not apply, however, to “preventive care.”⁸⁴ Such care can be covered with a lower deductible, or even none at all. In April 2004, the Internal Revenue Service released a nonexclusive list⁸⁵ of what constitutes “preventive care,” including the following:

- periodic health evaluations, including diagnostic procedures
- routine prenatal and well-child care
- immunizations
- tobacco cessation programs
- obesity weight-loss programs

A much longer list⁸⁶ of screening services were included as well, covering tests for such maladies, among others, as:

- cancer of the breast, cervix, prostate, colon, skin, and ovaries
- heart and vascular diseases
- sexually transmitted diseases
- substance abuse and suicide
- periodontal disease
- metabolic conditions, including diabetes
- glaucoma and hearing impairment

Thus, many typical medical procedures need not be subject to the health insurance plan’s relatively high annual deductible.

82. *Id.* § 223(c)(2)(A)(i)(I). This amount will be indexed for inflation after 2004. *See id.* §§ 1(f)(3), 223(g)(1)(B)(ii).

83. *See id.* 223(c)(2)(A)(i)(II). This amount will be indexed for inflation after 2004. *See id.* §§ 1(f)(3), 223(g)(1)(B)(ii).

84. *Id.* § 223(c)(2)(C).

85. I.R.S. Notice 2004-23, 2004-15 I.R.B. 725.

86. *Id.* 726-27.

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2. Maximum Limit on Out-of-Pocket Expenditures

A qualifying health insurance plan must also limit the out-of-pocket expenses of the insured to *no more than* \$5,000 for self-only coverage,⁸⁷ or \$10,000 for family coverage.⁸⁸ A plan can offer varying levels of co-payments or other cost-sharing arrangements, but this limit on out-of-pocket expenses, other than premiums for the insurance plan itself,⁸⁹ must apply. Lower limits are allowable, subject to the minimum annual deductibles that were considered above. But the point is that the insurance plan that is associated with a HSA must limit an insured's out-of-pocket expenses to a maximum of \$5,000 for self-only coverage or \$10,000 for family coverage.

For example, assume that Kevin has a policy with a 20% co-payment feature, and his medical expenses this year were \$3,000. If the policy has a \$1,000 annual deductible, Kevin pays the first \$1,000 and 20% of the remaining \$2,000 (\$3,000 of expenses less the \$1,000 annual deductible), or \$400. His total out-of-pocket expenses, therefore, are \$1,400 (\$1,000 annual deductible plus \$400 co-payment obligation). If the policy had an out-of-pocket expense limit of, say \$4,000, he would reach this limit once his medical costs exceeded \$16,000.⁹⁰ All of Kevin's medical expenses above this amount would be covered by the insurance plan.

There are, however, two important exceptions. First, higher out-of-pocket expense limits are allowable for medical services that are received from outside the health insurance plan's network of providers.⁹¹ Second, a policy may impose a "reasonable lifetime limit" on benefits,⁹² and the Service has indicated that a \$1,000,000 cap meets this standard.⁹³

87. I.R.C. § 223(c)(2)(A)(ii)(I) (West 2004) (*enacted by MPDIMA, supra note 80, § 1201(a)*). This amount will be indexed for inflation after 2004. *See Id.* §§ 1(f)(3), 223(g)(1)(B)(ii).

88. *Id.* § 223(c)(2)(A)(ii)(II) (West 2004) (*enacted by MPDIMA, supra note 80, § 1201(a)*). This amount will be indexed for inflation after 2004. *See Id.* §§ 1(f)(3), 223(g)(1)(B)(iii).

89. *Id.* § 223(c)(2)(A)(ii) (parenthetical clause).

90. This amount is computed as follows:

Policy's out-of-pocket limit	\$4,000
Annual deductible	<u>(1,000)</u>
Co-payment of obligation	\$3,000
Divided by co-payment	<u>.20</u>
Costs subject to co-payment	\$15,000
Annual deductible	<u>\$1,000</u>
Medical costs to reach cap	<u>\$16,000</u>

91. I.R.C. § 223(c)(2)(D)(i) (West 2004). Similarly, expenses that exceed "usual, customary, and reasonable amounts" need not be considered in applying a policy's limit on out-of-pocket expenses. I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, 199-200 (Q&A 16).

92. I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, 199 (Q&A 14).

93. *Id.*

3. Other Permitted Health Insurance

A person with a HSA must have a qualifying “high deductible health plan” and no other form of health insurance.⁹⁴ Neither tax law nor health law seem capable of articulating a requirement without providing exceptions, so some specific types of health insurance are allowed notwithstanding this putative limitation. That is, certain types of health insurance do not jeopardize an insured’s ability to have a HSA—namely, disability, dental, vision, or long-term care insurance;⁹⁵ plans that cover specified diseases⁹⁶ (e.g., cancer insurance); and plans that pay a fixed amount for each hospital day.⁹⁷ Also allowed are health benefits from plans that primarily insure property,⁹⁸ with automobile accident insurance being the most typical example.

C. Operation of the HSA Itself

The tax code imposes significant limitations on the HSAs themselves in three areas: how much can be contributed to the accounts, what expenses may be paid out of the accounts, and what happens to unused balances in the accounts.

1. Contributions to a HSA

Contributions to a HSA by a person’s employer are excludible from that person’s income for purposes of computing income⁹⁹ and employment taxes.¹⁰⁰ A person may also contribute his or her own funds to a HSA,¹⁰¹ in which case those contributions are deductible in deriving that person’s “adjusted gross income.”¹⁰² This tax treatment is far more favorable than that accorded medical expenses generally.¹⁰³ Those expenses, after all, are deducted only by the minority of taxpayers¹⁰⁴ who claim so-called “itemized deductions”¹⁰⁵ and even then, only to

94. I.R.C. § 223(c)(1)(A) (West 2004). For this purpose, an employer-sponsored “wellness program” is not a form of health insurance. I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, 199 (Q&A 10, Ex. (3)).

