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The Promises and Pitfalls of Health Savings Accounts

*Adam Larson**

Good health is not something we can buy. However, it can be an extremely valuable savings account.[1]

I. INTRODUCTION

It is not surprising that a large number of Americans lack health insurance.[2] It is quite shocking, though, that each year an estimated 18,000 Americans die prematurely due to inadequate health insurance coverage.[3] Additionally, the number of uninsured Americans has trended upward in recent decades,[4] as the rate of uninsured in America has increased from 12.9% of the population in 1987 to 15.3% in 2007.[5] Concurrently, there has been a steady rise in real median household earnings[6] and a decrease in

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1. ANNE WILSON SCHAEF, NATIVE WISDOM FOR WHITE MINDS 113 (1995).

2. *See generally* HENRY J. KAISER FAMILY FOUND., KAISER PUBLIC OPINION SPOTLIGHT (2006), http://www.kff.org/spotlight/uninsured/upload/Spotlight_Jan06_Uninsured-3.pdf. In a 2005 survey, the Kaiser Foundation found that 76% of Americans felt that increasing the number of people covered by health insurance is a "very important" policy for the President and legislature to address. *Id.* at 3. Six in ten adults knew that the number of Americans without health insurance had increased in the past ten years. *Id.* at 6.

3. INSTITUTE OF MEDICINE, FACT SHEET 5: UNINSURANCE FACTS AND FIGURES, THE UNINSURED ARE SICKER AND DIE SOONER 1 (2004), http://www.iom.edu/CMS/17645.aspx. The fact sheet also notes that 43% of working-age adults without health insurance reported that they did not visit a physician when they had medical issues, compared to 10% of those with insurance coverage. *Id.* Additionally, the uninsured are less likely to receive preventive care, leading to the increased use of expensive crisis care in emergency rooms. *Id.* at 2.

4. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, U.S. DEP'T COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, at 61 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf.

5. *Id.* (showing that the number of uninsured Americans in 2007 was approximately 45.7 million).

6. *Id.* at 38.

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the percentage of those living in poverty, which seems dissonant to the rising number of uninsured.[7]

Considering the general economic health of most Americans,[8] it is a travesty that a majority of uninsured Americans in 2006 lived in households where one or more members had full-time employment.[9] Seventy percent of the uninsured who were employed full-time were either ineligible for employer-sponsored benefits, or were not offered health insurance by their employers.[10] In fact, the percentage of employers offering health benefits to at least some of their employees has declined from 69% in 2000 to 60% in 2007.[11]

Public programs, such as Medicare[12] and Medicaid,[13] provide coverage to a significant portion of the population, but a large percentage of the working poor are ineligible for these benefits.[14] A majority of uninsured

7. *Id.* at 44 (noting that the percentage of all Americans living below the poverty level decreased from 13.4 to 12.5% in the period between 1987 and 2007).

8. *See id.* (showing that, generally, Americans earned more money in recent years and were less likely poverty-stricken).

9. CATHERINE HOFFMAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED: A PRIMER 4 (2007), http://www.kff.org/uninsured/upload/7451-03.pdf.

10. *Id.* at 1.

11. *Id.* at 2; *see also* HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2006 SUMMARY OF FINDINGS 4 (2006), http://www.kff.org/insurance/7527/upload/7528.pdf (reporting that about 60% of firms with fewer than 199 employees provided coverage in 2006, while 98% of firms employing more than 200 provided access to coverage).

12. Medicare is a national insurance program which provides coverage for adults over the age of sixty-five, as well as adults under the age of sixty-five who are permanently disabled. HENRY J. KAISER FAMILY FOUND., MEDICARE AT A GLANCE 1 (2007), http://www.kff.org/medicare/upload/1066-10.pdf. Medicare now covers 43 million Americans. *Id.* Individuals and their spouses who are eligible for Social Security payments and have made payroll tax contributions for ten or more years are generally eligible for Medicare Part A coverage. *Id.* Part A coverage provides hospital, skilled nursing, home health, and hospice care. *Id.* Part A is funded through payroll deductions. *Id.* Part B coverage includes physician and outpatient care, and is funded from general revenue funds. Part C allows beneficiaries to enroll in a private (HMO, PPO, etc.) "Medicare Advantage Plan," which provides combined Parts A and B coverage, along with Part D prescription coverage. Part D is the prescription drug benefit. *Id.* Medicare benefits accounted for approximately 14% of the federal budget in 2006. *Id.*

13. Medicaid is the primary source of healthcare coverage for 55 million poor, elderly, and disabled Americans. HENRY J. KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE 1 (2007), http://www.kff.org/medicaid/upload/7235-02.pdf. Medicaid accounts for approximately one-fifth of all personal health care spending in the U.S., and about 45% of long-term care costs. *Id.* Individual states and the federal government jointly fund the Medicaid program, and the states administer services within broad federal guidelines. *Id.*

14. *See* HOFFMAN ET AL., *supra* note 9, at 3 ("Although public insurance covers over 40% of the poor, the categorical nature of the Medicaid program means that 37% of those below the poverty level remain uninsured.").

Americans are adults, as Medicaid and SCHIP[15] are available to low-income children, while Medicaid is generally available only to adults under the age of sixty-five who are disabled, pregnant, or have dependent children.[16]

The increasingly high cost of coverage is certainly one contributing factor to the uninsured rate in the United States.[17] Since 2000, the cost of health insurance premiums paid by employers and employees has nearly doubled.[18] In 2007, the average annual cost for employer-sponsored family coverage was approximately $12,000, with each employee contributing an average of $3,281.[19] As insurance costs continue to increase, employers potentially face three options: reducing or eliminating the availability of coverage, reducing salaries, or increasing employee contributions.[20]

A recent attempt to reduce the cost of insurance coverage arrived with the advent of Health Savings Accounts (HSAs). President Bush effectuated

15. The State Children's Health Insurance Program (SCHIP) was established in 1997 as part of the Balanced Budget Act. KAISER COMM'N ON MEDICAID & THE UNINSURED., STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AT A GLANCE 1 (2007), http://www.kff.org/medicaid/upload/7610.pdf. SCHIP, along with Medicaid, provides a safety net to ensure that poor children have adequate access to health insurance coverage. *Id. See generally* DONNA COHEN ROSS ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH COVERAGE FOR CHILDREN AND FAMILIES IN MEDICAID AND SCHIP: STATE EFFORTS FACE NEW HURDLES (2008). SCHIP was reauthorized through 2009, but President Bush vetoed an expansion (an additional $7 billion) which would have eliminated funding shortfalls and provided coverage for additional children. *Id.* at 5.

16. HOFFMAN ET AL., *supra* note 9, at 4.

17. A number of factors contribute to the rising cost of health care. The first is rapidly advancing technology, as U.S. spending on biomedical research alone grew from $37 billion in 1994 to $94 billion in 2003. CITIZENS' HEALTH CARE WORKING GROUP, THE HEALTH REPORT TO THE AMERICAN PEOPLE 14 (2005), *available at* http://www.saludparaamericanos.gov/healthreport/healthreport.pdf. The fee-for-service system may also contribute to higher costs. In this system, providers are paid each time they provide a service; thus the provision of more services results in higher reimbursement income. The backlash on managed care (which limits the amount of services that patients may receive) has led to increased reliance on the fee-for-service model. *Id.* Administrative costs (inclusive of professional liability insurance costs) in various government agencies, hospitals, and doctors' offices are high. Practice expenses and liability insurance account for 48% of Medicare payments to physicians. *Id.* at 15.

18. Vanessa Fuhrmans, *Health-Care Premiums Continue to Rise*, WALL ST. J., Sept. 12, 2007, at D9.

19. *Id.*

20. *See* Jon Gabel et al., *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*, 23 HEALTH AFF. 200, 206-08 (2004). The percentage of small employers offering insurance coverage continues to decrease as costs increase, while the offer rate among large employers is around 99%. *Id.* "One possible explanation for coverage not dropping more dramatically is that employers are paying for higher premiums by reducing their workers' earnings." *Id.* at 208. More than 80 % of large employers surveyed, and 44 % of small employers, say that they are very or somewhat likely to increase employee contributions. *Id.* at 207.

HSAs when he signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003.[21] An HSA is defined as "a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary."[22] HSAs allow Americans to set aside up to $4,500 per year, tax free, to save for medical expenses.[23] According to President Bush, HSAs were implemented to incentivize healthier lifestyles by making Americans more cognizant of the actual costs of health care and by helping small business owners decrease the cost of providing health insurance to employees.[24]

Theoretically, individuals with HSAs will implement healthier lifestyles in order to reduce their healthcare spending, and thus will watch their savings accounts grow. Businesses that offer HSAs will reduce costs by providing less-expensive, higher deductible plans designed to cover only major medical expenses. Individuals with HSAs are supposed to use the funds in their tax-free accounts to pay for minor, routine expenses, such as doctor visits and prescription drugs.[25]

This comment explores the likelihood that the purported benefits of HSAs will be realized, and whether improvements are necessary to accomplish the stated goals. Part II discusses the background of HSAs and consumer-directed health care. Part III discusses the positive and negative aspects of HSAs, and the likelihood of the program's success. Part IV examines current and proposed measures to allay the criticisms levied against HSAs. Part V discusses the current political environment and its possible impact to the future viability of HSAs. Part VI concludes that the current tax-benefit structure of HSAs must be overhauled to include subsidies for low-income families and incentives for small businesses to offer health insurance plans that are compatible with HSAs. This comment does not discuss universal single-payer coverage, nor coverage mandates, but instead focuses on potential enhancements to consumer-directed healthcare plans which will decrease the number of uninsured Americans.

21. President George W. Bush, President Signs Medicare Legislation, Address at DAR Constitution Hall (Dec. 8, 2003), *available at* http://www.whitehouse.gov/news/releases/2003/12/20031208-2.html.

22. 26 U.S.C. § 223(d)(1) (2006).

23. 26 U.S.C. § 223(b)(2) (2006).

24. Bush, *supra* note 21.

25. *See id.* ("[E]mployees and their families will use [HSAs] to cover doctors [sic] visits or lab tests or other smaller costs").

II. BACKGROUND OF HSAS AND CONSUMER-DIRECTED HEALTH CARE

Some analysts tout the use of consumer-directed health care (CDHC) as a solution to curb rising healthcare costs.[26] Many consumer-directed health plans combine HSAs (or similar accounts)[27] with catastrophic, high-deductible insurance coverage. Such plans typically require that patients pay out-of-pocket for minor health costs and prescription drugs until they reach the annual out-of-pocket limit in their high deductible insurance plan (HDHP).[28] Theoretically, this consumer-driven model will empower healthcare consumers to make intelligent, value-conscious decisions about the quantity of health care they receive because they must pay for many services out-of-pocket.[29] One study found that CDHC patients were three times as likely as those in traditional managed care plans to choose less-expensive treatment options.[30] The question remains, however, whether using fewer services or inexpensive treatment options will deliver the quality of outcomes tantamount to those under traditional healthcare plans.

Under traditional plans,[31] consumers bear the responsibility of paying nominal co-payments for services in lieu of annual deductibles.[32] When traditional-plan consumers visit healthcare providers within their plans' networks, the providers are typically reimbursed for 93 to 95% of eligible costs.[33] Some researchers suggest that employees under traditional healthcare plans unnecessarily and excessively overuse services because they are not cognizant the true cost of health care. Thus, because

26. JOHN GOODMAN, NETWORKS FINANCIAL INSTITUTE, POLICY BRIEF: CONSUMER DIRECTED HEALTH CARE 1 (2006) (arguing that CDHC "is a potential solution to two perplexing problems . . . how to choose between health care and other uses of money, and how to allocate resources . . . where normal market forces . . . have been systematically suppressed.").

27. *See* discussion *infra* Part III.

