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# Health Savings Accounts: Increasing Health Care Access in America?

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# Health Savings Accounts: Increasing Health Care Access in America?

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## I. Introduction

The number of people in the United States without health insurance coverage now exceeds forty-five million—accounting for more the fifteen percent of the population.[1] Several proposals on the federal level aim to decrease the number of uninsured and underinsured Americans.[2] Some legislation would increase health

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[1] CARMEN DENAVAS-WALT ET AL., U.S. DEP'T. OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003 14 (2004).

[2] During the last Congress, numerous bills addressed the issue. H.R. 2854, 108th Cong. (2003); Prescription Drug and Medicare Improvement Act of 2003, S. 1, 108th Cong. (2003) (enacted); Medicaid/SCHIP Optional Coverage for Young Adults Act of 2003, H.R. 3192, 108th Cong. (2003); Keep America Healthy Act of 2003, H.R. 1143, 108th Cong. (2003); Family Opportunity Act of 2004, S. 622, 108th Cong. (2003); Legal Immigrant Health Restoration Act of 2003, H.R. 322, 108th Cong. (2003); Legal Immigrant Children's Health Improvement Act of 2003, H.R. 1689, 108th Cong. (2003); Immigrant Children's Health Improvement Act of 2003, S. 845, 108th Cong. (2003); Health Care Coverage Expansion and Quality Improvement Act of 2003, S. 10, 108th Cong. (2003); Access to Affordable Health Care Act, S. 100, 108th Cong. (2003); Health Care Coverage Assistance for the Unemployed Act of 2003, H.R. 256, 108th Cong. (2003); Early Treatment for HIV Act of 2004, H.R. 3859, 108th Cong. (2004); Early Treatment for HIV Act of 2003, S. 847, 108th Cong. (2003); H.R. 56, 108th Cong. (2003); Health Insurance Certification Act of 2003, H.R. 2698, 108th Cong. (2003); MediKids Health Insurance Act of 2003, H.R. 1205, 108th Cong. (2003); MediKids Health Insurance Act of 2003, S. 588, 108th Cong. (2003); United States National Health Insurance Act, H.R. 676, 108th Cong. (2003); National Health Insurance Act, H.R. 15, 108th Cong. (2003); American Health Security Act of 2003, H.R. 1200, 108th Cong. (2003); Help for America's Uninsured Act of 2003, S. 713, 108th Cong. (2003); Health Care for Working Families Act of 2003, H.R. 3100, 108th Cong. (2003); Fair Care for the Uninsured Act of 2003, H.R. 583, 108th Cong. (2003); Fair Care

insurance coverage by expanding established programs. These proposals generally seek to increase coverage by expanding Medicare, Medicaid, the State Children's Health Insurance Program, the Federal Employees Health Benefits Program, or coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Other plans would increase coverage by implementing new public programs. Taking a different approach, several other proposals hope to expand coverage through changes to the Internal Revenue Code, either through tax credits and deductions for individuals and families or employer tax incentives. Among the numerous options, Congress recently approved only one of these proposals.

In December 2003, President George W. Bush signed Health Savings Accounts ("HSAs") into law as part of the Medicare Prescription Drug, Improvement, and Modernization Act ("MMA").[3] Throughout his campaign for reelection in 2004 and the early months of his second term, the President has continued to trumpet HSAs as the cornerstone of his plan to reduce the number of uninsured.[4] This article will examine how HSAs impact health care access in the United States. Part II will examine the design of HSAs. Part III will discuss the benefits of HSAs for health care consumers, including employers, individuals, and families. Finally, Part IV will raise some policy questions regarding the impact HSAs may have on health care access in the years to come.

## II. The Design of HSAs: Eligibility, Contribution, and Distribution Rules

HSAs are interest-bearing, tax-exempt health care savings accounts designed for use with a high-deductible health plan, which

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for the Uninsured Act of 2003, S. 1570, 108th Cong. (2003); Securing Access, Value, and Equality in Health Care Act, H.R. 1236, 108th Cong. (2003); Health Care Tax Credit Expansion Act of 2003, S. 1693, 108th Cong. (2003).