95. I.R.C. § 223(c)(1)(B)(ii) (West 2004).

96. *Id.* § 223(c)(1)(B)(i), (3)(B).

97. *Id.* § 223(c)(1)(B)(i), (3)(C).

98. *Id.* § 223(c)(1)(B)(i), (3)(A)(iii).

99. *Id.* § 106(d)(1) (enacted by MPDIMA, *supra* note 80, § 1201(d)(1)).

100. *Id.* §§ 3231(e)(11), 3306(b)(18), 3401(a)(22) (enacted by MPDIMA, *supra* note 80, § 1201(d)(2)(A)-(C)).

101. *Id.* § 223(a).

102. *Id.* § 62(a)(19) (enacted by MPDIMA, *supra* note 80, § 1201(b)). The phrase “adjusted gross income” refers to a person’s total income minus the deductions that are listed in section 62(a). *See generally* BORIS I. BITTKER ET AL., FEDERAL INCOME TAXATION OF INDIVIDUALS ¶ 2.01[3] (3d ed. 2002).

103. I.R.C. § 213(a) (West 2004).

104. *Supra* note 55.

105. I.R.C. §§ 63(d)(1), 62(a)(1)-(19), 213(a) (West 2004); *see also* BITTKER ET AL., *supra* note 102, ¶ 26.1.

the extent that those expenses exceed 7.5% of the taxpayer's "adjusted gross income."¹⁰⁶ This tax treatment of HSA contributions, in other words, is more akin to that of employer-provided health insurance, premiums for which are excluded from an employee's income without regard to the amount of deductions that are being claimed or the level of the taxpayer's income.¹⁰⁷

HSA contributions are subject, however, to an overall limitation, whether they come from the employer or from the employee.¹⁰⁸ This limitation is the *lesser*¹⁰⁹ of: (1) the annual deductible of the "high deductible health plan" that is associated with the HSA,¹¹⁰ or (2) a limit that is adjusted annually for inflation.¹¹¹ In 2004, that limit is \$2,600 for self-only coverage and \$5,150 for family coverage.¹¹² So, if Eric obtains a "high deductible health plan" with an annual deductible of \$2,500, he can contribute this amount to his HSA because it is less than this year's contribution limit of \$2,600. On the other hand, if Charlene purchases a family insurance plan with an annual deductible of \$6,000, the most that she can contribute to her HSA is \$5,150 because this year's family limit (i.e., \$5,150) is less than her insurance policy's \$6,000 annual deductible.

As is apparently always the case, there is an exception to the rule: persons who are aged fifty-five years or older by the end of the year may make additional contributions.¹¹³ The amount of this so-called "catch-up" contribution starts at \$500 for 2004 and increases by \$100 per year thereafter, until it reaches \$1,000 in 2009.¹¹⁴ On the other hand, any person who is entitled to Medicare benefits—which generally means someone who is sixty-five years of age or older¹¹⁵—may not make *any* contribution to a HSA,¹¹⁶ either regular or "catch-up."

2. Distributions from a HSA

Funds held by a HSA may be invested until they are needed to pay the account-holder's medical expenses. Any interest income, dividends, and capital gains thus realized by the HSA are free of income tax while they remain in the HSA.¹¹⁷ Moreover, funds that are withdrawn to pay "qualified medical expenses"

106. I.R.C. § 213(a) (West 2004).

107. *Id.* § 106(a).

108. *Id.* § 223(b)(4)(B).

109. *Id.* § 223(b)(2)(A), (B).

110. *Id.* § 223(b)(2)(A)(i), (B)(i).

111. *Id.* § 223(b)(2)(A)(ii), (B)(ii), (g)(1)(B)(i).

112. I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 270 (Q&A 12).

113. I.R.C. § 223(b)(3)(A) (West 2004).

114. *Id.* § 223(b)(3)(B).

115. See FROLIK & KAPLAN, *supra* note 8, at 58-61.

116. I.R.C. § 223(b)(7) (West 2004). *But see* I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, 198 (Q&A 2) (a person who is eligible for Medicare benefits but who has not enrolled in that program is not "entitled" to such benefits and may therefore contribute to a HSA).

117. I.R.C. § 223(e)(1) (West 2004).

are not taxed when they are withdrawn.¹¹⁸ Only withdrawals that are used for purposes other than to pay medical costs are subject to income tax.¹¹⁹ Such nonmedical distributions, however, are also subject to an *additional* tax of 10%,¹²⁰ unless those distributions occur upon the death or disability of the account-holder,¹²¹ or when that person attains sixty-five years of age.¹²²

The pivotal issue, therefore, is what constitutes “qualified medical expenses.” Generally, any expenditure that would be deductible as a “medical expense” under Internal Revenue Code Section 213(d) qualifies for this purpose.¹²³ This definition is quite extensive and even includes transportation that is undertaken primarily for medical care¹²⁴ and lodging “while away from home” to obtain such care.¹²⁵ Prescription drugs¹²⁶ and nonprescription drugs¹²⁷ alike qualify. Moreover, any medical costs that are not paid by the “high deductible health plan” because of that plan’s annual deductible or co-payment provisions can be paid with distributions from the HSA.¹²⁸

Such distributions may not, however, be used to buy supplemental health insurance beyond the “high deductible health plan.”¹²⁹ Certain types of insurance are excepted from this prohibition, including long-term care insurance¹³⁰ and enrollee premiums for Medicare coverage.¹³¹ So-called “medigap” insurance¹³² is not included in this exception,¹³³ so HSA funds may not be used to pay for such policies.