28. Joann Nolin & Janet Killackey, *Redirecting Health Care Spending: Consumer-Directed Health Care*, 22 NURSING ECON. 251, 251 (2004).

29. *See* GOODMAN, *supra* note 26, at 2. ("[I]f health care were really were free . . . everybody would have at least an economic incentive to . . . order dozens of blood tests, check out all their genes, and consult physicians at the drop of a hat . . . [U]nconstrained patients would attempt to spend the entire gross domestic product on health care . . .").

30. *Id.* at 6.

31. The term "traditional plans" is used interchangeably with "managed care plans" throughout this comment. The great majority of Americans have coverage through an HMO or PPO, and therefore, this widespread use has made such plans "traditional" in the sense that indemnity-type plans are no longer the norm. *Cf.* CLAXTON ET AL., *infra* note 129, at 64-66.

32. Nolin & Killackey, *supra* note 28 at 251.

33. *Id.*

employers must pay for these benefits, employees are basically "buying health care with someone else's money."[34]

A. History of HSAs

Health Savings Accounts were created as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Act).[35] Under the Act, an individual must procure health insurance through an HDHP in order to be eligible to contribute to an HSA.[36] Originally, the Act limited an insured's annual HSA contributions to the lesser of his or her deductible, or $2,250 ($4,500 for families).[37] The minimum deductible for health insurance was $1,000 for individuals and $2,000 for families under the Act's original provisions.[38] The minimum deductible limit increased to $1,150 and $2,300, respectively, for calendar year 2009.[39] In order to qualify for the tax deduction, an insured's expenditure of HSA funds is restricted to "qualified medical expenses."[40] Such qualified expenses exclude HDHP premiums, but include medical expenses which would otherwise qualify for an IRS income tax deduction.[41] Therefore, employees without employer-sponsored coverage receive preferential tax treatment solely for HSA contributions, but receive no tax benefits for purchasing healthcare plans on the individual market.

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34. Goodman, *supra* note 26, at 5.

35. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 § 1201, 17 Stat. 2066, 2469-79 (2003) (codified as amended at 26 U.S.C. § 223 (2006)).

36. 26 U.S.C. § 223 (c)(1)(A) (2000 & Supp. V 2005).

37. *See id.* § 223(b)(2) *amended by* Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, §303(a), 120 Stat. 2922, 2949-50 (2006). The contribution limits were increased to $3,000 for individual coverage and $5,950 for family coverage in 2009. Rev. Proc. 2008-29, 2008-22 I.R.B. 1039.

38. 26 U.S.C. § 223(c)(2)(A) (2006). High deductible health plans may provide certain preventive care benefits without a deductible, such as periodic health evaluations, prenatal and well-child care, immunizations, tobacco cessation, obesity weight-loss programs, and cancer screening programs. I.R.S. Pub. 969, at 3 (2006). Originally, annual out-of-pocket expenses were limited to $5,000 for individuals and $10,000 for families. 26 U.S.C. § 223 (c)(2)(A)(ii). The out-of-pocket amount was increased to $5,800 (individual) and $11,600 (family) for calendar year 2009. Rev. Proc. 2008-29, 2008-22 I.R.B. 1039.

39. Rev. Proc. 2008-29, 2008-22 I.R.B. 1039.

40. I.R.S. Pub. 969, at 6 (2006).

41. I.R.S. Pub. 969, at 6-7 (2006). The IRS provides a laundry list of deductible expenses, including abortions, alcoholism treatment, artificial limbs, dental treatments, vision treatments, fertility enhancement, prescriptions, psychiatric care, and oxygen. I.R.S. Pub. 502, at 5-14 (2007). Non-deductible expenses include cosmetic surgery, hair transplants, hair removal, household help, weight loss programs (unless weight loss is for a specific, physician-diagnosed disease), nonprescription drugs, and drugs imported from other countries. *Id.* at 15-16.

An employer, an individual, or both may make contributions to an HSA.[42] Employer contributions to employee health plans (and contributions to HSAs) are excluded from the employee's gross income, but only an individual's contributions to the HSA are tax deductible.[43] If an individual uses account funds to pay for non-qualified expenses, the spent funds are susceptible to income tax and an additional 10% penalty intended to discourage accountholders from spending HSA funds on non-medical expenses.[44] In 2007, the tax savings generated from contributions to HSAs ranged from $75 for an individual earning $20,000 per year and contributing $500 to an HSA, up to $1,719 for a married couple with children contributing the maximum amount to the HSA and earning $120,000 per year.[45]

B. Similarities and Differences between HSAs and Other Consumer Directed Health Accounts

Health Savings Accounts are conceptually similar to Flexible Spending Accounts (FSAs), Medical Savings Accounts (MSAs) and Health Reimbursement Arrangements (HRAs), but differ in key ways.[46] First, FSAs do not require coverage by an HDHP.[47] Thus, an employee may have traditional health plan coverage and still retain eligibility for FSA enrollment.[48] With an FSA, an employee selects an amount to be withheld from her compensation at the beginning of the year which is deducted from

42. CTRS. MEDICARE & MEDICAID SERVS., CMS LEGISLATIVE SUMMARY: SUMMARY OF H.R. 1 MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 § 1201 (2004).

43. *Id.*

44. *Id.*

45. Dep't of the Treasury, Reduction in Federal Income Tax from HSA Contributions in 2007: Illustrative Examples, http://www.treasury.gov/offices/public-affairs/hsa/pdf/hsa-examples_2007.pdf (last visited Oct. 14, 2008).

46. FSAs came into existence after passage of the Revenue Act of 1978. Haneefa T. Saleem, Bureau Lab. Stat., Health Spending Accounts (2003), http://www.bls.gov/opub/cwc/cm20031022ar01p1.htm#author1 (last visited Sept. 20 2008). FSAs are offered as part of an employer's "cafeteria plan," which is "a written plan under which all participants are employees, and the participants may choose among [two] or more benefits consisting of cash and qualified benefits." 26 U.S.C. § 125(d)(1) (2006). MSAs were created in 1996 as part of HIPAA to allow small employers and self-employed persons to purchase high-deductible health plans and keep tax-exempt MSAs. Employers may make contributions to MSAs, but individuals may not unless they are self-employed. 26 U.S.C. § 220 (2006); Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996). HRAs were created by I.R.S. Revenue Ruling 2002-41, and allow employers to reimburse employees who pay for medical expenses out-of-pocket. Rev. Rul. 2002-41, 2002-28 I.R.B. 75-76. HRAs are employer-funded and not paid for by salary reduction. *Id.*

47. Saleem, *supra* note 46, at 3.

48. I.R.S. Pub. 969, at 13 (2006).

her taxable income, and then placed into an account.[49] Participants forfeit any tax benefit if they fail to use the FSA funds within the year, while HSA funds rollover if unused by the end of the year.[50] Accordingly, FSAs are advantageous for those who expect to incur certain out-of-pocket expense during the year, but do not wish to enroll in an HDHP (which is required with an HSA-qualified plan). Employees are reimbursed for qualified medical expenses through a distribution from the account.[51] Under this arrangement, an insured person can retain a low deductible with minimal out-of-pocket expenses and spend the tax-advantaged account contributions on orthodontia, vision care, or other qualified expenses that might not be covered under the health insurance plan.

In contrast to HSAs, MSAs are limited to self-employed individuals and those employed by small employers.[52] Additionally, MSAs are available to Medicare enrollees, whereas Medicare beneficiaries are not eligible to participate in HSAs.[53] Medicare beneficiaries are ineligible for HSAs because those accounts require purchase of a traditional HDHP plan, resulting in redundant coverage. Another key distinction between MSAs and HSAs is that only an employee *or* an employer may make contributions to an MSA, but not both.[54] HSA participants may contribute to their own account, even if their employers also contribute.[55] Further, MSA contributions are limited to 75% of the annual HDHP deductible, while HSA contributions are limited only to I.R.S. prescribed contribution limits—thus, many HSA participants can contribute the full amount of their deductible.[56] This limitation makes MSAs less attractive to self-employed individuals when compared with HSAs, as the potential tax benefit is higher under an HSA.

HRAs bear less similarity to HSAs than do the other types of accounts (FSAs and MSAs). HRAs are funded solely through employer contributions, and cannot be funded by a voluntary reduction in an employee's salary.[57] There is no contribution limit for HRAs, and funds in these arrangements can be used to pay for health insurance premiums and

49. *Id.*
50. *Id.* at 14.
51. *Id.*
52. *Id.* at 4, 8.
53. I.R.S. Pub. 969, at 8 (2006). Medicare Advantage MSAs are traditional Archer MSAs available exclusively to Medicare beneficiaries. *Id.* Medicare Advantage MSA holders are required to enroll in an HDHP that meets Medicare guidelines. *Id.* at 12.
54. *Id.* at 9.
55. *Id.* at 4.
56. *Id.* at 4, 10.
57. *Id.* at 14.

long-term care, unlike funds contributed to HSAs.[58] Further, while funds in HSA accounts are interest-bearing, HRA funds are not.[59] HRAs are beneficial for employers wishing to make tax-free contributions to employees' health care, while allowing the participant/employee to choose appropriate healthcare coverage.[60] Employers are not required to offer health insurance coverage for eligibility in the program; thus, potentially, many employees under HRA plans must purchase coverage on the individual market.[61] This requirement may create affordability issues for people in high-risk categories who cannot purchase coverage at risk-pooled, group rates.[62]

C. Recent Developments in HSAs

Aside from increased contribution limits discussed in Part II.A., Congress recently drafted significant changes to the HSA program. These changes materialized upon passage of the Health Opportunity Patient Empowerment Act of 2006, part of the Tax Relief and Health Care Act of 2006.[63] Among the revisions, the total amount of funds contributed to an HSA is no longer limited to the participant's annual HDHP deductible.[64] After the Act's passage, for example, a person with a $1,100 deductible could contribute up to $2,250 to her HSA, and use the excess contributions to pay for additional qualified medical expenses that might be excluded from her HDHP coverage.[65] For instance, a participant can now use the tax-free, interest-bearing funds resulting from her additional contributions to purchase medication if her HDHP does not provide prescription coverage.

Another notable change allows an employee to make a one-time transfer of funds from an IRA into an HSA without adverse tax implications.[66] Similarly, participants may now roll over funds from FSAs or HRAs into their HSAs.[67] Therefore, unspent funds from the previous year held in an

58. *See id.* at 14-15.

59. *See* I.R.S. Pub. 969, at 2(2006), at 2.

60. *Id.* at 14.

61. *Id.*

62. *See infra*, Part IV and accompanying notes.

63. Tax Relief and Health Care Act of 2006, Pub. L. 109-432, §§ 301-07, 120 Stat. 2948, 2948-53 (2006) (codified as amended in scattered sections of 26 U.S.C.).

64. *Id.* at § 303(a) (amending 26 U.S.C. § 223(a) (2006)).

65. *Id.* at § 303(a)(1); *see also* I.R.S. Pub. 969, at 6 (2006).

66. Tax Relief and Health Care Act of 2006 § 307(a) (amending 26 U.S.C. § 408 (2006)) (stating that the election to make such a transfer is irrevocable and may only be performed once during the individual's lifetime).

67. *Id.* at § 302 (amending 26 U.S.C. § 106 (2006)). The employer must make the contribution directly into the participant's HSA before January 1, 2012. *Id.* The amount

FSA or HRA that would otherwise be subject to taxation may be transferred into an HSA to prevent the incurrence of additional tax liability. This new provision, in effect, allows participants to fund an HSA without an initial cash outlay, which is especially significant for people who wish to glean the benefits of HSAs but lack the financial liquidity to so initially fund the account. While this change offers people with IRAs an additional opportunity to save on healthcare costs, it is unlikely to reduce the number of uninsured Americans. The demographic least likely to have IRAs—lower income earners—is also least likely to have health insurance, so it follows that this change is inconsequential in encouraging HSA adoption among the uninsured poor.[68]

Another amendment allows employers the option of contributing larger amounts to the accounts of lower-paid employees.[69] Employers may contribute less to the accounts of "highly compensated" employees, but must contribute equally to accounts of all non-highly compensated HSA participants.[70] Employers who exercise this option give lower-paid employees who are qualified to participate in HSAs an additional inducement to do so.