[3] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified at 26 U.S.C.A. §§ 139A, 223, 4980G (West 2005); 42 U.S.C.A. §§ 299b-7, 1395b-8, 1395b-9, 1395w-3a, 1395w-3b, 1395w-27a, 1395w-29, 1395w-101 to 1395w-104, 1395w-111 to 1395w-116, 1395w-131 to 1395w-134, 1395w-141, 1395w-151, 1395w-152, 1395cc-3, 1395kk-1, 1395zz, 1395hhh, 1396u-5 (West 2005)) [hereinafter MMA].

[4] CINDA BECKER ET AL., *Here's a Look at Some of the Key Issues to Watch*, MODERN HEALTHCARE 32 (Nov. 29, 2004) ("HSAs . . . remain a cornerstone of the Bush administration's agenda to control insurance costs and help the uninsured gain access to coverage.").

became available for the first time in 2004.[5] Similar to other types of health-related savings accounts, like Flexible Spending Accounts,[6] Medical Savings Accounts,[7] and Healthcare Reimbursement Arrangements,[8] HSAs are designated to pay for the out-of-pocket

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[5] *See* I.R.C. § 223 (West 2005) (defining both the requirements and limitations of HSAs).

[6] Flexible Spending Accounts ("FSAs") emerged in the mid-1980s as the first type of health-related account. They are employer-sponsored arrangements where employees can divert pre-tax dollars into accounts used to pay for medical expenses not covered by insurance or otherwise reimbursable. *See* I.R.C. § 125 (West 2005) (addressing tax treatment of employer contributions through cafeteria plans); Tax Treatment of Cafeteria Plans, 66 Fed. Reg. 1837 (Jan. 10, 2001) (to be codified at 26 C.F.R. pt. 1) (clarifying the circumstances under which a cafeteria plan may permit an employee to change his or her cafeteria plan election); Tax Treatment of Cafeteria Plans, 65 Fed. Reg. 15548 (Mar. 23, 2000) (to be codified at 26 C.F.R. pt. 1) (clarifying the circumstances under which a cafeteria plan election may be changed); Benefits Provided Under Certain Employee Benefit Plans, 54 Fed. Reg. 9460 (proposed Mar. 7, 1989) (to be codified at 26 C.F.R. pt. 1) (proposing regulations relating to circumstances under which participants may revoke existing elections and make new elections under a cafeteria plan); Tax Treatment of Cafeteria Plans, 49 Fed. Reg. 19321 (proposed May 7, 1984) (to be codified at 26 C.F.R. pt. 1) (proposing tax treatment of cafeteria plans). *See also* Rev. Rul. 03-102, 2003-2 C.B. 559 (discussing whether reimbursements by an employer of amounts paid by an employee for medicine, drugs, or dietary supplements purchased by an employee without a physician's prescription are excludable from gross income).

[7] Medical Saving Accounts ("MSAs") are interest-bearing, tax-exempt health-related savings accounts designed to be coupled with a high-deductible health plan that Congress created as part of the Health Insurance Portability and Accessibility Act of 1996. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, (1996) (codified at I.R.C. § 220 (2000)). These accounts were later renamed "Archer Medical Savings Accounts." I.R.C. § 220 (West 2005). Less than 100,000 exist nationwide. Bob Lyke & Chris L. Peterson, Library of Congress, Congressional Research Service Report for Congress, Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison at 3 (2003). MSAs were the template for HSAs.

[8] In 2002, the Treasury Department administratively created an additional means for employers to reimburse employees for health care expenses when it issued guidance on the tax treatment of healthcare reimbursement arrangements ("HRAs"). *See* Rev. Rul. 02-41, 2002-2 C.B. 75 (discussing whether employer-provided coverage and medical care expense reimbursements made under a reimbursement arrangement that allows unused amounts to be carried forward are excludable from gross income); I.R.S. Notice 02-45, 2002-2 C.B. 93 (providing basic information about employer-provided HRAs). *See also* Rev. Rul. 03-43, 2003-21 I.R.B. 935 (discussing whether employer-provided expense reimbursements made through debit or credit cards or other electronic media are excludable from gross income). These health-related accounts are paid for solely by

medical expenses of an individual and his or her family.[9] This section will examine the design of HSAs, including eligibility requirements, contribution rules, and distribution requirements.