3. Unused HSA Balances

As noted above, distributions from a HSA are tax-free to the extent of “qualified medical expenses.”¹³⁴ But what if the HSA has a balance remaining in the account after all qualifying medical costs have been paid? This balance

118. *Id.* § 223(f)(1).

119. *Id.* § 223(f)(2).

120. *Id.* § 223(f)(4)(A).

121. *Id.* §§ 223(f)(4)(B), 72(m)(7).

122. *Id.* § 223(f)(4)(C).

123. *Id.* § 223(d)(2)(A).

124. *Id.* § 213(d)(1)(B).

125. *Id.* § 213(d)(2).

126. *Id.* § 213(d)(3).

127. *See* Rev. Rul. 2003-102, 2003-38 I.R.B. 559; I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 272 (Q&A 26).

128. *See* Sarah Lueck, *Medicare Law Reaches The Under-65 Set, Too*, WALL ST. J., Dec. 16, 2003, at D1.

129. I.R.C. § 223(d)(2)(B) (West 2004).

130. *Id.* § 223(d)(2)(C)(ii); *see generally* FROLIK & KAPLAN, *supra* note 8, at 134-49.

131. I.R.C. § 223(d)(2)(C)(iv); (West 2004) I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 272 (Q&A 27).

132. *See generally* FROLIK & KAPLAN, *supra* note 8, at 90-96.

133. *Supra* note 129.

134. I.R.C. § 223(f)(1) (West 2004).

simply carries forward and remains available for the account-holder's use in a subsequent year.¹³⁵ This feature applies, moreover, even if the account-holder is eligible for Medicare¹³⁶ in that subsequent year and is therefore not eligible to make new contributions to his or her HSA.¹³⁷ And distributions remain tax-free as long as they are used to pay for "qualified medical expenses."

Should an account-holder die with a balance remaining in the HSA, the tax consequences depend upon who inherits the HSA balance. If the new owner is the surviving spouse of the account-holder, the HSA becomes the HSA of that person,¹³⁸ and all of the other HSA provisions apply without change. But if anyone other than the account-holder's surviving spouse succeeds to the HSA, that account loses its status as a HSA,¹³⁹ and the balance in the account is included in that person's taxable income.¹⁴⁰ In other words, a HSA is intended to cover medical expenses of the person who establishes the account, and possibly that person's spouse, but otherwise it gets no special tax treatment.

VI. PLANNING AND POLICY ANALYSIS OF HSAS

This Part examines some of the planning considerations that HSAs present for employees and employers, as well as related issues of public policy. This analysis proceeds through five C's: Complexity-Confusion, Control-Choice, and finally, the Cost of health care.

A. Complexity and Confusion

The basic concept of HSAs is fairly straightforward: pair a high-deductible health insurance policy with a dedicated discretionary account. But as the preceding part of this article suggested, the actual implementation of this concept can be quite involved.¹⁴¹ There are three major sources of HSA complexity and resulting employee confusion: the range of packages available, compliance and administration of the accounts themselves, and difficulties in considering alternative arrangements.

135. See Lueck, *supra* note 128, at D1.

136. I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 272 (Q&A 28).

137. I.R.C. § 223(b)(7) (West 2004).

138. *Id.* § 223(f)(8)(A). This treatment applies only if the surviving spouse receives the HSA as that account's "designated beneficiary." *Id.*

139. *Id.* § 223(f)(8)(B)(i)(I).

140. *Id.* § 223(f)(8)(B)(i)(II). If the new owner is not the account-holder's estate, the amount taxed is reduced by "qualified medical expenses" incurred by the account-holder that were paid within one year after that person died. *Id.* § 223(f)(8)(B)(ii)(I).

141. See Todd F. Maynes & Thomas L. Evans, *A Guide to Health Savings Accounts and a Plea for Practicality*, 102 TAX NOTES 775 (2004).

1. Possible Configurations

The key parameters of HSAs provide bounded but still fairly wide flexibility in shaping the exact dimensions of these arrangements, with the result that very different packages can emerge. Analysis of HSAs, therefore, necessarily depends to a great extent on the precise contours of the HSAs that are established. For example, the health insurance policies associated with HSAs must have a deductible of at least \$1,000 for self-only coverage¹⁴² and a limit on out-of-pocket expenses of no more than \$5,000.¹⁴³ Thus, the deductible on these policies could be as low as \$1,000 or as high as \$5,000—an enormous range. The annual contribution to the HSA, moreover, is a *maximum* of either the policy's actual deductible¹⁴⁴ or \$2,600 (in 2004),¹⁴⁵ whichever is lower.¹⁴⁶ The actual contribution might be less than this limit, in some cases substantially less. Indeed, an employer is not required to contribute to an employee's HSA at all.

Employees may make their own contributions, of course, to these accounts, either as supplements to their employer's contributions or as substitutes for those contributions, subject to the overall limits that were set forth above.¹⁴⁷ The ability and willingness of employees to make such contributions, however, will vary considerably, depending upon an individual employee's anticipated health costs and financial situation, including that person's marginal tax rate. That is, employee contributions to an HSA are deductible from that person's taxable income,¹⁴⁸ but this provision provides only minimal incentive to fund a HSA for the three-quarters of American workers whose marginal tax rate is 15% or less.¹⁴⁹ The simple reality is that a \$2,000 contribution to a HSA lowers a person's tax liability by only \$200 to an employee in the 10% tax bracket. In contrast, that same contribution lowers an executive's tax liability by \$700 if that person is in the 35% tax bracket. Accordingly, the ability of employees to fund their own HSAs will have very different effects across the economic spectrum of affected individuals.

142. I.R.C. § 223(c)(2)(A)(i)(I) (West 2004).

143. *Id.* § 223(c)(A)(ii)(I).

144. *Id.* § 223(b)(2)(A)(i).

145. I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 270 (Q&A 12).

146. I.R.C. § 223(b)(2)(A) (West 2004).

147. *Id.* § 223(b)(4)(B).