D. Proposed Changes to HSAs

The House of Representatives proposed additional changes to HSAs through the HSA Improvement and Expansion Act of 2007.[71] Among the

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transferred from the HRA may not exceed the balance of the HRA at the time of distribution. *Id.*

68. *See* CRAIG COPELAND, EMPLOYEE BENEFIT RESEARCH INSTITUTE, ISSUE BRIEF NO. 293, INDIVIDUAL ACCOUNT RETIREMENT PLANS: AN ANALYSIS OF THE 2004 SURVEY OF CONSUMER FINANCES 1, 10 (May 2006). IRA participation increases dramatically with income. In 2004, 10.3% of families with incomes between $10,000 and $24,999 had IRAs; 23.2% of families with incomes between $25,000 and $49,000; and 60.0% of families earning over $100,000 annually had IRAs. *Id.* Compare these numbers with the statistics for those families lacking health insurance coverage: 24.5% of households with income under $25,000 were uninsured in 2007; 21.1% for households with income between $25,000 and $50,000; and only 7.8% of families earning over $75,000 lacked health insurance. DENAVAS-WALT, *supra* note 4, at 21. The inverse relationship between health insurance coverage and IRA participation suggests that HSA funding through IRA rollovers are unavailable for a majority of the uninsured.

69. Tax Relief and Health Care Act of 2006 § 306(a) (amending 26 U.S.C. § 4980G(d) (2006)) ("[H]ighly compensated employees shall not be treated as comparable participating employees."). A highly compensated employee means any employee who owned at least 5% of the company, or whose compensation exceeds $80,000 and was in the top-paid group of employees the preceding year. 26 U.S.C. § 414(q) (2006).

70. Tax Relief and Health Care Act of 2006 § 306(a).

71. HSA Improvement and Expansion Act of 2007, H.R. 3234, 110th Cong. (2007). This bill was introduced on July 31, 2007 and referred to the House Committee on Ways and Means. *Id.* The Subcommittee on Health held hearings on HSAs and consumer-driven healthcare on May 14, 2008. *Hearing on Health Savings Accounts (HSAs) and Consumer*

major changes, the bill seeks to allow HSA participants to pay their health insurance premiums through account distributions, unlike the current law which prohibits the use of HSA funds for this purpose.[72] Not only would qualified medical expenses be excludable from an individual's taxable income, but payment of healthcare premiums would be excludable as well. This bill also proposes to allow participants to pay for medical expenses from HSAs, HRAs, and FSAs, without the need to choose between accounts, provided that the total amount of contributions does not exceed the sum of the annual deductible and out-of-pocket expenses.[73] This change would make HDHPs much more attractive, as the positive attributes of the various accounts provide incentives for employers and participants alike because of the added flexibility. For example, employers benefit from funding tax-advantaged HRAs and employees benefit from making tax-free contributions to HSAs to purchase healthcare coverage.

Another bill introduced in 2007 would allow Medicare and Veteran's Administration healthcare enrollees to become eligible to contribute to HSAs.[74] The Promoting Health Care Act of 2007, if implemented, would also classify the purchase of a Medicare Supplemental Policy as a qualified medical expense which, in turn, would allow working seniors to purchase "medigap"[75] coverage with funds from an interest-bearing HSA account, and would result in a tax savings.[76] A significant proposal in this bill allows for the transfer of funds in HSAs to an adult child of an account holder.[77] The current law allows contributions to rollover to a contributor's spouse in the event of death or divorce, but the proposed legislation would expand the tax advantage gained by the contributor to surviving adult children.[78]

Driven Health Care: Cost Containment or Cost-Shift? Before the Subcomm. on Health of the H. Comm. on Ways & Means, 110th Cong. 85 (2008), *available at* http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=632.

72. H.R. 3234.

73. *Id.*

74. Promoting Health for Future Generations Act of 2007, H.R. 2639, 110th Cong. (2007). This bill was introduced on June 7, 2007 by Rep. Boustany, and referred to the House Subcommittee on Health. *Id.*

75. *See* MEDICARE AT A GLANCE, *supra* note 12. "Medigap" plans combine private supplemental insurance plans with Medicare parts A, B, and D. These plans provide "first dollar" coverage, providing benefits not otherwise covered under the traditional Medicare program. *See Hearing on Medicare Cost-Sharing and Medigap Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 108th Cong. (2003).

76. H.R. 2639 § 6.

77. *Id.* § 11.

78. 26 U.S.C. § 223(f) (2006). "The transfer of an individual's interest in [an HSA] to an individual's spouse or former spouse under a divorce . . . shall not be considered a taxable transfer . . . and such interest shall . . . be treated as [an HSA] with respect to which such spouse is the account beneficiary." *Id.* § 223(f)(7). In the event of the account beneficiary's

III. THE PROMISES AND PITFALLS OF HSAS

A. An Overview of the Contentious Environment

On the surface, HSAs appear to have the potential to drive down healthcare costs and dramatically increase access, because tax-free and interest bearing accounts, used in conjunction with low-cost HDHP plans, could lead to more affordable coverage.[79] However, HSAs are not a panacea to the health care crisis, and many detractors aver that HSAs increase savings for the wealthy, while offering little tax benefit or increased access to health care for the working poor.[80] The poor are unable to afford the high out-of-pocket limits and lofty deductibles, and do not realize substantial benefits, as the tax savings for workers in the lowest tax brackets are negligible at best.[81]

Detractors further contend that HSA plans primarily benefit younger workers without costly health problems or children, and are especially beneficial for wealthy individuals[82] who enjoy a much more significant tax break than poorer workers.[83] Additionally, opponents posit that HSAs will add $156 billion to the budget deficit over the next ten years, while unsatisfactorily reducing the number of uninsured Americans, and providing a much more significant benefit to the wealthy than to the working poor.[84]

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death, the interest in that HSA is transferred to an HSA where the surviving spouse is the beneficiary. *Id.* § 223(f)(8). If the beneficiary dies, transfer of the interest in the HSA to any other person defeats the HSA, and the amount is includible in the deceased's gross income (reduced by the amount of qualified medical expenses incurred before death), and estate taxes also are deducted from the interest in the HSA. *Id.* § 223(f)(8)(B).

79. *See* discussion *supra* Part II.

80. *See generally* CTR. ON BUDGET & POLICY PRIORITIES, A BRIEF OVERVIEW OF THE MAJOR FLAWS WITH HEALTH SAVINGS ACCOUNTS (2006), http://www.cbpp.org/hsa-overview.pdf (explaining that HSAs leave less-healthy, poorer individuals facing substantial out-of-pocket costs, and provide the largest tax benefit to the wealthiest Americans who are much more likely to already have insurance coverage).

81. *See* discussion *infra* Part III.B.

82. Presumably, President Bush is satisfied with his HSA-eligible plan. He and the First Lady took the maximum deduction ($4,250) in 2007, which reduced their adjusted gross income to $923,807. His effective income tax rate was approximately 24% in 2007. George W. Bush & Laura W. Bush, U.S. Individual Income Tax Return Form 1040, 2007 (2008), *available at* http://www.taxhistory.org/thp/presreturns.nsf/Returns/43394514D22A89F185256E750075F0F4/$file/GW_Bush_2007.pdf.

83. *Health Savings Accounts Hearing Before the H. Comm. on Ways & Means,* 109th Cong. 66 (2006) (joint statement of Gail Shearer and William Vaughan, Consumers Union), *available at* http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5214.

84. CTR. ON BUDGET & POLICY PRIORITIES, *supra* note 80, at 4.

Champions of HSAs provide compelling counterpoints which outline the successes of the program since its inception in 2003.[85] The Bush Administration, which signed HSAs into law, pointed to the fact that 40% of HSA plans are purchased by families earning less than $50,000 annually, and concluded that HSAs provide an attractive option for those who have difficulty purchasing traditional insurance policies.[86] Further, President Bush called attention to data which indicates that one-third of those participating in HSAs in the individual market were uninsured previously.[87]

Recent reports suggest that both camps have valid points in the debate. For example, a 2008 America's Health Insurance Plans (AHIP) report demonstrates that 6.1 million Americans were covered under HSA and HDHP insurance as of January 2008, and an AHIP 2007 report shows that 27% of those who purchased coverage in the individual market were uninsured previously.[88] While neither report specifies the total number of HSA enrollees who were uninsured previously, the 2008 report does state that a total 1.5 million people were enrolled in the individual market.[89] Therefore, the 27% of individual-market purchasers who were uninsured previously amounts to a net gain of about 405,000 newly-insured individuals.[90] A recent census report, however, shows that the actual number and percentage of uninsured Americans has trended upward since

85. Press Release, The White House, Fact Sheet: Health Savings Accounts: Myth vs. Fact (Apr. 5, 2006), *available at* http://www.whitehouse.gov/news/releases/2006/04/20060405-3.html.

86. *Id.* The press release presents the example of a family of four with an HSA-qualified plan. *Id.* Their HDHP premium is $5,150 annually, with a $5,500 deductible, and co-insurance of 20% up to a maximum of $10,000 out-of-pocket. *Id.* Under a PPO policy, the premium would be $9,900 annually, with a deductible of $1,000 and maximum out-of-pocket of $4,000. *Id.* If the family had $10,000 in medical expenses annually, they would save almost $1,000 with an HSA-qualified plan. *Id.*

87. *Id.*

88. AHIP, CTR. FOR POLICY & RESEARCH, JANUARY 2008 CENSUS SHOWS 6.1 MILLION PEOPLE COVERED BY HSA/HIGH-DEDUCTIBLE HEALTH PLANS 5 (2008), http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf [hereinafter AHIP, 2008 CENSUS REPORT]. Overall, 1.5 million individuals were covered by HSA-eligible plans in the individual market in January 2008, whereas 1.8 million were covered under plans in the small-group market, and 2.8 million in the large-group market. *Id.* at 5, 7, 8. The 2008 report updates a similar 2007 AHIP report, but does not break out the numbers of HDHP participants who were uninsured previously. The 2007 report provides the 27% figure. AHIP, CTR. FOR POLICY & RESEARCH, JANUARY 2007 CENSUS SHOWS 4.5 MILLION PEOPLE COVERED BY HSA/HIGH-DEDUCTIBLE HEALTH PLANS 5 (2007), http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf [hereinafter AHIP, 2007 CENSUS REPORT].

89. AHIP, 2008 CENSUS REPORT, *supra* note 86 at 5.

90. *See* AHIP 2007 CENSUS REPORT, *supra* note 86, at 5. While 27% of recent HSA-eligible plan enrollees in the individual market were uninsured previously, over 90% of new enrollees in the group market were insured previously by a PPO plan. *Id.* at 4.

the introduction of HSAs.[91] While the introduction of HSAs did not necessarily cause this increase, the census data may indicate that HSAs have had little discernible impact on Americans' overall access to insurance coverage.[92]

These polar-opposite views of the proponents and detractors of HSAs must be fully explored to find common ground and formulate solutions to expand upon the successes of the program, while mitigating the drawbacks. More importantly, common ground must be sought in order to help achieve the ultimate goal of reducing aggregate costs while concurrently increasing the insurance coverage rate and safeguarding high-quality outcomes. Thus, there are three options for the future of HSAs: continue the status quo to determine whether the long-term use of HSAs deliver upon the initial promises to reduce cost and increase access, tweak the system to address the perceived shortcomings, or scrap the system entirely and address alternatives to achieving increased health care coverage for the uninsured.