## A. Eligibility for HSAs

An HSA is a tax-exempt account established by an individual or by his or her employer and used exclusively to pay for the qualified medical expenses of an account beneficiary.[10] To be eligible for an HSA, individuals and families must be covered by a high-deductible health plan ("HDHP") and not by any other health plan.[11] Under limited circumstances individuals with coverage in addition to an HDHP remain eligible to make and receive HSA contributions.[12] Neither individuals age sixty-five or older,[13] nor individuals who are eligible to be claimed as a dependent on another person's tax return, are eligible to make contributions to HSAs.[14]

An HDHP is a health insurance plan structured similar to a traditional health plan but with markedly higher out-of-pocket deductibles. For an HDHP to qualify for use with an HSA it must satisfy certain thresholds with regard to deductibles and out-of-pocket expenses.[15] An HSA-eligible HDHP must have an annual deductible of at least $1,000 in the case of self-only coverage and at least $2,000

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the employer and not provided pursuant to a salary reduction or otherwise under a cafeteria plan. I.R.S. Notice 02-45, 2002-2 C.B. 93.

[9] I.R.C. § 223 (West 2005).

[10] *Id.*

[11] I.R.C. § 223(c)(1)(A).

[12] I.R.C. § 223(c)(3). Permitted insurance includes: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under workers' compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property, or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. *Id.* Permitted coverage includes coverage for accidents, disability, dental care, vision care, or long-term care. I.R.C. § 223(c)(1)(B).

[13] I.R.C. § 223(b)(7). *See also* I.R.S. Notice 2004-02 (Dec. 23, 2003) (providing guidance on health savings accounts).

[14] I.R.C. § 223(b)(6). *See also* I.R.S. Notice 2004-02 (Dec. 23, 2003) (providing guidance on health savings accounts).

[15] I.R.C. § 223(c)(2)(A).

in the case of family coverage.[16] In addition, the plan's maximum out-of-pocket expenses must be no more than $5,100 in the case of self-only coverage and no more than $10,200 in the case of family coverage.[17] Out-of-pocket expenses include deductibles, coinsurance, and other amounts that the individual must pay for covered benefits under the plan.[18] A plan continues to qualify as an HDHP even if it provides first-dollar coverage of preventive care, where no deductible or coinsurance is applicable.[19] However, a plan fails to qualify if substantially all of the coverage under the plan is certain permitted insurance or is coverage for accidents, disability, dental care, vision care, or long-term care.[20]

To understand how an HDHP works, take, for example, Mary Lopez, a married mother of two, who is offered health coverage through her employer and elects an HDHP. Assume that she is the head of a relatively healthy family, and they each receive annual physicals. Her daughter also visits an asthma specialist twice each year and takes regular medication. And like many families, Mary's children usually visit a pediatrician for ear infections and take antibiotics when prescribed. This spring, while skateboarding, Mary's son breaks his arm and makes a trip to the emergency room. After years of playing softball, late in the summer, her husband is hospitalized for shoulder surgery.

Under the HDHP, the Lopez's medical expenses would break down as follows: Mary's plan covers some preventive care, and thus they would each receive their physicals at no additional cost. Mary would, however, pay out-of-pocket for the two visits to the asthma specialist ($200), the asthma medication ($100), the pediatrician visits for the ear infections ($180), the antibiotics ($50), and her son's trip to the emergency room ($500). At this point, the family's total out-of-pocket medical expenses would be $1,030. The family's health benefits would not be triggered until Mary's husband undergoes surgery, which costs $2,500. The Lopez family would pay for the first $970 in surgical costs out-of-pocket. At this point, they would

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[16] I.R.C. § 223(c)(2)(A)(i).