148. *Id.* § 223(a).

149. See EDWIN PARK ET AL., HEALTH SAVINGS SECURITY ACCOUNTS: A COSTLY TAX CUT THAT COULD WEAKEN EMPLOYER-BASED HEALTH INSURANCE 4 (2003), available at <http://www.cbpp.org> (last visited July 9, 2003).

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Be that as it may, a few examples of possible combinations of insurance plan deductibles and HSA contributions will illustrate the range of alternative packages that are available under the HSA regime:

<u>Scenario</u>	<u>Deductible</u>	<u>HSA Contribution</u>
A	\$1,000	\$1,000
B	\$2,500	\$2,500
C	\$5,000	\$2,600
D	\$5,000	\$500

In scenario A and B, the HSA contribution fully matches the deductible of the associated insurance policy, and the employee should have little financial exposure. Of course, if the HSA contributions actually came from the employee, in whole or in part, those contributions already represent a financial cost borne by the employee. But if those HSA contributions came entirely from the employer, the employee might actually have *less* financial exposure to health care costs than under a more conventional health insurance policy with a “low” annual deductible of, say \$250, for example.

In contrast, scenarios C and D posit significant financial exposure to the employee, even if the HSA contributions came entirely from the employer. The health insurance policies in these scenarios are a bit extreme, to be sure, but they fall within the stipulated HSA parameters.¹⁵⁰ These policies would pay for no costs until an employee's costs reached \$5,000 on an annual basis; thereafter, they would cover *all* costs because the \$5,000 limit on out-of-pocket expenses would already be in effect. In scenario C, the HSA has been funded to the legal maximum, but it still falls far short of closing the gap that is created by the insurance policy's high deductible. And in scenario D, that gap is even larger. More possible combinations could be fashioned, but the point would remain the same: there is no stipulated relationship between the associated insurance policy's deductible and the HSA's actual contribution. Therefore, an employee's financial exposure with a HSA is dependent upon the parameters of the specific package that he or she confronts—a fact that complicates analysis of HSAs considerably. Just a quick comparison of scenarios A and D precludes any easy generalizations about the benefits and burdens of HSAs.

150. See I.R.C. § 223(c)(2)(A)(i)(I), (ii)(I) (West 2004).

2. Compliance and Administration

Once a HSA is established, withdrawals may be made free of any tax to pay for “qualified medical expenses,”¹⁵¹ as noted previously. Funds that are used for any other purpose are included in the account-holder’s taxable income,¹⁵² however, and further subjected to an additional tax of 10% in most cases.¹⁵³ As a result, the tax consequences of withdrawing funds from a HSA can range from zero to 45%,¹⁵⁴ or even higher in some cases.¹⁵⁵ With such a dramatic difference at stake, it is important that someone monitor how HSA withdrawals are in fact used.

HSAs are established as trusts,¹⁵⁶ and the trustee can be a bank, an insurance company, or some other institution that will administer the account appropriately.¹⁵⁷ The Internal Revenue Service has indicated, however, that the responsibility for assuring that HSA distributions are used exclusively to pay medical costs lies not with the HSA’s trustee or custodian,¹⁵⁸ or even with the employer.¹⁵⁹ That decision leaves only one person left to do this important task—the account-holder of the HSA.

Of course, taxpayers have the burden of complying with tax provisions generally. But this burden may be particularly difficult with regard to HSAs for three reasons. First, the HSA account-holder must ensure that only “qualifying medical expenses” are paid with HSA funds. The definition of such costs, as noted previously,¹⁶⁰ is quite broad, but there are exceptions. Cosmetic surgery, for example, does not qualify¹⁶¹ in most circumstances.¹⁶² Lodging to obtain medical treatment qualifies, but only up to \$50 per night.¹⁶³ Premiums for long-

151. *Id.* § 223(f)(1).

152. *Id.* § 223(f)(2).

153. *Id.* § 223(f)(4)(A). Exceptions are in *id.* § 223(f)(4)(B), (C).

154. The highest statutory tax rate of 35% plus the “additional” tax of 10% equals 45%. *See id.* § 1(i)(2) (*amended by* Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108-27, § 105(a), 117 Stat. 752, 755).

155. Any additional income above \$142,700 (in 2004) reduces the taxpayer’s itemized deductions, thereby raising the effective tax rate on that additional income. *See* I.R.C. § 68(a), (b)(2) (West 2004); Rev. Proc. 2003-85, sec. 3.11; 2003-49 I.R.B. 1184, 1188. *See generally* BITTKER ET AL., *supra* note 102, ¶ 21.03, at 21-27 to 21-28.

156. I.R.C. § 223(d)(1) (West 2004).

157. *Id.* § 223(d)(1)(B).

158. I.R.S. Notice 2004-2, 2004-2 I.R.B. 269, 272 (Q&A 29).

159. *Id.* (Q&A 30).

160. *See supra* text accompanying notes 123-28.

161. I.R.C. §§ 213(d)(9)(A), 223(d)(2)(A) (West 2004). For this purpose, “cosmetic surgery” is “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.” *Id.* § 213(d)(9)(B).

162. Such surgery does qualify if it “is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.” *Id.* § 213(d)(9)(A).

163. *Id.* § 213(d)(2) (last sentence).

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term care insurance also qualify,¹⁶⁴ but only up to certain age-based limits¹⁶⁵ that are adjusted annually for inflation.¹⁶⁶ It is a bit much to ask ordinary people to monitor these distinctions. And yet, if the Internal Revenue Service decides to question the tax-free status of a HSA withdrawal, it is the HSA account-holder who must document the appropriateness of the expenditures that the withdrawal at issue was used to pay.¹⁶⁷

Second, the account-holder must also keep track of the cumulative total of medical expenses that have been paid in order to know when the associated health insurance policy takes over.¹⁶⁸ For example, a deductible of \$2,000 means that the HSA owner pays the first \$2,000 of medical expenses and then must document such payment before the insurance company will pay a claim for benefits under its policy. Low-deductible insurance plans have this same requirement, of course, but a high-deductible plan necessarily increases this administrative burden because many more small expenditures are typically involved in reaching a high-deductible plan's threshold for payment.