B. The Pitfalls of HSAs

Opponents of HSAs believe that HSAs have the potential to exacerbate the problems with America's health care system because such plans will do little to decrease the aggregate costs of health care, and could instead increase the number of uninsured in the United States.[93] Several factors contribute to this assertion, including the possibility that employers might discontinue traditional insurance plans in order to save money, making poorer employees less likely to purchase the new HDHP due to high out-of-pocket costs.[94] Consequently, the working poor would increasingly rely upon public health services and safety net insurance programs.[95] Opponents also indicate that HSAs shift financial risks from employers and insurers to individuals, leaving less-healthy individuals facing substantial costs, and possibly reduced-quality health care.[96] The fact that the current policy favors upper-income Americans who already have coverage, coupled with the risk-shifting of HSAs could result in a strain on the available funds

91. DENAVAS-WALT, *supra* note 4, at 19-27.

92. *See generally id.* The report does not mention a causal connection between the introduction of HSAs and the overall upward trend in the percentage and number of uninsured Americans, nor a connection to the increase in the number of those covered by government-sponsored programs and employer-sponsored insurance in recent years, but does show that fewer people are covered through employer-sponsored plans and individual coverage than in past years. *Id.*

93. CTR. ON BUDGET & POLICY PRIORITIES, *supra* note 80, at 1.

94. *Id.* at 2.

95. *See* CLAXTON ET AL., *infra* note 129 and accompanying text; *cf. id.* at 2-3

96. *See* CLAXTON ET AL., *infra* note 129 and accompanying text.

for safety net (i.e., Medicaid) programs.[97] A third argument against HSAs is that some insured individuals may procrastinate in seeking treatment for seemingly minor ailments if they have insufficient funds in their HSA. This effect could necessitate much more expensive treatment if the ailment develops into a chronic condition in the future.[98] While this is already true for uninsured people, a massive shift away from traditional (low out-of-pocket) plans to HDHPs may increase the number of those who are hesitant to seek necessary medical care because of the high cost.[99] At this point, the actual impact of decreased use of medical services is speculative because, so far, HSA enrollees tend to be healthier and wealthier than those enrolled in other plans, and evidence shows that these early adopters have not sacrificed care in exchange for reduced costs.[100] This could change if lower-income consumers purchase these plans in greater numbers, are in poorer health, and have deductibles which exceed their ability to pay for

97. *Id.*

98. *See generally* John W. Rowe et al., *The Effect of Consumer-Directed Health Plans on the Use of Preventive and Chronic Illness Services*, 27 HEALTH AFF. 113 (2008). The authors address the argument that HDHP plan enrollees are less likely to use preventive care, and posit that there is no discernable difference between preventive care usage rates between HDHP and PPO enrollees. *Id.* at 120. This study was limited, however, as all of the HDHP-covered (HRA in this case) individuals had complete coverage for preventive care and the study was limited to screenings for diabetes, pap smears, and mammograms. *Id.* at 115-16. Additionally, the employer-based HDHP plans in the study contributed an average of $5,000 to family accounts. *Id.* at 115. This methodology does not take into account the fact that many of the employers providing HSA-eligible plans do not contribute to employee accounts. CLAXTON ET AL., *infra* note 129 at 6. The authors conclude, without adequate support, that HDHP plan enrollees do not use preventive services any less than PPO enrollees without including data from plans where enrollees had no preventive care coverage outside of their deductible. From a recent survey, 41% of HSA/HDHP policies purchased in the individual market do not provide preventive care coverage outside of the deductible. AHIP, CTR. FOR POLICY & RESEARCH, A SURVEY OF PREVENTIVE BENEFITS IN HEALTH SAVINGS ACCOUNT (HSA) PLANS, JULY 2007 4 (2007), http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf [hereinafter AHIP, PREVENTATIVE BENEFITS IN HSAS]. Further, only 60% of firms offered health benefits in 2007, leaving many workers to be uninsured, purchase insurance on the individual market, rely on a spouse for coverage, or seek government benefits. *See* CLAXTON ET AL., *infra* note 129 at 3. Therefore, the conclusion in Rowe's article, *The Effect of Consumer-Directed Health Plans on the Use of Preventive and Chronic Illness Services*, that there is no difference in use of preventive care between HDHP and PPO users, should be limited to the specific context where the plan is (1) employer-provided, (2) provides preventive care coverage, and (3) the employer contributes funds to employee accounts.

99. If, for example, a person is unable to adequately fund his HSA account, he may lack the available "in pocket" resources to seek necessary treatment.

100. Melinda Beeuwkes Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFF. (WEB EXCLUSIVES) w516, w519 (2006), http://content.healthaffairs.org/cgi/reprint/25/6/w516.pdf.

necessary medical care without a significant adverse impact on their already precarious financial positions.[101]

Using data from 2005, the Government Accountability Office found that HSA-eligible plans had significantly lower premiums, higher deductibles, and higher out-of-pocket spending limits than traditional plans.[102] Lower premiums translate into measurable savings over PPO plans for healthier individuals, while less-healthy individuals pay significantly more under HSA-eligible plans.[103] In addition, this cost disparity may have monumental implications for women than for men.[104] Annually, the average insured woman spends $997 more for health care than does the average man.[105] Additionally, a survey taken in 2005 found that only 6.3% of families enrolled in HSA and MSA plans had purchased coverage for normal baby delivery,[106] while 32.2% of families enrolled in PPO plans and 98.8% of families enrolled in HMO and POS plans had purchased this coverage.[107] These coverage statistics are troubling when coupled with the

101. For a detailed explanation on the impact of cost sharing on healthcare usage and quality of care, see WILLARD G. MANNING ET AL., RAND CORP., HEALTH INSURANCE AND THE DEMAND FOR MEDICAL CARE (1988), *available at* http://www.rand.org/pubs/reports/2005/R3476.pdf.

102. U.S. GOV'T ACCOUNTABILITY OFF., CONSUMER-DIRECTED HEALTH PLANS, EARLY ENROLLEE EXPERIENCE WITH HEALTH SAVINGS ACCOUNTS AND ELIGIBLE HEALTH PLANS 11 (2006). For the group insurance market, HSA-eligible plan premiums, on average, were 35% less than traditional plan premiums for individuals, and 29% less for family coverage. *Id.* at 12. Annual deductibles under HSA-eligible plans were about six times higher ($1,901 for single coverage, $4,070 for family) than deductibles under traditional plans ($350 for single coverage, $700 for family). *Id.* at 12-13. Annual out-of-pocket spending limits under HSA-eligible plans ranged from $3,750 to $5,000 for single coverage and $7,500 to $10,000 for family coverage; traditional plans ranged from $1,000 to $2,350 for singles and $2,000 to $4,700 for families. *Id.*

103. *Id.* at 17. The report states an example of an illness resulting in hospitalization costs of $20,000. Total costs paid by HSA-enrollees would range from $3,710 to $5,111, while costs for a PPO enrollee would range from $2,136 to $3,472. *Id.* Therefore, a healthy person who uses minimal hospitalization services would simply pay the lower premium under the PPO plan, while the user of greater services incurs an additional charge of about $1,500 for the hospital utilization.

104. *See* Steffie Woolhandler & David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, 22 J. GEN. INTERNAL MED. 879, 880 (2007).

105. *Id.* at 880.

106. AHIP, CTR. FOR POLICY & RESEARCH, INDIVIDUAL HEALTH INSURANCE: A COMPREHENSIVE SURVEY OF AFFORDABILITY, ACCESS, AND BENEFITS 26 (2005), http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf [hereinafter AHIP, COMPREHENSIVE SURVEY 2005]. "With marked regional variation, estimates of the cost of having a baby in the U.S. range from $6,000 to $8,000 for a normal vaginal delivery and $10,000 to $12,000 for a cesarean birth." Dr. Spock.com, Ask Dr. Greenfield (July 18, 2001), http://www.drspock.com/faq/0,1511,8285,00.html.

107. AHIP, COMPREHENSIVE SURVEY 2005, *supra* note 106, at 26. The survey indicates that 100% of HSA, MSA, HMO, and POS family plans offer (including by rider) normal

fact that, on average, women earn about 25% less than men.[108] Thus, a single woman who is taxed at a lower rate than the average single man will receive a lesser tax benefit under an HSA-eligible plan, and is likely to pay higher out-of-pocket costs.[109]

In addition to the negative implications for women, increased HSA market penetration could adversely affect middle-aged Americans. To take advantage of probable savings, healthier and younger people are currently enrolling in HSA plans in larger numbers than older and unhealthier people, thus leaving the latter individuals remaining in traditional plans and paying exorbitant plan premiums for this coverage.[110] Removing infrequent users of health services from the individual market could create significant savings for the young and healthy at the cost of concentrating frequent users, thus increasing premiums overall.[111] In 2004, the U.S. healthcare

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baby delivery coverage, while 98% of PPO family plans offer (including by rider) that same coverage. *Id.* at 26-27. The survey states that the "results suggest that the typical HMO benefit package automatically includes most of the optional benefits common in [the] market." *Id.* at 27. The survey also notes that "HSA/MSA products generally include preventive care, though most routine expenses are likely funded through the savings account" and that it "appears that maternity-related benefits are among those that consumers are most likely to consider optional." *Id.*

108. DENAVAS-WALT, *supra* note 4, at 8. In 2006, women employed fulltime earned an average of $33,437, while men earned $43,460. *Id.*

109. *See* IRS.gov, 2007 Federal Tax Rate Schedules, http://www.irs.gov/formspubs/article/0,,id=164272,00.html (last visited Oct. 13, 2008) (showing that on the 2007 Federal Tax Schedule, income between $7,825 and $31,850 is taxed at 15%, while income between $31,850 and $77,100 is taxed at 25%).

110. *See* EDWIN PARK, CTR. ON BUDGET & POLICY PRIORITIES, GAO STUDY AGAIN CONFIRMS HEALTH SAVINGS ACCOUNTS PRIMARILY BENEFIT HIGH-INCOME INDIVIDUALS 3 n.7 (2008), http://www.cbpp.org/5-19-08health.pdf. Many states have high-risk health pools, which are "[s]tate programs that offer health insurance to residents who are considered uninsurable and unable to buy coverage in the individual market. Typically, people are considered uninsurable if they have been turned down, charged substantially higher premiums, or if they have been offered private coverage with an elimination rider." Statehealthfacts.org, State High Risk Pool Programs and Enrollment, 2007, http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7 (last visited Nov. 29, 2008). The potential impact of healthier individuals leaving the general pool could increase rates for those left behind, and the large rate increase could potentially make more people qualify for a state's high risk pool, thereby increasing strain on those programs and requiring increased subsidies. *See* PARK, *supra*, at 3 n.7.

111. *See* AHIP, COMPREHENSIVE SURVEY 2005, *supra* note 106, at 3.

Many states have high-risk pools, which allow people who cannot get individual health insurance because of a medical issue to purchase coverage. However, premiums in high-risk pools can be high, which can limit their usefulness for people with lower incomes.