[17] I.R.C. § 223(c)(2)(A)(ii). The deductible and out-of-pocket expenses dollar amounts are for 2005. Rev. Proc. 04-71, 2004-50 I.R.B. 970. These amounts are adjusted annually to the Consumer Price Index (CPI). 26 C.F.R. § 601.602 (West 2005).

[18] I.R.C. § 223(d)(2)(A).

[19] I.R.C. § 223(c)(2)(C).

[20] I.R.C. § 223(c)(2)(B).

satisfy the HDHP's $2,000 deductible, and the health plan would cover the remaining $1,530 in surgical costs. As this example illustrates, HDHPs work similar to traditional health plans, but simply are triggered through greater out-of-pocket expenses. Since coverage by a qualifying HDHP is mandatory, the rules regarding HDHPs are an integral part of HSA eligibility.

### B. Contributions to HSAs

In addition to the requirements regarding HSA eligibility, there are a series of rules related to HSA contributions. Any eligible individual may contribute to an HSA, which are subject to an annual limit.[21] Family members may also make contributions on behalf of other eligible family members.[22] The maximum amount an eligible individual may contribute to an HSA is based on whether he or she has self-only or family coverage.[23] Returning to the example of the Lopez family, if Mary opened an HSA on January 1, 2005, she could contribute up to $2,000 to the account, the amount of her deductible. In addition, individuals aged fifty-five or older may make bonus contributions in excess of the annual limit.[24]

HSAs are the first health-related accounts to allow for contributions by individuals and families in the same year as contributions by employers.[25] All contributions are aggregated for

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[21] HSA contribution levels are calculated on a monthly basis, as follows: 1/12th of the lesser of 100% of the annual deductible under the HDHP but no more than $2,650 for individuals and $5,250 for family coverage. I.R.C. §§ 223(c)(2), 223(b)(2)(A)-(B), 223(g). *See* Rev. Proc. 04-71, 2004-50 I.R.B. 970 (providing guidance on HSAs). Take, for example, Bob, a single, self-employed man who purchases a qualifying HDHP with a $3,000 deductible on January 1, 2005. Assuming that Bob continues coverage for the reminder of the year, he can contribute $2,650 to his HSA. Because contributions are calculated on a monthly basis, if Bob had not purchased the HDHP until April 1, 2005, his annual contribution limit would be reduced to $1,987 (9 months x $220.83). *See also* I.R.S. Notice 04-2, 2003 WL 22999095 (providing certain basic information about the HSAs in a question and answer format, without attempting to enumerate all of the specific rules that apply under I.R.C. § 223).

[22] I.R.C. § 223(a) (West 2005) and I.R.S. Notice 2004-2 Dec. 23, 2003). Family members receiving HSAs contributions must be eligible individuals. *Id.*

[23] Rev. Rul. 05-25 (providing guidance on family contributions to HSAs).

[24] Initially this amount is up to $500, rising to $1,000 by tax year 2009. I.R.C. § 223(b)(3)(B). *See also* I.R.S. Notice 2004-2 (Dec. 23, 2003) (describing basic examples about HSA).

[25] I.R.C. § 223(a).

purposes of calculating the maximum annual contribution limit.[26] When employer contributions do not reach the contribution limit, employees can fund the corridor between their account balance and their deductible with pre-tax dollars.[27] This allows HSAs to truly reflect the notion that employers and employees can share the burden of increasing health care costs.

One of the unique design features of HSAs is that contributions are tax-advantaged. Individual contributions to an HSA are deductible, within limits, in determining adjusted gross income and are deductible whether or not the individual itemizes his or her deductions.[28] The same is true for contributions made by a family member.[29] For employer contributions, the HSA contributions are excludable from gross income and wages for employment tax purposes, within limits.[30] At the end of each year, the amount remaining in an HSA rolls over and accumulates interest that is not includable in gross income tax while held in the HSA. [31] Funds held in these accounts may be placed in various investment vehicles such as stocks and bonds, with earnings accruing on a tax-free basis, like IRAs and 401(k) plans.[32] The tax advantages of HSAs are not limited to contributions, as certain distributions from HSAs can also be made on a tax-free basis.