Finally, certain medical costs may be eligible for payment with HSA funds but do not count toward satisfying the insurance policy's deductible.¹⁶⁹ While the definition of "qualified medical expenses" for HSA purposes is very broad, the scope of expenses that may be counted against the insurance policy's annual deductible is determined by the insurance policy itself. Some insurance policies may simply adopt the HSA definition, but they are not required to do so.

Assume, for example, that Patty has a high-deductible insurance policy that pays for all doctors' bills and hospital costs after the first \$1,000 of such expenses, but does not cover dental or vision expenses. Assume further that Patty uses \$850 from her HSA to pay for a crown on one of her molars and for prescription sunglasses—both of which are "qualified medical expenses" for purposes of HSA withdrawals. Nevertheless, Patty's insurance policy does not consider these expenditures as covered medical costs, so if Patty subsequently goes into a hospital, she will still be responsible for the first \$1,000 of hospital charges incurred—not the \$150 that she might surmise.¹⁷⁰ Clearly, the distinction between allowable HSA expenses and covered expenses in the associated insurance policy is critical, if subtle, and can easily create a trap for the unwary.

164. *Id.* § 213(d)(1)(D).

165. *Id.* § 213(d)(1) (last sentence), (10)(A); I.R.S. Notice 2004-50, 2004-33 I.R.B. 196, 203-04 (Q&A 41).

166. I.R.C. § 213(d)(10)(B) (West 2004). *See* Rev. Proc. 2003-85, sec. 3.18, 2003-49 I.R.B. 1184, 1189 (limits applicable in 2004).

167. Letter from Leslie Samuels, Assistant Secretary for Tax Policy, U.S. Treasury Department, to Congressman Bill Archer, *quoted in* Martin A. Sullivan, *The Side Effects of Health Savings Accounts*, 100 TAX NOTES 301, 311 (2003).

168. *See* Sullivan, *supra* note 167, at 310.

169. *See* Nancy Ann Jeffrey, *New Medical Plans for Small Businesses Carry Investment Options but Also Risks*, WALL ST. J., Jan. 3, 1997, at C1 (discussing this issue in the context of the predecessor to HSAs).

170. The policy deductible of \$1,000 less the \$850 expended equals \$150.

3. Alternative Arrangements

Understanding HSAs would be difficult enough if their enabling legislation had been written on a clean slate. But it was not. Health reimbursement accounts¹⁷¹ and flexible spending accounts¹⁷² predated the creation of HSAs and continue to exist. Thus, workers and their employers must try to fathom how these new accounts fit within the existing framework and how to coordinate the benefits of these alternatives.¹⁷³ That is, there is a complexity cost and a corresponding increase in consumer confusion whenever a new option is added to an existing array of choices.¹⁷⁴

It is beyond the scope of this Article to explore the various alternatives to HSAs, but consumers and those who advise them will most certainly need to do so. To that end, elaborate columnar presentations set forth the different features and limitations of the options that are now available.¹⁷⁵ But the real difficulty comes in applying these various regimes to a specific person's situation. Survey research has shown that many consumers do not understand their present health care plans very well.¹⁷⁶ And people have even greater difficulty trying to forecast their future medical needs.¹⁷⁷ A major study entitled "Decision Making in Consumer-Directed Health Plans" concluded as follows:

The difficulty of the decision tasks required of consumers and the skills needed to successfully manage within these plans may be beyond the level of effort consumers are willing to expend or may even be beyond the ability of many consumers to understand These plans pose particular challenges for individuals with less than adequate literacy and decision skills.¹⁷⁸

171. Rev. Rul. 2002-41, 2002-2 C.B. 75; *see also* I.R.S. Notice 2002-45, 2002-2 C.B. 93. *See generally* Stanley D. Baum, *Health Reimbursement Arrangements—Who Will Benefit from the Service's Newest Healthcare Plan?*, 97 J. TAX'N 162 (2002).

172. Such accounts are authorized as part of so-called "cafeteria plans" under I.R.C. section 125. *See* Prop. Treas. Reg. § 1.125-2 Q&A-7 (1989). *See generally* Franklin Lowenthal & Philip Storrer, *Medical FSAs: An Expected Value Analysis*, 100 TAX NOTES 521 (2003).

173. *See* Rev. Rul. 2004-45, 2004-22 I.R.B. 971 (addressing the interaction between HSAs, flexible spending accounts, and health reimbursement arrangements).

174. *See* Victoria Craig Bunce, *MSAs Are Not FSAs Are Not HRAs*, HEALTH CARE NEWS, Jan. 2003, at 12 ("Many consumers and employers are confused about the differences among plans and which approach is best."). *Cf.* Richard L. Kaplan, *Funding a Grandchild's College Education*, J. RETIREMENT PLAN., Sept.-Oct. 2001, at 15 (analyzing the various options for financing a college education and how those options interact).

175. *See, e.g.*, Stanley D. Baum, *The Advantages of Health Savings Accounts—the Code's Newest Healthcare Arrangement*, 100 J. TAX'N 101, 108-09 (2004); Bunce, *supra* note 174.

176. *See* Peter J. Cunningham et al., *Do Consumers Know How Their Health Plan Works?*, HEALTH AFF., Mar./Apr. 2001, at 159.

177. *See* Johanna Bennett, *Custom Health Plans Let Members Design Benefit Mix, Control Costs*, WALL ST. J., July 9, 2002, at D4.