In a few states, age-based premiums and medical underwriting for new policies are not allowed. However, those states tend to have higher average premiums. In those cases, younger and healthier people may not purchase coverage in sufficient numbers to balance insurance pools. When this happens, premiums reflect the higher average costs of older and less healthy people, and people with low- or moderate- incomes may not be able to afford coverage. *Id.*

spending per capita was $3,370 for those aged nineteen to forty-four, and $7,787 for those aged fifty-five to sixty-four.[112] The numbers show that younger workers, with lower expected out-of-pocket healthcare costs and significant tax savings, stand to gain the most from HSA enrollment. Further, middle-aged people are more likely to be denied health coverage on the individual market, and thus are precluded more frequently from potential HSA savings.[113] In 2006, about 25% of those aged fifty-five to sixty-four who applied for individual health insurance were denied coverage, compared with about a 10% rejection for those aged eighteen to forty-four.[114] For those aged fifty-five to sixty-four who were offered coverage, many were subject to higher premiums and were required to sign condition waivers.[115]

Health Savings Account enrollees not only trend younger, but also trend wealthier. According to a 2006 General Accountability Office report, HSA-eligible plan enrollees have higher-than-average incomes, with 51% of tax filers reporting HSA contributions having gross incomes in excess of $75,000, while only 18% of all filers under the age of sixty-five reported this income level.[116] This phenomenon could be attributed to several factors. First, since wealthier people stand to gain a larger tax benefit from HSAs, it could be in their best financial interest to enroll in HSA-eligible plans.[117] Second, wealthier people are in a better financial position to pay unexpected out-of-pocket costs should they require significant medical care. Third, even if the uninsured can afford the reduced premiums of HSA-eligible plans, most lack adequate assets to meet the high deductibles that HSA-eligible plans require, and have insufficient liquid assets to pay substantial out-of-pocket expenses.[118] Fourth, lower-paid workers are less

112. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH EXPENDITURES BY AGE, 2004 AGE TABLES 2, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf (last visited Nov. 29, 2008).

113. *See* AHIP, CTR. FOR POLICY & RESEARCH, INDIVIDUAL HEALTH INSURANCE 2006-2007: A COMPREHENSIVE SURVEY OF PREMIUMS, AVAILABILITY, AND BENEFITS 11-12 (2007), http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf [hereinafter AHIP, COMPREHENSIVE SURVEY 2007] (stating that older Americans are more likely to be denied health insurance coverage in the individual market than younger Americans). In this AHIP report, HSAs/MSAs comprised 10.2% of individual market policies in force during the study period and 23.3% of family policies. *Id.* at 16. PPO/POS plans constituted about 78% of individual and 65.7% of family plans; HMOs accounted for 6.0% and 5.5% of individual and family plans, respectively. *Id.* at 12 tbl.7.

114. *Id.* at 12 tbl.7.

115. *Id.* at 14 tbl.9.

116. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 100, AT 5. The cited data was derived from 2004 tax returns. *Id.*

117. *See* IRS, *supra* note 109 (showing that wealthier taxpayers are taxed at a higher rate).

118. *Health Care Affordability and the Uninsured: Hearing on the Instability of Health*

likely to be offered employer-sponsored coverage, and must pay the full plan premium on the individual market, in addition to the out-of-pocket expenses and deductibles.[119]

Even for those whose employers offer HDHP coverage, out-of-pocket expenses remain a barrier to the ultimate adoption of such plans. The average maximum out-of-pocket expense for HSA-eligible plans is $4,800, so even though a family is covered by a health plan, it still might be unable to afford medical treatment.[120] This "average maximum" does not consider the fact that current policy allows annual out-of-pocket expenses to run more than twice that amount—up to $11,600 for a family in 2009.[121] As an example,[122] one HSA-eligible plan covers 80% of most medical expenses after the family deductible ($6,000) and out-of-pocket limits ($4,000) are paid.[123] The resulting $10,000 family responsibility, along with the fact that some plans do not cover prescription medications, could leave a covered family with significant medical bills after just one accident or serious illness.

Coverage Before the H. Comm. on Ways & Means Health Subcomm., 110th Cong. 6 (2008) (testimony of Diane Rowland, Executive Vice President, Henry J. Kaiser Family Foundation; Executive Director, Kaiser Commission on Medicaid and the Uninsured) [hereinafter Rowland Testimony], http://waysandmeans.house.gov/media/pdf/110/Rowland.pdf. Diane Rowland indicates that three-quarters of the uninsured population come from households with incomes below 300% of the poverty level, and that a Kaiser study showed that the average family in this situation had about $300 in discretionary cash to cover deductibles and out-of-pocket expenses. *Id.*

119. *Id.* at 2.

120. Paul D. Jacobs & Gary Claxton, *Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans*, 27 HEALTH AFF. (WEB EXCLUSIVES) w214, w215 (2008), http://content.healthaffairs.org/cgi/reprint/hlthaff.27.3.w214v1.pdf.

121. Rev. Proc. 2008-29, 2008-22 I.R.B. 1039.

122. This is simply an illustrative example for a family plan in the upper range of allowable deductibles and out-of-pocket expenses. A recent survey of the individual market indicates that the average deductible for an HSA-eligible family plan in 2006 was $5,329, with 18.5% of family HSA-eligible plan deductibles exceeding $6,000 annually. AHIP, COMPREHENSIVE SURVEY 2007, *supra* note 113, at 17 tbl.13. In contrast, the average family deductible in the individual market was $2,753 for PPO plans and only $1,234 for families in HMO plans. *Id.* at 17-18 tbls.13 & 14. The average out-of-pocket limit for families covered under HSA plans in the individual market was $6,020, with 17.6% of plans requiring out-of-pocket limits greater than $10,000. *Id.* at 19 tbl.15. In contrast, average out-of-pocket limits in the individual market for family policies were $4,410 and $4,388 for PPOs and HMOs, respectively. *Id.* Virtually none of the PPO or HMO plans had out-of-pocket limits greater than $10,000. *Id.*

123. Humana, Illinois Health Insurance Plans, http://www.humana-one.com/illinois-health-insurance/autograph/individual-health-plans-benefit-sheet.asp (last visited Oct. 13, 2008). This is merely an illustrative example of coverage. Other plans offer lower deductibles and out-of-pocket limits, but the premiums could be cost-prohibitive for many families. Further, plan premiums may vary widely by state.

Also, note that the maximum family contribution to an HSA account is just $5,950.[124] Consequently, a family that endures just one serious illness over the course of a year will receive an HSA tax benefit only for one-half of their healthcare spending for that year, exclusive of plan premiums. This conclusion assumes the maximum allowable deductible and out-of-pocket expenses. A family might choose this plan to achieve maximum savings on a premium, but it is often difficult, if not impossible, to predict significant future health issues. Furthermore, only about one in five uninsured households has net financial assets sufficient to pay even the *minimum deductibles* in HSA-eligible plans, barring consideration of additional out-of-pocket expenses and plan premiums.[125]

Even the average HDHP-insured family is not immune from substantial healthcare debt under such plans.[126] The typical insured family had $4,000 in available liquid assets in 2004, which is significantly less than the $11,000 the family might have to pay in the event of a hospitalization or serious illness.[127] When median household debts are added into the picture, the situation worsens, as most insured households have net positive assets of only $30.[128]

The cost-shifting burden that households face is further magnified for employees covered by HSA-qualified HDHP plans whose employers do not contribute to their accounts. Although many employers partially or fully offset their employees' out-of-pocket liability, 28% of employers offering HSA-eligible plans do not contribute to employees' HSAs,[129] but this

124. Rev. Proc. 2008-29, 2008-22 I.R.B. 1039.

125. Rowland Testimony, *supra* note 118, at 7.

126. AHIP, 2008 CENSUS REPORT, *supra* note 88, at 12 tbl.9 (indicating that in 2007, 50% of HSA accounts had balances less than $1,000, while 7% of accounts had balances of more than $5,000).

127. Jacobs & Claxton, *supra* note 120, at w216.

128. *Id.* at w217. When household debts like car loans, educational expenses, credit card debt, etc. are taken into consideration, many insured families face a bleak financial outlook, especially when they experience unexpected healthcare costs.

129. CLAXTON ET AL., KAISER FAMILY FOUND. – AND – HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS, 2008 ANNUAL SURVEY 6 (2008), http://ehbs.kff.org/pdf/7790.pdf. The above assertion raises another question. Are employers pocketing the savings by switching employees to lower-cost plans, and then expecting employees to contribute a greater percentage of their income to healthcare costs? The average annual premium for an employer-provided PPO plan for single coverage was $4,802 in 2008, with employees contributing an average of $731. *Id.* at 2 exhibit B. The average annual cost of an employer-provided HDHP/SO plan for single coverage was $3,922 in 2008, with employees contributing an average of $468. *Id.* From these statistics, it seems that the employer saves $617 per employee per year by offering HDHP/SO plans in lieu of traditional PPO plans, yet this savings has not yet resulted in more firms offering insurance coverage to their employees. It would be interesting to determine the effect that these plans have on average employee wage/benefit packages. According to the survey, 84% of small, non-offering firms believed that employees would rather have two dollar per

contribution rate has improved significantly since 2007.[130] For employers that contributed to employees' HSAs, the average contribution was $1,139 for single coverage and $2,067 for family coverage.[131] Thus, an individual "heavy user," whose employer contributes at the average rate, might contribute around $871 in annual deductibles in addition to paying his portion of the plan premium and out-of-pocket expenses, assuming the average deductible for HSA-eligible plan.[132]

The higher incidence of HSA utilization by wealthier individuals also can be explained by the fact that persons earning between $25,000 and $49,999 annually are 68% less likely to be offered employer-sponsored coverage than those earning over $100,000.[133] Thus, many families in this earning group must purchase coverage on the individual market.[134] For example, assume that in 2007 a fifty-year-old person earning $25,000 purchased the average HSA-eligible policy ($2,668 annual premium,

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hour raises than insurance coverage. *Id.* at 35. The two-dollar-per-hour figure approximates the cost of providing health insurance. *Id.*

130. CLAXTON ET AL., *supra* note 129, at 123.

131. *Id.*

132. This assumes the average plan deductible ($2,010) and the average employer contribution ($1,139), exclusive of plan premiums and any additional out-of-pocket expenses.

133. SHARON A. DEVANEY & SOPHIA T. ANONG, BUREAU OF LABOR STATISTICS, THE LIKELIHOOD OF HAVING EMPLOYER-SPONSORED HEALTH INSURANCE (2007), http://www.bls.gov/opub/cwc/cm20071128ar01p1.htm.

134. Many families in this income range are ineligible for Medicaid. While income eligibility for children is typically around 200% of the federal poverty level, parent eligibility is often below poverty level. JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, CHARACTERISTICS OF THE UNINSURED: WHO IS ELIGIBLE FOR PUBLIC COVERAGE AND WHO NEEDS HELP AFFORDING COVERAGE? 8 (2007). In 2007, 765,000 families of four earned between $42,500 and $49,999, and 200% of the federal poverty level was $42,406 for the same period. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY, ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT, SELECTED CHARACTERISTICS OF FAMILIES BY TOTAL MONEY INCOME IN 2007 (2008); U.S. CENSUS BUREAU, POVERTY THRESHOLDS FOR 2007 BY SIZE OF FAMILY AND NUMBER OF RELATED CHILDREN UNDER 18 YEARS, http://www.census.gov/hhes/www/poverty/threshld/thresh07.html. Illinois, however, allows families to purchase insurance from the State at relatively low costs. *See* Familycareillinois.com, FamilyCare, http://www.familycareillinois.com (last visited Oct. 13, 2008). In the standard FamilyCare plan, there are small co-pays, from $2 to $5, for doctor visits and prescriptions. *Id.* Parents in the FamilyCare Premium plan pay a monthly premium, from $15 to $40, depending on the number of family members covered. *Id.* Under the highest FamilyCare Premium level, a family of four can earn up to $84,404 and still purchase state-sponsored coverage. Familycareillinois.com, FamilyCare Monthly Income Standards, http://www.familycareillinois.com/income.html (last visited Oct. 13, 2008). FamilyCare plans offer healthcare coverage to parents living with their children 18 years old or younger, and also covers relatives who are caring for children in place of their parents. Familycareillinois.com, FamilyCare, http://www.familycareillinois.com (last visited Oct. 13, 2008).

$3,449 out-of-pocket limit) on the individual market,[135] contributed the maximum to her HSA ($2,850),[136] and consumed the average quantity of healthcare services ($5,210).[137] She would save $428 from her tax deduction, and therefore spend about 20% of her gross income ($5,127) on healthcare coverage.[138] Assuming the same out-of-pocket spending limit, HSA contribution, deductible, and service utilization, a person earning $100,000 with an employer-offered HSA-eligible plan would pay $522 in annual premiums,[139] and save $758 in taxes.[140] Here, the person earning $100,000 only spends $3,213 in annual healthcare costs—much less than the poorer person—and a mere 3% of her gross income.