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[26] For example, assume Gary has individual coverage with a $4,000 deductible under a HDHP offered by his employer, Acme Incorporated. If Acme contributes $100 each month to his HSA, Gary can contribute an additional $120 each month. ([$100 + $120.83 = $220 month] x 12 = $2,650). I.R.C. § 223(a)(4)(B).

[27] *See id.* (showing that this is an improvement over HRAs, which in contrast, allow employer contributions only, leaving employees to fund gaps with taxed income).

[28] I.R.C. § 223(a).

[29] *Id.*

[30] *See* I.R.C. § 106(d) (West 2004) (discussing tax treatment of employer contributions to HSAs). *See also* Rev. Rul. 04-45, 2004-22 I.R.B. 971 (finding that the exclusion does not apply to contributions made through a cafeteria plan).

[31] *See* I.R.C. §§ 223(f)(5), 223(e) (showing one way that HSAs improve over FSAs). Although FSAs provide a tax-favored way for employees to fund their anticipated medical expenses, the annual forfeiture of year-end balances does nothing to control health care spending. *Id.* In fact, this concept actually creates a perverse incentive for individuals and families with FSAs to make unnecessary medical expenditures in a scramble to avoid losing their remaining balances at the end of each year. *Id.* HSAs take away any incentive to spend account funds needlessly.

[32] I.R.C. § 223(e)(1).

## C. Distributions

Distributions from HSAs are designed exclusively to pay for the out-of-pocket medical expenses of an individual and his or her family. Qualified medical expenses include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, qualified long-term care expenses, and insurance premiums for individuals eligible for COBRA and Medicare, other than premiums for Medigap policies.[33] Distributions from an HSA for qualified medical expenses are generally excludable from gross income.[34] Furthermore, distributions for qualified medical expenses using previously contributed funds are generally excludable even if the individual is no longer eligible to make contributions to an HSA as a result of age or type of insurance coverage.[35]

Qualified medical expenses do not, however, include expenses for insurance other than long-term care insurance, premiums for health coverage during any period of continuation coverage required by Federal law and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or state law.[36] Distributions from an HSA that are not qualified medical expenses are includible in gross income and subject to an additional ten percent tax[37] unless made after death, disability, or the individual attains the age of sixty-five.[38] No penalty applies to non-medical withdrawals made after reaching age sixty-five, and, unlike other retirement accounts, there are no mandatory withdrawals upon retirement.[39]

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[33] I.R.C. § 213(d).

[34] *See* I.R.C. § 223(f)(1) (marking another advantage of HSAs for individuals and families). The treatment of "qualified medical expenses" can differ greatly between HSAs and HRAs. *Id.* HSAs allow all qualified medical expenses under IRC section 213(d) to be reimbursed by account funds. *Id.* In contrast, HRAs allow the employer to define which expenses qualify for account reimbursement, leaving open the possibility that the employer's definition of qualified medical expenses could be more restrictive than the standard HSA definition. *Id.*

[35] I.R.C. § 223(d)(1)(E).

[36] I.R.C. § 223(d)(2)(C).

[37] I.R.C. §§ 223(f)(2), 223(f)(4)(A).

[38] Additional rules apply to the tax treatment of HSAs upon divorce and death of the account holder. I.R.C. §§ 223(f)(7)-(8).

[39] I.R.C. § 223(f)(4)(C).

### D. HSA Design Summary

HSAs are an innovative tool for health care spending. Any individual who enrolls in an HDHP may establish one of these tax-favored savings accounts, regardless of whether that plan is offered by an employer—making them the first of the health-related accounts to be simultaneously available to both the employer consumer and individual and family consumers.[40] Contributions to HSAs enjoy a number of unique tax advantages, with interest accruing on a tax-free basis. Withdrawals from the account are also exempt from tax if they are used to pay for out-of-pocket medical costs. As a result, money put into an HSA and withdrawn to pay permissible medical expenses is never subject to federal income tax. The following section will discuss the consumer benefits of HSAs.