178. JUDITH H. HIBBARD ET AL., DECISION MAKING IN CONSUMER-DIRECTED HEALTH PLANS 23 (2003), available at <http://www.aarp.org/ppi> (last visited June 10, 2003). *See also* George Loewenstein, *Is More*

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To take one example that predates HSAs, flexible spending accounts enable employees to set aside up to \$5,000 of pre-tax earnings to pay for medical costs that are not covered by their existing health insurance.¹⁷⁹ But due to employee inertia, and a feature of these plans that forfeits any unused balance at the end of the year,¹⁸⁰ only 12% of employees who have access to these plans choose to enroll in them.¹⁸¹ To be sure, HSAs do not have this use-it-or-lose-it feature,¹⁸² but the experience with flexible spending accounts is symptomatic of the psychological and educational barriers that similar health care arrangements pose for many people.

B. Choice and Control

Against this backdrop, one must consider a recent poll of business economists that found two-thirds of the respondents believe that consumer-driven plans like HSAs are “the future of health insurance.”¹⁸³ Why? Primarily because the American workforce has become infatuated with individual control over a range of benefits, from pensions to health care. As this Comment has explained elsewhere, the overwhelming movement in employer-sponsored retirement plans has been to shift the responsibility for investing and managing retirement money to individual employees.¹⁸⁴ Whether through the substitution of so-called “defined contribution” plans¹⁸⁵ for traditional “defined benefit” plans,¹⁸⁶ or the increasing predominance of so-called 401(k) plans¹⁸⁷ and individual retirement accounts (IRA),¹⁸⁸ this trend is apparently unstoppable. To some extent, the focus on individual control also manifests itself in the growing fascination with

Choice Always Better? NAT'L ACAD. SOC. INS. SOCIAL SECURITY BRIEF NO. 7 (Oct. 1999), at 6 (“When people are forced to make decisions for which they lack the requisite expertise, the consequences are likely to be lost time, bad choices, anxiety and self-recrimination.”); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. (forthcoming 2006).

179. Prop. Treas. Reg. § 1.125-2 Q&A-7(f) Ex. 2 (1989).

180. *Id.* (b)(7); see also Baum, *supra* note 175, at 109.

181. Daniel Kadlec, *Inflexible-Spending Accounts*, TIME, Oct. 21, 2002, at 86.

182. A proposal has been made to allow unused balances of up to \$500 in flexible spending accounts to be carried forward to the next year. H.R. 4279, 108th Cong., 2d Sess. (2004). There is no limit to how much can be carried forward in a HSA.

183. See John C. Goodman, *Responding to Critics of HSAs*, HEALTH CARE NEWS, Feb. 2004, at 15. See also Linda Stern, *Pumped-Up Savings Or Just a Raw Deal?*, AARP BULL., July-Aug. 2004, at 22 (reporting that “three out of four large employers are likely to offer” HSAs to their employees); Louise Story, *Health-Savings Accounts gain Momentum*, WALL ST. J., Sept. 9, 2004, at D2 (reporting that “HSAs are expected to become a standard product of many health insurers and large financial-services firms”).

184. Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53, 54-63 (2004).

185. See generally FROLIK & KAPLAN, *supra* note 8, at 356-58.

186. See generally *id.* at 353-56.

187. See generally Kaplan, *supra* note 184, at 63-67.

188. See generally Richard L. Kaplan, *Retirement Funding and the Curious Evolution of Individual Retirement Accounts*, 7 ELDER L.J. 283 (1999).

“privatizing” Social Security.¹⁸⁹ In each of these instances, the motivating force is the same: let *me* make the choices!

As it is with pensions, so it is becoming with health care. People like control, and that is what HSAs give them. As one employee said when presented with various health plan options, “I don’t want the company making decisions for me I want the options. I want to do the math. I want to make the decisions.”¹⁹⁰ Indeed, a particularly intriguing aspect of HSAs is that an employee may establish a HSA and purchase the required high-deductible insurance policy without *any* involvement by that person’s employer. Self-created mechanisms like HSAs, akin to IRAs in the retirement savings context, are a relatively recent innovation for health care, but they fit perfectly with the sentiment that “[p]eople are tired of being ‘steered’ by faceless bureaucrats with suspect motives. They will do their own steering, thank you.”¹⁹¹

In the health care field especially, the focus on individual control is especially appealing to many people, in part as a reaction to control of medical decisions by managed care companies.¹⁹² With a HSA, the account-holder makes the decision whether to undergo an additional medical procedure. The HSA account-holder—and not some “faceless bureaucrat”—negotiates the price with the health care provider and makes his or her own cost-benefit analysis of whether a given medical service is worth the expense involved. This sense of empowerment in an area as vital and personal as health care is heady stuff indeed. It may even be irresistible.

Given these realities, appeals for a broader sense of community sound positively dated. For example, a recent lecture by Humphrey Taylor, chairman of *The Harris Poll*, addressed this very issue as follows:

Perhaps my biggest concern about consumer choice of health plans is that it undermines the social contract and social solidarity on which, I believe, health insurance must be based My anxiety is increased by our polls suggesting that this social contract or social solidarity is under attack In this country, this social solidarity is beginning to unravel.¹⁹³

189. See Kaplan, *supra* note 184, at 81-82 & sources cited in nn.181-85.

190. Bennett, *supra* note 177.

191. Greg Scandlen, *Commonwealth Fund Distorts Employer Attitudes*, HEALTH CARE NEWS, May 2004, at 13.

192. See Sullivan, *supra* note 167, at 302; Ron Winslow & Carol Gentry, *Health-Benefits Trend: Give Workers Money, Let Them Buy a Plan*, WALL ST. J., Feb. 8, 2000, at A1.