Since HSAs are a relatively recent phenomenon, and such a small percentage of Americans are covered under such policies,[141] it is too early to determine conclusively whether the purported benefit of consumer choice[142] will outweigh the potentially worse outcomes resulting from lower consumption of healthcare services.[143] This phenomenon, termed "adverse selection," occurs where those with naturally high medical costs tend to purchase insurance to cover high expenses.[144]

The theory underlying consumer directed health care is that traditional health insurance plans insulate consumers from the actual cost of treatment by requiring only small co-payments. Therefore, the consumer has an incentive to request additional services (which may only provide marginal benefits) at a high cost to the insurer, but a relatively low out-of-pocket cost to the consumer.[145] This "moral hazard effect" occurs when consumers use a greater quantity or more expensive health care services when they are

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135. AHIP, 2007 CENSUS REPORT, *supra* note 88, at 6, 7.

136. Rev. Proc. 2007-36, 2007-22 I.R.B. 1335.

137. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 112, at 2. The number indicated is in 2004 dollars.

138. *See* Dep't. of the Treasury, *supra* note 45.

139. *See* CLAXTON ET AL., *supra* note 129, at 68.

140. Dep't. of the Treasury, *supra* note 45.

141. In 2008, 8% of covered workers were enrolled in an HDHP plan, while 58% were enrolled in PPOs, 20% in HMOs, and 12% in POS plans. CLAXTON ET AL., *supra* note 127, at 64.

142. Referring to the notion that people will indeed realize lower overall costs by choosing alternative treatments, foregoing "unnecessary" or expensive treatments, or demanding more upfront price transparency from providers. This point is discussed further *infra* § III.B.

143. Katherine Baiker et al., *Lowering the Barriers to Consumer-Directed Health Care: Responding to Concerns*, 26 HEALTH AFF. 1328, 1328 (2007).

144. ECONOMIC REPORT OF THE PRESIDENT 104 (2008), *available at* http://www.gpoaccess.gov/eop/2008/2008_erp.pdf.

145. Martin Feldstein, *Balancing the Goals of Health Care Provision and Financing*, 25 HEALTH AFF. 1603, 1604 (2006).

required to pay less because their insurance covers a greater portion of the cost.[146] For example, where a new drug costs substantially more but provides a negligible benefit over an older drug, an insured person has no incentive to use the cheaper drug when she is not exposed to the true cost. Theoretically, HSAs coupled with HDHPs reduce the moral hazard effect by ensuring that consumers are cognizant of true costs, and will henceforth think twice about spending significant amounts of money for services which provide negligible or marginal therapeutic value.

If the moral hazard and adverse selection theories prove true, then HSA proponents have a valid point. If the significant drawbacks of HSAs materialize over the long-term, however, then HSAs will simply exacerbate the healthcare crisis.

C. The Promises of HSAs

Thus far, evidence suggests that HSA-eligible plan premiums have increased at a lesser rate than traditional plans, and as such, these plans reduce overall costs for both businesses and consumers.[147] Lower costs make these plans attractive for smaller businesses, which are traditionally less likely to offer health insurance coverage.[148] Proponents say that as consumer choice increases, the healthcare industry will react to market demands by providing innovative value-conscious services, improving efficiency, and working to reduce administrative costs.[149] The consumer choice movement will prod providers to create transparency in service pricing to facilitate truly informed choice, lower costs, and adequate care.[150] Further, HSAs will increase access to affordable coverage to pay for major medical events, thereby reducing governmental expenditures on health care for the uninsured.[151]

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146. ECONOMIC REPORT OF THE PRESIDENT 104 (2008).

147. *See* CLAXTON ET AL., HENRY J. KAISER FAM. FOUND. -AND- HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY, 68-74, 120-24 (2007).

148. *Id.* at 34. Small firms with 3-199 workers account for 97% of employers in America, but only 59% of these firms offered health benefits in 2007 (down from 68% in 2000). *Id.* Forty-five percent of firms with 3-9 employees offered coverage. *Id.* In contrast, 99% of larger firms offered coverage in 2007. *Id.* Seventy-two percent of surveyed employers who did not offer coverage cited cost as a deterrent factor. *Id.* at 35.

149. *See* DEVON M. HERRICK, NAT'L CTR. FOR POLICY ANALYSIS, CONSUMER-DRIVEN HEALTH CARE SPURS INNOVATION IN PHYSICIAN SERVICES 1-2 (2006), *available at* http://www.ncpa.org/pub/ba/ba559/ba559.pdf.

150. *See generally* Gail R. Wilensky, *Consumer-Driven Health Plans: Early Evidence and Potential Impact on Hospitals*, 25 HEALTH AFF. 174, 183-84 (2006).

151. NAT'L ECON. COUNCIL, REFORMING HEALTH CARE FOR THE 21ST CENTURY 4 (2006), *available at* http://www.whitehouse.gov/stateoftheunion/2006/healthcare/healthcare_booklet.pdf.

As mentioned previously, small businesses are less likely to offer health coverage, and cite the high expense as the main barrier.[152] Many small businesses would welcome an affordable way to cover their employees because they find that their failure to provide coverage hampers their ability to attract and retain top talent.[153] One explanation for why the rate of small businesses offering health insurance has dropped from 68% in 2000 to 59% in 2007 is the fact that the cost of provision has more than doubled over the same period, significantly outpacing both inflation and wages.[154] Given that a business with fifteen employees could save 40% on health care costs over traditional plans by offering HSA-eligible plans, HSAs become an attractive option.[155] In fact, 31% of HSA plan adoption in the small group market (firms with 50 employees or less) came from firms that previously did not cover their employees.[156]

In addition to savings for businesses, HSA proponents posit that increased consumer choice in healthcare decisions will encourage smarter choices, less waste, and innovative solutions to reduce cost without sacrificing quality.[157] In other words, HSAs will help reduce the moral hazard effect.[158] One practical example of this concept is the recent phenomenon of limited-service health clinics[159] located in pharmacies and supermarkets.[160] Nurse practitioners staff these clinics, which offer limited treatments, such as vaccines, strep tests, cholesterol screening, and treatment for common illnesses (i.e. allergies, ear infections, pink eye).[161] Prices for each service are clearly listed on a "treatments and services"

152. Mark E. Battersby, *A Health Savings Account for Every Business—and Owner*, PROOFS 61, 62 (Jan. 2008).

153. *See Id.*

154. CLAXTON ET AL., *supra* note 147, at 18, 34.

155. Stanley Kess, *Tax Tips for Small Businesses*, NAT'L PUB. ACCT., June-July 2007, at 6.

156. AHIP, 2008 CENSUS REPORT, *supra* note 86, at 1.

157. HERRICK, *supra* note 149, at 1-2.

158. *See generally id.*

159. Critics of these clinics include many physicians, who believe that such clinics lead to suboptimal outcomes because there is lack of access to complete patient records, improper follow-up after treatment, and public health issues that could arise when patients with contagious diseases are in a commercial, retail environment, among other issues. Additionally, many physicians see visits for minor ailments as an opportunity to identify other possible illnesses or maladies that nurse practitioners are not trained to notice. ROBERT M. CORWIN ET AL., AMERICAN ACADEMY OF PEDIATRICS, AAP PRINCIPLES CONCERNING RETAIL-BASED CLINICS 1-2 (2006), http://www.aap.org/advocacy/releases/rbc.pdf.

160. *Id. See also* PricewaterhouseCoopers' Health Research Inst., *Top Eight Health Industry Issues in 2008*, MED. BENEFITS, Mar. 15, 2008, at 1.

161. Minuteclinic.com, Treatment and Cost at Minute Clinic, http://www.minuteclinic.com/en/USA/Treatment-and-Cost.aspx (last visited Nov. 11, 2008).

menu, allowing consumers to determine costs upfront, which tend to be much lower than similar treatment at a traditional doctor's office.[162]

Retail clinics are simply an illustrative example of how price transparency can empower consumers to make value-conscious healthcare decisions. The advent of instant electronic access to medical information is another factor leading to value-conscious decision-making. According to a Pew Research survey, 80% of American internet users (113 million adults) use the web to research medical-related issues.[163] Many states have recognized that this unprecedented access to instant information gives consumers a powerful tool for reducing costs. Now, some states require that healthcare providers publish hospital "parts and labor" prices online.[164] Critics charge that the current requirements do not depict the actual fees that hospitals charge (i.e. whether hospitals give insurance companies rates that are substantially discounted from the published prices), the pricing information is too complex, is not readily comparable by average consumers, and therefore will have a negligible impact on consumers' ability to make value-conscious choices.[165]

Consumer driven health care rests on the idea that transparency causes competition among providers to offer quality services at more market-driven prices. In order to remain competitive on price without a calamitous impact on quality, providers may attempt to reduce administrative expense, a key factor in the high cost of health care.[166] Efficiency boosts (and corresponding reductions in administrative costs) can come through the use

162. *Id.* Treatments for common illnesses at Minute Clinic range from $59 to $69. *Id.* An average office visit to a physician can cost $87, and in addition, customers might pay double for lab costs. Laura Landro, *The New Force in Walk-In Clinics*, WALL STREET J. ONLINE, July 26, 2006, http://online.wsj.com/public/article_print/SB115387157235517194.html. To illustrate this point, consider a parent seeking a school-mandated sports physical for her child. Such a service is not technically preventive care, and therefore might not be a qualified covered expense under the HDHP. The consumer may choose between the expensive (some might say unnecessary) doctor visit and the convenient retail center clinic.

163. SUSANNAH FOX, PEW INTERNET & AM. LIFE PROJECT, ONLINE HEALTH SEARCH 1 (2006), http://www.pewinternet.org/pdfs/PIP_Online_Health_2006.pdf.

164. At least thirty states have proposed or enacted legislation that includes measures affecting disclosure, transparency, reporting and/or publication of health care and hospital charges and fees. Ncsl.org, State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges (Sept. 25, 2008), http://www.ncsl.org/programs/health/transparency.htm.

165. As an example, the "charge description master" for one hospital is 99 pages long, and includes terms that may be unfamiliar to anyone outside of the medical profession. Xnet.kp.org, Kaiser Foundation Hospitals, Northern California Region Charge Description Master, http://xnet.kp.org/hospitalcharges/downloads/kfh_nocal_cdm_ab1627.pdf (last visited Nov. 11, 2008).

166. Administrative costs comprise 7% of health care spending. Kaiseredu.org, U.S. Health Care Costs: Background Brief, http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358 (last visited Nov. 11, 2008).

of electronic medical records, promotion of evidence-based medicine, and provider pay-for-performance.[167]

The Veterans Administration hospital system exemplifies how vast gains in efficiency, productivity and patient safety can be achieved through the use of a comprehensive electronic patient management system.[168] This system, VistA,[169] allows providers complete access to patients' records from computers throughout the hospital, including care history, medications, allergies, imaging results, and many other pertinent patient details.[170] Thus, a treating physician can access laboratory results or medical images immediately, without waiting for information to arrive from a separate facility. This system resulted in a dramatic reduction in error,[171] increase in favorable patient outcomes, a 6% annual improvement in operating efficiency, and a 32% reduction in costs.[172] The private healthcare market, however, has not adopted electronic patient records to the extent that the Veterans Administration has, in part because of high implementation costs necessary for such a comprehensive system.[173] The

167. HENRY J. KAISER FAM. FOUND., HEALTH CARE COSTS: A PRIMER 13 (2007), http://www.kff.org/insurance/upload/7670.pdf.

168. *See generally* Dwight C. Evans et al., *Effect of the Implementation of an Enterprise-Wide Electronic Health Record on Productivity in the Veterans Health Administration*, 1 HEALTH ECON. POL'Y & LAW 163 (2006) (describing the dramatic change in service quality and efficiency after the implementation of a system-wide electronic health record database).