## III. Consumer Benefits of HSAs: Employers, Individuals, and Families

Employment and health insurance have been intertwined in the United States for decades[41] and a discussion of HSAs must be mindful that, in some respects, the patient is not necessarily the consumer. When an employer offers health care as a benefit, it is the employer, not the individual or his or her family, who is the true consumer. Only when individuals and families purchase insurance independent of an employer are they both the consumer and the patient. HSAs are the first health-related savings account designed for use by a range of consumers acting independently or jointly. This section will examine HSAs for employer-consumers and then move into an analysis of HSAs for individual and family consumers—those currently uninsured, those currently insured through the non-group market, and those with employer-based coverage.

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[40] *See* I.R.C. §§ 223(b). *See also* I.R.C. § 106(d)(1) (West 2004) (discussing tax treatment of employer contributions to HSAs).

[41] In the United States, health care has been tied to employment since national wage freezes during World War II induced employers to offer health care coverage as an employment benefit. While prevented from increasing wages, offering health care benefits allowed employers to remain competitive for employees by offering additional incentives. In time, health care benefits became standard in employee compensation. *See* U.S. General Accounting Office, *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion* 3 (2001), *available at* http://www.gao.gov/new.items/d01374.pdf (examining trend of decline of employer-sponsored health coverage).

### A. HSAs For Employer-Consumers

More than eight of every ten uninsured individuals are from working families.[42] Over half of all workers in the United States have an employment-based health insurance policy in his or her own name.[43] As a result, the success of HSAs as a tool to increase health care access for Americans may well rest in their attractiveness to employers. The advent of HSAs offers employers an attractive alternative to traditional health care. HSAs can help employers gain greater control of health care spending and immediately reduce health care costs if they choose.

For employers, the primary benefit of HSAs is their ability to help them gain greater control over health care spending. When employers purchase health insurance through a health plan, they run the risk that premiums will increase from year to year. With traditional health plans, employers have three options when premiums increase. Employers can increase the amount they spend on health care, they can pass along the increase by requiring employees to pay a great percentage for their health care costs, or they can reduce the coverage that they offer to employees.

Because HSAs must be combined with HDHPs, the risk of increased health care costs is alleviated for employers since HDHPs shift health care costs from employers to employees.[44] When health care costs increase, those increases will result in higher out-of-pocket expenses for employees and should not affect employer premiums. To offset increased out-of-pocket expenses, employers may chose to increase the contribution level to employees' HSAs, if any. That decision, however, is within the employer's full discretion.[45] Under

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[42] KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 4 (2004), *available at* http://www.kff.org/uninsured/7216.cfm [hereinafter KAISER COMM'N] (reviewing the basic profile of the uninsured population, how they receive care, and options to increase health care coverage among the uninsured).

[43] *See* ROBERT J. MILLS & SHAILESH BHANDARI, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002, U.S. DEP'T OF COMMERCE 7-8 (2003), *available at* http://www.census.gov/prod/2003pubs/p60-223.pdf [hereinafter MILLS] (estimating health insurance coverage in the United States based on data collected by the 2003 current population survey annual social and economic supplement).

[44] Bernadette Fernandez, Library of Congress, Congressional Research Service Report for Congress, Health Insurance: A Primer at 18 (2004).

[45] *Id.*

HDHPs the employer is in control of decisions regarding HSAs contribution levels, and if the employer chooses to contribute, it is the employee—not the employer—who bears the risk that those contributions may diminish at some point in the future.[46] In addition, as discussed below, increased employee cost-sharing is designed to induce employees to reduce health care utilization.[47] Resulting utilization decreases are designed to further reduce employer premiums over time.[48]

The tension between rising health care costs and the competitive business environment is a perennial challenge for employers.[49] HSAs can be a useful tool for employers whether or not they are currently offering health care benefits to employees. For those who are currently offering coverage, but struggling to do so, greater control of increasing health care costs should allow them to continue offering some coverage. The benefits of HSAs may also induce some employers to begin offering health care coverage to employees for the first time.

Less than half of all small businesses offer health care

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[46] *Id.*

[47] *Id.* at 19.