193. Humphrey Taylor, *The Big Health Care Debates that Lie Ahead*, HEALTH CARE NEWS, March 11, 2004, at 10-11.

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Well, Mr. Taylor, wake up and smell the latte! The individualism that has always been more predominant in American culture than in other western democracies sees HSAs as a way to use health care dollars earned through employment for one's *own* benefit—either now or in later years, as unused balances remain invested and grow tax-free until they are used.

A critical counterpoint is whether consumers in charge of their own health care accounts will shortchange their care to save money.¹⁹⁴ After all, the flipside of traditional health insurance's tendency to encourage overuse of health care services is the possibility of arrangements like HSAs to encourage *underuse*. Money in a HSA that is not spent on medical services remains the property of the account-holder.¹⁹⁵ Some folks might even be tempted to use HSAs as supplemental retirement savings accounts, letting balances accumulate until after they reach age sixty-five. At that time, HSA funds may be withdrawn for any purpose—medical or otherwise—without incurring the 10% additional tax that is usually imposed on HSA withdrawals that pay for nonmedical expenditures.¹⁹⁶ Those withdrawals will still be subject to income tax,¹⁹⁷ but the former HSA account-holder may be in a lower tax bracket by then.¹⁹⁸ In effect, the HSA account-holder will have gained a tax bracket benefit in addition to having the funds compound tax-free in the HSA over several years or even several decades.

The possibility of such maneuvers cannot be casually dismissed. Some people who currently have health insurance policies that adjust premiums for past usage already curtail doctor visits to avoid higher insurance costs in the future.¹⁹⁹ This pattern would be even more likely to occur in arrangements like HSAs where the consumer can see immediately the financial gain from such actions. For some people, such decisions would be quite unfortunate. The short-term savings could well lead to larger health care expenses down the road as their medical conditions get out of control. One study found that increasing the portion of prescription drugs' costs that were paid by employees reduced consumption of those drugs, but visits to hospital emergency rooms went up correspondingly.²⁰⁰ One company, in fact, tried the opposite approach: it *reduced* the co-payment portion for certain prescription drugs, resulting in increased consumption of those

194. See Jim Jaffe, *Consumer-Driven Health Benefits: A Continuing Evolution?*, EMP. BEN. RES. INST. NOTES, Sept. 2002, at 3.

195. I.R.C. § 223(d)(1)(E) (West 2004).

196. *Id.* § 223(f)(4)(A), (C).

197. *Id.* § 223(f)(2).

198. See generally *id.* §1(a)-(d) (tax brackets).

199. See Chad Terhume, *Is All Fair in Health and Insurance?*, WALL ST. J., July 30, 2002, at D3.

200. See Vanessa Fuhrmans, *Higher Co-Pays May Take Toll on Health*, WALL ST. J., May 19, 2004, at D1. Similar results were reported in Robyn Tamblyn et al., *Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 JAMA 421 (2001). But see Mitchell D. Wong et al., *Effects of Cost Sharing on Care Seeking and Health Status: Results From the Medical Outcomes Study*, 91 AM. J. PUB. HEALTH 1889 (2001) (four-year longitudinal study found that cost-sharing reduced the use of care without any observable differences in self-reported health status).

drugs but fewer emergency room visits and hospital admissions.²⁰¹ Consequently, overall health care costs actually declined on a net basis.²⁰²

Would HSA owners really endanger their own health simply to accumulate more funds in their accounts? This possibility certainly exists, especially over a multi-year period. That is, as long as the net savings over several years exceed the deductible on the associated health insurance policy, the extra costs of a resulting hospital stay would be paid by that insurance policy, leaving the HSA account-holder with a net gain. Such a strategy is certainly risky behavior, but hospitals are filled with people who indulge in a wide variety of risky behaviors, most of which are far better documented than avoiding or minimizing health care treatments. Be that as it may, HSAs clearly reflect the increasingly prevalent ethos of individual control and will resonate with those who want the maximum freedom of choice.

C. Cost of Health Care

The impact of HSAs on the cost of health care will probably be fairly minimal. On the one hand, there is the often-quoted aphorism of Milton Friedman, Nobel Laureate in economics, that “nobody spends somebody else’s money as wisely as he spends his own.”²⁰³ But how much bargaining power can individual consumers really wield, acting one patient at a time? To be fair, HSAs might sensitize American health care consumers to the cost of their health care and may even clarify the connection between health costs and behaviors that are within their control. If so, HSAs might in fact moderate the growth in health care costs,²⁰⁴ though this possibility is still conjectural and undoubtedly very long-term in nature.

In any case, HSAs seem less paternalistic and more respectful of individual autonomy than do some other employer-created health care initiatives. For example, some companies decline to hire smokers outright.²⁰⁵ Other companies increase the employee health insurance co-payments of overweight workers.²⁰⁶ By comparison to these rather blunt approaches, HSAs are much less dictatorial: if an employee chooses to keep smoking or overeating, there will be a health care

201. See Vanessa Fuhrmans, *A Radical Prescription*, WALL ST. J., May 10, 2004, at R3.

202. *Id.*

203. See John F. Cogan et al., *Healthy, Wealthy and Wise*, WALL ST. J., May 4, 2004, at A20 (quoting Milton Friedman).

204. See Ron Lieber, *New Way to Curb Medical Costs: Make Employees Feel the Sting*, WALL ST. J., June 23, 2004, at A1 (reporting that HSA-like accounts at a major employer reduced overall medical costs). See also Susan Lee, *A Tax-Code Cure for Ailing Health Care*, WALL ST. J., Aug. 9, 2004, at A13 (“Since low coinsurance and deductions are the engine behind rocketing costs and wasteful medical practices, providing consumers with the incentive to shift to policies with high coinsurance and deductibles is an elegant remedy.”).