169. VistA is an acronym for Veterans Health Information Systems and Technology Architecture. The VHA is the largest integrated health system in the United States, providing care for 5.3 million patients who tend to be older, sicker, and poorer than the general population. DEP'T VETERANS AFF., VISTA WINNER OF THE 2006 INNOVATIONS IN AMERICAN GOVERNMENT AWARD, overview at 2 (2006), *available at* http://www.innovations.va.gov/innovations/docs/InnovationsVistAInfoPackage.pdf.

170. Evans et al., *supra* note 168, at 164.

171. For example, an average of one out of twenty prescriptions contains errors, while the VHA's automated drug distribution process has a seven-per-million failure rate. The system uses bar codes such that the nurse scans the patient's unique barcode, then the barcode on the medication, and the patient's medication dosage automatically updates on his chart. DEP'T VETERANS AFF., *supra* note 167, intro. at 1.

172. *Id.* at overview 1. "Adjusted for inflation, VHA care is 32% less expensive than a decade ago, with measurably better outcomes in quality, satisfaction, access, and patient function." *Id.* Over the same period, "the nominal dollar medical consumer price index has increased 50%." *Id.*

173. HEALTHCARE FIN. MGMT. ASS'N, OVERCOMING BARRIERS TO ELECTRONIC HEALTH RECORD ADOPTION 2 (2006), *available at* http://www.hhs.gov/healthit/ahic/materials/meeting03/ehr/HFMA_OvercomingBarriers.pdf. Among cited reasons for not implementing an electronic system, lack of funding was a major concern, along with lack of national information standards, lack of interoperability, and concern about physician usage. *Id.* Mid-sized and rural hospitals cited funding as a more significant barrier than did larger urban hospitals. *Id.* The Department of Health & Human Services is working to alleviate these concerns by creating national certification and awarding grants to smaller providers to implement electronic health records. Press Release, U.S. Dep't of Health & Human Servs.,

market, though, is stepping in to provide less-costly alternatives. Recently, Google partnered with Kaiser Permanente and the Cleveland Clinic to develop a web-based system to allow patients (consumers) to refill prescriptions and schedule appointments online.[174] So far, the system has increased productivity and reduced routine phone calls to doctors.[175]

If HSA proponents are correct, all Americans will benefit from increased market penetration of these plans. If consumer choice indeed encourages value-conscious decisions, leading to pricing transparency, and compelling increased provider efficiency and productivity, then the aggregate costs of the entire healthcare system will decrease. In theory, this will allow greater access to coverage for the uninsured.

The question remains whether a policy allowing wealthy individuals to pay *less* for insurance (through de facto regressive tax treatment) than middle-class individuals is wise in light of the dual aims of reducing costs and increasing affordable access to health care. Also, would HSAs work more effectively to achieve the stated goals if all healthcare consumers were placed on parity with regard to the tradeoff between lower costs or comprehensive coverage? These questions remain unanswered, so the HSA/CDHP paradigm will either evolve through efforts to ensure a balance between cost containment and adequate care, or it will remain as an additional option for the healthy and/or wealthy to save money on premiums and create lucrative tax shelters without discernable benefits to the healthcare system.[176] If improvements are made quickly to make these plans viable for a wider range of healthcare consumers, then there may be a realization of net benefits once a critical mass embraces the plans.

IV. IMPROVING THE OUTCOME—PROPOSED AND ADOPTED MEASURES TO ENSURE THAT HSAS CONTAIN COSTS, REDUCE THE NUMBER OF UNINSURED, AND MAINTAIN QUALITY CARE

President Bush proposed giving a tax credit to less-wealthy individuals to enable them to purchase HDHP coverage, while also replacing the current tax exemption for employer-sponsored coverage.[177] This change

Announcement to Help Speed Adoption of Electronic Health Records (July 18, 2006), *available at* http://www.hhs.gov/news/press/2006pres/20060718.html.

174. John Carey & Catherine Holahan, *Google Goes to the Doctor's Office*, BUS. WK. ONLINE (Feb. 21, 2008), *available at* http://www.businessweek.com/print/technology/content/feb2008/tc20080220_109894.htm. John Privacy and security issues may arise from web-based services, and need to be fully addressed before such a project is implemented on a wide scale. *Id.*

175. *Id.*

176. This assumes no further changes to HSA policy. *See infra* Part IV. for a discussion of how proposed changes to the law may increase HSA-plan adoption.

177. ECONOMIC REPORT OF THE PRESIDENT 108-09 (2008).

aimed to incentivize the purchase of lower cost plans by putting the choice in the hands of consumers, rather than employers by creating a deduction for the first $7,500 of income for individuals or $15,000 for families.[178] Under the current policy employees have an incentive to choose more coverage than necessary from their employers because this benefit lowers their tax exposure (insurance is not a taxable benefit), and the employer benefits by not paying a payroll tax on health benefits.[179] Under the proposed policy, the HSA-related tax credit would encourage employees to choose more appropriate coverage. Another purported benefit of this change is that individual purchasers without access to employer-sponsored coverage will receive the same favorable tax treatment as those who purchase group coverage.[180] Each family would receive an equal tax credit, so there is an incentive to reduce costs by only purchasing a plan which meets the family's specific needs, not one that provides costly coverage for unnecessary services.[181] An objection to this proposal is that many small employers may stop offering coverage to employees because the tax implications in the proposed HSA policies erase any tax advantage to be gained by offering such plans, as wages are taxed, but under current policy, the payment of insurance premiums is not taxed.[182]

In light of the decline in the percentage of small employers that offer coverage, and the federal government's inaction in addressing this phenomenon, some states have stepped into the fray by creating incentives for employers to provide insurance coverage.[183] Such measures allow employers the option of providing HSA-eligible plans. Some state statutes address many of the coverage problems addressed in this comment, including the challenges that small employers face in providing coverage.[184]

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178. *Id.* Under the proposed policy, every family that purchases health insurance would receive the same flat tax break. *Id.* Unlike the tax exemption, people who purchase more expensive policies are not rewarded with an extra tax benefit that is not available to families who cannot afford such an expensive insurance plan. The Report gives the example of a family of four earning $50,000 with an employer-sponsored plan. *Id.* at 109. Under the current rules, the family that purchases a $10,000 plan receives a $3,000 tax break, while the family that purchases a $20,000 plan receives $6,000. *Id.* The proposed flat deduction means that either family would receive the same $4,500 tax savings, regardless of the plan purchased. *Id.*

179. *Id.* at 108.

180. *Id.* at 109.

181. ECONOMIC REPORT OF THE PRESIDENT 109 (2008).

182. JONATHAN GRUBER, CTR. BUDGET & POL'Y PRIORITIES, THE COST AND COVERAGE IMPACT OF THE PRESIDENT'S HEALTH INSURANCE BUDGET PROPOSALS 3 (2006), *available at* http://www.cbpp.org/2-15-06health.pdf.

183. *See* MD. CODE ANN., INS. § 15-12A-02 (2008); *see also* OR. REV. STAT. § 414..839 (2008).

184. Maryland's subsidies, discussed *infra*, have the purported goals of incentivizing small-business employee coverage for low to moderate income workers, reducing

Maryland, for example, will provide subsidies to small employers which did not previously offer coverage to workers, and also will give subsidies to employees not previously eligible for employer-sponsored coverage.[185] The subsidy applies to HSA-eligible policies if employees receive a wellness benefit, and the state may provide additional employer subsidies for contributions to HSA accounts.[186] One positive aspect of the program is the inverse relationship between the amount of the employee subsidy and his or her wages. A person earning less than $25,000 might receive a $5,000 subsidy, while a person earning $45,000 might receive $1,000.[187] If these incentives are coupled with HSA-eligible plans, the goal of consumer choice is met, since Maryland's plan does not affect minimum deductibles, and the HSA plans themselves become much more affordable. Hence, consumers still have an impetus to keep costs low (because out-of-pocket costs are not affected), while access to adequate health coverage is increased.[188] The overall efficaciousness of Maryland's approach remains unknown, as the plan is limited in scope and has not yet been implemented. If, however, the plan proves successful, the federal government and other states should consider similar measures to entice small businesses to provide coverage, thereby reducing risk exposure to the low-income insured.

Oregon approaches the issue differently. The Healthy Oregon Act, passed in 2007, provides the statutory framework for an overhaul of the state's health insurance funding schema.[189] Part of the Act requires the Oregon Health Fund Commission to explore options to make HSAs more accessible to the uninsured.[190] The general thrust of the legislation mirrors

uncompensated care in hospitals and emergency rooms, and promoting access to preventive care services. MD. CODE ANN., INS. § 15-12A-02 (2008).

185. MD. CODE ANN., INS. § 15-12A-02 (2008). The subsidies are limited in scope, however, to employers with fewer than nine full-time employees, where the average wages at the company are less than $50,000. Maryland Health Care Commission, *Maryland's Small Employer Subsidy Program*, http://mhcc.maryland.gov/smallemployersubsidy/index.html (last visited Nov. 11, 2008). An eligible company may grow to twenty employees without losing the subsidies. *Id.* Under the program, both employers and employees receive a subsidy of up to 50% toward the cost of the premium. *Id.* These are preliminary regulations, though, and final details of the plan may change. *Id.* Maryland also attempted a mandate for all large employers within the state to provide health insurance coverage, including HSAs, but the plan was preempted under ERISA. *See generally* Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007).

186. MD. CODE ANN., INS. § 15-12A-04 (2008).

187. Maryland Health Care Commission, *supra* note 183.

188. *See* MD. CODE ANN., INS. § 15-12A-02 (2008).

189. Healthy Oregon Act, 2007 Or. Laws ch. 697, *amended by* 2008 Or. Laws Spec. Sess. ch. 51.

190. 2007 Or. Laws ch. 697. Sections one to thirteen of the Act relating to the Health Fund Commission are temporary in nature and will expire on January 2, 2010. *Id.* § 27.

many of the same goals promoted as benefits of HSAs—cost transparency, consumer participation, cost containment, efficiency, and access for the uninsured.[191]

The Oregon Health Policy Commission submitted its final report to the governor in 2007.[192] Part of the comprehensive reform recommendation calls for partially subsidized insurance coverage for families earning less than 300% of the federal poverty level.[193] Families earning above 300% of the federal poverty level receive no state benefits or tax incentives for purchasing health care.[194] The rationale here is that providing benefits to this group does little to reduce the number of uninsured, since this group is the most likely to have insurance, and can afford out-of-pocket costs without detrimentally affecting their standard of living.[195] Another provision of the Oregon plan which may have potential benefits for the expansion of HSA plans is risk adjustment.[196] The proposal suggests that the state engage in risk adjustment to smooth costs across carriers wherever a certain plan or company insures a disproportionately high number of unhealthy or chronically ill people.[197] The state then pays a certain percentage of claims within the "risk corridor."[198] Thus, a chronically ill person may gain affordable health insurance, while the insurer avoids the risk of gaining too many heavy users.

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191. 2007 Or. Laws. ch. 697.

192. OR. HEALTH POLICY COMM'N, ROAD MAP FOR HEALTH CARE REFORM (2007). The report outlines short term goals (focused on decreasing the uninsured population) and long term goals (focused on the symptoms of uninsurance—health care delivery and finance). *Id.* at 16.

193. *Id.* at 28. The proposal recommends a gradual sliding scale, where residents at the federal poverty level pay nothing for insurance, which is completely subsidized by Medicaid. *Id.* at 26, 28. Up to 299% of the federal poverty level, residents pay a maximum of $622 monthly for health care, with subsidized coverage above this spending limit. *Id.* at 26, 28. The premium subsidies could be used to purchase insurance through an employer or in the individual market. *Id.* at 28. The proposal mentions that such an expansion of public subsidies could encourage employers to drop coverage for employees, so other means must be explored to ensure employer participation in the state's new health care plan. *Id.* at 30.