[48] A decrease in administrative costs may also result, though this appears to be an open question. Arguably, an increased emphasis on system efficiency would drive down costs. On the other hand, the responsibilities associated with tracking and reporting HSA expenditures could offset any potential for savings. Some posit that administrative costs per unit benefit will actually increase under HSAs. *See Health Savings Accounts and Tax Preferences for High Deductible Policies Purchased in Non-Group Market: Potential Impacts on Employer-Based Coverage in the Small Group Market: Hearing on H.R. 3901 Before the House Small Bus. Comm. Subcomm. on Workforce, Empowerment and Gov't Programs*, 108th Cong. 9 (2004) (statement of Linda J. Blumberg, Senior Research Associate, Urban Inst.), *available at* http://www.urban.org/UploadedPDF/900696_blumberg_testimony.pdf [hereinafter Statement of Blumberg] ("[A] larger share of premiums paid for high deductible policies will be attributable to administrative charges than when comprehensive coverage is purchased.").

[49] This problem is particularly acute for small businesses. Double-digit premium increases have left many small businesses that already offer coverage struggling to keep up with rising costs. *See* NEWT GINGRICH & VINCE HALEY, SMALL BUSINESS ARE SAVING MONEY AND INSURING MORE PEOPLE TODAY WITH HEALTH SAVINGS ACCOUNTS, U.S. CHAMBER OF COMMERCE (2004), *available at* http://www.uschamber.com/publications/dotcom/2004/october/0410_special_healt h.htm [hereinafter GINGRICH] ("[T]he high cost of health insurance has been the principal reason why half of all small business owners do not offer any health care coverage for their employees.").

benefits to employees.[50] HSAs may enable a greater portion of employers to do so. Because they are necessarily coupled with HDHPs, which are generally less costly than more comprehensive coverage,[51] to the extent that HSAs and HDHPs are cheaper and decrease employer risk, they are a viable option for those employers looking to offer low-cost, comprehensive coverage to all employees.[52] According to the U.S. Chamber of Commerce, HSAs "allowed small business to realize, on average, 40%-50% immediate savings on health insurance in 2004."[53] As a result of substantial savings, many small businesses "will be able to make significant contributions to the HSAs of their employees."[54] Despite all of these benefits to employers, HSA uptake has been less than anticipated.[55]

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[50] GINGRICH & HALEY, *supra* note 49, at 1.

[51] *See* U.S. TREASURY DEP'T., BASICS OF HSAS 22 (May 15, 2004), *available at* http://www.hsainsider.com/treasury/treasury_1.pdf (noting that "HDHP premiums should be cheaper than health insurance with traditional deductibles").

[52] *Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future?: Hearings Before the Special Senate Comm. on Aging*, 108th Cong. 6 (2004) (statement of Robert Greenstein, Executive Dir., Ctr. on Budget and Policy Priorities), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_senate_hearings&docid=f:94992.pdf [hereinafter Statement of Greenstein] (finding that Professional employees may not be satisfied with a HDHP, which generally provide a more slender benefit package, because unlike non-professional employees, executives and managers may have greater ability to seek employment with another employer offering more generous coverage). The tax incentives inherent in HSAs help employers overcome concerns regarding the HDHPs. *Id.* High-income executives and managers can use their HSAs as tax shelters by making substantial contributions on a tax-deductible basis. *Id.* Since the value to the HSA tax break is greatest for those with the highest incomes, the tax benefits could arguably make up for the increases in deductibles and other reductions in covered benefits resulting from the substitution of high-deductible plans for more comprehensive coverage. *Id.*

[53] GINGRICH & HALEY, *supra* note 49, at 1.