205. See Howard M. Leichter, “*Evil Habits*” and “*Personal Choices*”: *Assigning Responsibility for Health in the 20th Century*, 81 MILBANK Q. 603, 609 (2003); Kris Maher, *Companies are Closing Doors on Job Applicants Who Smoke*, WALL ST. J., Dec. 21, 2004, at B6.

206. Leichter, *supra* note 205, at 609.

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cost and the employee will pay it out of his or her HSA. Thus, HSAs are more like differential insurance rates for nonsmokers and smokers in this respect: make your choice and pay the price.

On the other hand, most of the dollars spent on health care currently are not really subject to the sort of discipline that HSAs stimulate. A study of Americans aged 18-64 years with employment-based health insurance revealed that 95% of all health care costs were incurred by only 50% of this population.²⁰⁷ The distribution of costs was even more skewed:

<u>Percent of Population</u>	<u>Cumulative Percent of Expenditures</u> ²⁰⁸
Top 1	20
Top 5	43
Top 10	58
Top 15	68
Top 22	77

In other words, more than three-quarters of all health care costs that were incurred by this group were attributable to the sickest quintile, and a full fifth of such costs was incurred by the sickest one percent. Within this top one percent, moreover, almost two-thirds of their costs represented charges for inpatient hospital stays²⁰⁹—the sort of expenditures that would be covered by the high-deductible insurance policies that are associated with HSAs, rather than by the HSAs themselves. Furthermore, 75% of all health care costs are spent by persons who incur more than \$6,000 of such costs in that year,²¹⁰ an amount in excess of the maximum out-of-pocket limit that is allowed for HSA-associated health insurance plans.²¹¹ The potential of HSAs to effect major declines in health care consumption, in other words, is rather circumscribed.

Where the impact of HSAs might be more likely felt, however, is in the nature of health *insurance*. HSAs might bring health insurance more in line with other types of insurance, rather than an arrangement to prepay most health costs, including expenditures that are highly predictable. That is, we do not use automobile insurance to cover engine tune-ups, and we do not file home insurance claims when the gutters must be cleaned. Realigning Americans' expectations of what health insurance should cover with more general conceptions of insurance might encourage those people who presently have no health insurance to purchase high-deductible coverage for major medical

207. Paul Fronstin, *Can "Consumerism" Slow the Rate of Health Benefit Cost Increases?*, EMP. BEN. RES. INST. BRIEF NO. 247 (July 2002), at 17.

208. Adapted by author from data in footnote 207 at 18.

209. Fronstin, *supra* note 207, at 19.

210. Sullivan, *supra* note 167, at 306.

211. I.R.C. § 223(c)(2)(A)(ii)(I) (West 2004) (\$5,000 for self-only coverage).

episodes.²¹² This population would still need to use its own money for ordinary medical costs, but that is precisely the structure that HSAs create for people with employer-provided health insurance.

In any case, the days of comprehensive low-deductible health insurance policies appear limited. The increasing prevalence of managed care arrangements²¹³ has largely supplanted this mechanism as a means of financing ordinary health care costs. Where low-deductible policies are still offered, employers have been increasing the portion of the premiums that are paid by the employees, raising deductibles, and expanding co-payment obligations.²¹⁴ HSAs merely make clear a development that is already underway—namely, more personal responsibility for the financial implications of one's health care.

VII. CONCLUSION

Most Americans of pre-retirement age obtain their health insurance through their place of employment. This reality began as an accident of history, but it has been bolstered since that time by federal tax policy. That policy, in turn, has largely anesthetized most employees to the real costs of health insurance and the effect of lifestyle choices and personal habits on the consumption, as well as the cost, of health care. One cannot change one's behavior in response to what one does not see.

The newly created Health Savings Accounts seek to alter this paradigm by making Americans conscious about the cost of the health care services that they use. Combining a "high deductible" insurance plan to cover major health care expenditures with an account that they control *and own*, HSAs make clear that health care is not a free good and that economic trade-offs affect this key service just like other important purchases. Proponents of these accounts are virtually messianic in their enthusiasm for this radically different approach to health care in the United States. President George W. Bush declared, "I believe that the best health care policy is one that entrusts and empowers consumers. [With a HSA,] you're the decisionmaker, not a bureaucrat."²¹⁵ Speaker of the House of Representatives, Dennis Hastert, observed that HSAs "will revolutionize the health care market in this country, giving consumers better health care at a lower

212. See Laura Trueman, *HSAs Spread Quickly, Surprise Critics*, Health Care News, Sept. 2004, at 1, 4 (reporting that 43% of HSA applicants had no prior health insurance).

213. See Paul Wallace, *A Survey of Health-Care Finance: Treating the Symptoms*, ECONOMIST, July 17, 2004, at 15 (92% of workers with employer-provided health insurance participate in managed care plans).

214. See, e.g., Fuhrmans, *supra* note 201; PARK, *supra* note 149, at 13.

215. See Dustin Stamper & Karla L. Miller, *HSA Backers Continue Campaign for Crane Bill*, 102 TAX NOTES 1465, 1465-66 (2004) (quoting President George W. Bush).

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price.”²¹⁶ Former House Speaker Newt Gingrich claimed that creation of HSAs was “the single most important change in health-care policy in 60 years.”²¹⁷

These sentiments may be overstated, but the movement towards greater personal responsibility in health care is clearly here to stay, and HSAs will only accelerate it further. Rather than harsh and restrictive edicts from employers, HSAs empower consumers to decide for themselves how they will spend their health care dollars and on what. The associated high-deductible insurance policies still protect them against the cost of major medical calamities, but the key message remains: use health care funds prudently, for they are ultimately your own resources.

216. 149 CONG. REC. H12881 (daily ed. Dec. 8, 2003).

217. Newt Gingrich, *The Medicare Bill: A Solid Platform for Reviving Health Care*, SAN DIEGO UNION-TRIBUNE, Dec. 7, 2003, at G1.