194. OR. HEALTH POLICY COMM'N *supra* note 190, at 28. The recommendation to withhold tax incentives from this income group only applies to state taxes, as the plan attempts to avoid ERISA implications which would render it invalid. *Id.* at 57. Under ERISA, states may not mandate that employers provide a specific level of insurance coverage. *Id.* at 45. Nor may the state usurp any federal tax laws relating to health plans or the provision of coverage. *Id.* at 45.

195. *See* JOHN MCCONNELL ET AL., OFFICE FOR OR. HEALTH POLICY & RESEARCH, COVERING THE UNINSURED: THE COST TO OREGON 7 *passim* (2007), *available at* http://www.oregon.gov/OHPPR/HPC/OHPCReformModeling ReportFINAL.pdf.

196. OR. HEALTH POLICY COMM'N *supra* note 190, at 23.

197. *Id.*

198. *Id.*

In addition to state plans that address tax policies to make HSA adoption more widespread, private organizations also offer suggestions. The American Medical Association (AMA) spelled out its own comprehensive blueprint for tax reforms to expand access to affordable health care.[199] The AMA suggests that tax credits for purchasing health insurance should be refundable and large enough to make health care affordable.[200] The AMA states that overregulation increases costs, so it proposes national uniform regulation, risk-related subsidies for high risk pools (financed through tax revenues, not "community ratings" or premium surcharges), guaranteed renewability, and additional measures to ensure advancement of market innovation and efficiency[201]

In addition, the AMA states that tax credits should vary with family size, should be inversely related to income,[202] and should be applicable only for the purchase of health insurance (and not for out-of-pocket expenses).[203] The credits must allow almost all individuals to obtain insurance, so the lowest earners should receive almost 100% of the premium cost.[204] Targeting tax credits to lower income individuals (more likely to be uninsured) conserves taxpayer resources.[205] Also, people with low incomes should receive a government voucher to purchase insurance when the value of the credit exceeds their overall tax liability.[206]

The AMA also suggests "fair ground-rules" to ensure protection for high-risk individuals while keeping aggregate costs low.[207] Risk protection must be structured in such a way as to prevent upward pressure on costs for the rest of the population—which would encourage healthier individuals to avoid high costs by remaining uninsured.[208]

In many respects, the AMA proposals mirror those from the Oregon plan. For example, Oregon proposes full financial responsibility for health insurance premiums and out-of-pocket costs for those earning in excess of 300% of the federal poverty level,[209] while the AMA proposes the same measure for those earning 500%.[210] Additionally, both plans suggest risk

199. *See generally* AM. MED. ASS'N, EXPANDING HEALTH INSURANCE: THE AMA PROPOSAL FOR REFORM (2007).
200. *Id.* at 6.
201. *Id.* at 8-9.
202. *Id.* at 6.
203. *Id.* at 7.
204. *Id.* at 6.
205. AM. MED. ASS'N, *supra* note 197, at 6.
206. *Id.* at 18.
207. *Id.* at 8.
208. *Id.*
209. OR. HEALTH POLICY COMM'N, *supra* note 190, at 28.
210. AM. MED. ASS'N, *supra* note 199, at 11.

mitigation measures to ensure that high risk individuals can obtain affordable coverage without substantially increasing costs for all who purchase policies.

The proposals differ, however, in their stance toward employer responsibility. The Oregon plan uses a "carrot and stick" approach by creating a "health insurance exchange" to allow small employers vast coverage choices and information by pooling with other employers in the state to reduce risk exposure, and considers, as well, a state payroll tax for employers who do not offer coverage. The tax would then be used to fund coverage subsidies for the uninsured. The tax disincentive, if implemented, should increase the number of employers who offer coverage and should have the latent effect of reducing the number of Oregonians on Medicaid.[211]

The AMA plan places more emphasis on providing individual income tax credits and reshaping the regulatory environment to enable more opportunities for individuals to purchase coverage under group rates (e.g. through unions, trade associations, religious groups, and ethnic coalitions).[212] Under this rationale, employers would continue to offer insurance as the market demands, and individuals dissatisfied with their employer's coverage could purchase coverage elsewhere without giving up their tax savings.[213]

V. THE FUTURE OF HSAS

Currently, it is unclear whether measures to improve HSA plan effectiveness will ever be implemented, or whether the plans will have a chance to succeed if implemented. With the recent power shift in Washington, the future viability of HSAs is in doubt. Several factors account for the uncertainty surrounding the future of HSAs. First, the biggest supporter of HSAs, President Bush, leaves office in late January 2009, and his replacement, President-elect Obama, has not expressed support for such plans.[214] Second, HSAs never gained universal support among House and Senate democrats who recently expanded their control of both houses after the 2008 election.[215] However, HSAs will remain viable for the foreseeable future if health care reform proposals prove to be less of a priority in Washington as the Nation focuses on repairing the economy.

211. OR. HEALTH POLICY COMM'N, *supra* note 192, at 22.

212. AM. MED. ASS'N, *supra* note 199, at 6.

213. *Id.*

214. Jerry Geisel et al., *Change is Coming . . . to Benefits*, WORKFORCE MGMT. (CRAIN'S BENEFITS OUTLOOK 2009), Nov. 2008, at 8.

215. *Id.*

Barack Obama's ascendancy to the presidency may destabilize the future for HSA plans. While President-elect Obama is not an outspoken critic of HSAs, these plans have not appeared in his healthcare proposals.[216] Moreover, Obama's Senate votes on the subject tend to show disfavor for HSA expansion, but are insufficient to establish a definite track record for or against HSAs.[217]

A quick read of Obama's plan reveals many of the same goals that HSAs intend to address, like improving access to coverage, reducing cost the cost of health care, and increasing competition.[218] Upon closer inspection, however, part of the President-elect's plan is antithetical to a main tenet of consumer-directed plans—it does not purport that consumers will make "value-conscious," cost-saving decisions if they are required to pay significant out-of-pocket costs.[219] Rather, Obama's plan stresses the value of preventive care, cost transparency and efficiency, research of more cost-effective treatments, and (most notably) "[a]ffordable premiums, co-pays, and deductibles."[220] His plan also proposes measures similar to the Oregon and AMA plans, such as refundable tax credits, a health insurance exchange, and employer contribution measures.[221]

The House also has been wary of HDHPs and HSAs as methods to increase access to health insurance coverage. In 2008, House Democrats were virtually united in legislating a substantiation requirement for HSAs to

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216. *See* Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf (last visited Dec. 1, 2008) [hereinafter Obama Health Plan]; *see also* Geisel et al., *supra* note 212, at 8 (stating that President-elect Obama has not clarified his stance on HSAs, but "at a minimum, he lacks President Bush's enthusiasm" for them).

217. As a senator, Barack Obama voted "yea" on the Tax Relief and Health Care Act of 2006, which, among other things, repealed the annual deductible limitations on HSA contributions and allowed enrollees to make a one-time distribution from an IRA to fund an HSA. H.R. 6111, 109th Cong. (2006) (enacted); 152 CONG. REC. S11672-73 (daily ed. Dec. 8, 2006). He did, however, vote against HSA expansion on several occasions. Senator Ensign proposed amendment no. 154 to the 2007 minimum wage bill, which would have allowed people to use pre-tax dollars to purchase HSA-eligible plans in the individual market. After debates on the merits of the amendment (whether it would increase access to insurance or whether it would give the wealthy an additional tax break), it narrowly failed by one vote. 153 CONG. REC. S898-99 (daily ed. Jan. 23, 2007); 153 CONG. REC. S1148-52 (daily ed. Jan. 25, 2007). Obama also voted against two amendments to the Small Business Act of 2007 (SCHIP reauthorization) that would have: (1) given premium assistance to families above 200% of the poverty level to purchase employer-sponsored coverage (including HSAs); and (2) required families otherwise eligible for SCHIP to purchase employer-sponsored coverage (if available, including HSAs). 153 CONG. REC. S10746 to -47 (daily ed. Aug. 2, 2007).

218. Obama Health Plan, *supra* note 214, at 1 *passim*.

219. *See id. See also* discussion *supra* Part III.C.

220. Obama Health Plan, *supra* note 216, at 1, 2, 4.

221. *Id.* at 4-6.

require HSA trustees to prove that account disbursements were used for qualified medical expenses.[222] The Senate has not yet taken any action on the bill, but the provision may survive because Republicans, if united, could defeat the bill.[223] The substantiation requirement would not necessarily eliminate HSAs, but would increase administrative costs for bank-trustees, and therefore increase the cost of providing the accounts, hence decreasing their appeal.[224]

Regardless of the political zeitgeist against HSAs, the worsening economy may delay substantial changes to HSA policy. While comprehensive healthcare reform is a pressing issue for the nation, other urgent issues—like the economy and energy policy—are vying for federal money and could take precedence, thus limiting healthcare reform to more incremental changes in the next few years.[225] The reality of large budget deficits and industry bailouts could also hinder any large expansions of coverage, other than the reauthorization of SCHIP.[226] Some in the insurance industry also believe that a prolonged recession could spur cost-conscious employers into offering HSA-eligible plans to positively affect the bottom line by increasing employee cost sharing.[227]

VI. CONCLUSION

Health Savings Accounts can be a successful tool in reshaping the healthcare environment, but they must provide more than tax shelters for the well-off. With a revamped policy, HSAs could reduce aggregate healthcare costs, promote healthier lifestyles, encourage small businesses to provide coverage, and increase access to health care by lowering the cost to consumers.

To realize the stated goals of HSAs, several possible avenues must be explored. To start, lower income people need additional assistance to make HSA-eligible plans truly affordable. However, such assistance cannot overcome the goal of value-conscious decision-making among healthcare consumers. To balance such goals, an adequate, inverse, refundable tax credit based on expected family contribution, in addition to the tax-free,

222. Jerry Geisel, *HSA Reporting Rule Faces Uphill Struggle*, BUS. INS., April 21, 2008, at 1, 26.

223. *Id.* at 26.

224. *See id.* at 1, 26.

225. Leah Carlson Shepherd, *Average Premium Hike is 5%*, EMP. BENEFIT NEWS, Dec. 2008, at 1, 62.

226. Jerry Geisel, *Health Reform Gets New Hope; Plan's Shape, Cost Remain Big Questions*, BUS. INS., Nov. 10, 2008, at 1.

227. Jeremy Smerd, *High-Deductible Plans Could be 'Next Frontier,'* WORKFORCE MGMT., Nov. 3, 2008, at 12, 12.

interest-bearing HSAs, would expand the viability of such accounts while encouraging value-conscious decision-making. This credit, however, should be structured to exclude high income earners (for example, AMA's proposal at 500% of federal poverty level) from receiving an additional benefit. The tax-free savings accounts should be a sufficient impetus for wealthy individuals and families to purchase HSA plans; thus, refundable tax credits or premium subsidies are unnecessary for these groups.

If the healthcare system transitions into an individual market, families may need additional subsidies to afford coverage. If the system continues to rest on primarily employer-based coverage, employers must be rewarded or taxed in order to increase the offer rate of such plans. Maryland's plan to encourage small business participation serves as a learning tool for nationwide implementation. Finally, an effective risk-structuring/pooling plan would encourage less-healthy individuals to participate in HSA plans, and the pooling would prevent increased costs for certain insurance companies or employers with a high percentage of chronically-ill individuals. All of these proposals must be considered and coupled with funding and ideas to increase cost transparency, promote wider market penetration of electronic health records, and encourage evidence-based medicine. Health Savings Accounts will not "cure" the ailing healthcare system, but do provide good starting point to reduce aggregate costs in an ever-evolving private market.