[54] *Id.*

[55] Press Release, America's Health Insurance Plans, Health Savings Accounts Off to Fast Start, New AHIP Study Shows (Jan. 12, 2005), *available at* http://www.ahip.net/content/pressrelease.aspx?docid=7303 [hereinafter Press Release] (finding that the Administration has not released any information concerning the total number of HSAs opened in 2004, but the most comprehensive study released showed less than 438,000 people had opened HSAs as of September 2004). According to Karen Ignagni, president and CEO of America's Health Insurance Plans, "[b]ecause employers generally make health benefit decisions in the fall, and larger employers often make benefit decisions for several years ahead, the new accounts came too late in the 2004 benefits cycle for most businesses." *Id.*

Many observers expect more employers to offer HSA-based plans in the coming years notwithstanding a sluggish start.[56] HSAs and HDHPs are likely to remain an attractive option for employers. While their long-term benefits remain to be seen, HSAs are designed initially to make it easier for employers to continue to offer health care coverage. They offer higher cost-sharing by employees, resulting in lower employer costs. For those employers choosing to make HSA contributions, those are far easier to budget than unanticipated premium increases.

Over the long term, HSAs may reduce utilization and further reduce health care costs. To the extent that HSAs make health care more affordable, more employers will be able to continue offering coverage. Some may choose to do so by offering HSAs and HDHPs in addition to traditional plans. Others may opt to move to HSAs and HDHPs as an alternative to dropping health benefits altogether. Some employers may be able to afford to offer employees health benefits for the first time through HSAs. On balance, HSAs present employers with an attractive opportunity to manage rising health care costs. To the extent that HSAs increase the number of employers who offer health care benefits, a greater number of individuals and families will have access to affordable health care.

### B. Individual and Family Consumers

Two-thirds of Americans want better, more affordable health care.[57] And, although HSAs are the most innovative health-related

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Ignagni also suggests that the availability of HSAs and compatible HDHPs may have also played a significant role. *Id.* Ninety-two insurers are currently offering HSA compatible HDHPs. The HSA Insider, *Health Savings Accounts, High Deductible Health Plans, and Industry News, available at* http://www.hsainsider.com/hsa_insurers.asp (last visited May 12, 2005). Furthermore, "[t]he initial predictions that financial service companies would flood the market and take control of key aspects of the consumer interaction have not come to fruition." *See* Kathryn Weismantel, *Building the Cornerstones of CDHC: Market Leaders Offer Construct for the New Paradigm*, AM.'S HEALTH INS. PLANS (Nov.-Dec. 2004), *available at* http://www.ahip.net/content/default.aspx?bc=31|130|136|7079|7081 (noting the lack of clarity regarding who would handle the transactional and advisory aspects of HSAs). Sixty-six trustees are now offering HSAs. HSA Insider, *Who Can Open My Account* (last visited May 12, 2005).

[56] Press Release, *supra* note 55, at 2.

[57] Ed Rabinowitz, *Now in Session: Grappling With A Health Care Agenda: With Much at Stake, Congress Carefully Weighs its Next Moves*, AM.'S HEALTH INS. PLANS (Jan.-Feb. 2005), *available at*

savings account available, the advantages of HSAs and HDHPs necessarily depend on a baseline comparison to the individual's current insurance situation. These consumers can be separated into three groups: (1) currently uninsured individuals and families; (2) individuals and families with insurance purchased on the non-group market; and (3) individuals and families with employer-based coverage.

### 1. Currently Uninsured Individuals and Families

Last year, nearly one-third of HSA purchasers were previously uninsured for at least six months.[58] Lack of health insurance translates directly to the inability to access necessary medical care.[59] It impacts where people get their health care and, ultimately, impacts their health. The uninsured are up to three times more likely than those with insurance to report problems getting necessary medical care.[60] Forty percent of the uninsured report that they postpone or forgo needed care because they do not have a regular place to go when they are sick or need medical advice.[61] One in five without coverage report that their usual source of care is the emergency room.[62] Even when the uninsured find a health care provider, they are less able to afford prescription drugs and follow through with recommended treatments.[63]

Moreover, the uninsured are far less likely to have access to preventive care. [64] The uninsured are more likely to be hospitalized for avoidable health problems, and when they are hospitalized, the

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http://www.ahip.net/content/default.aspx?bc=31|130|136|8031|8032.

[58] eHealthInsurance, *Health Savings Accounts: The First Year in Review* (Feb. 15, 2005), *available at* http://www.flinthills.org/Master%20Articles%20Library/Health/HSA%20First%20Year%20in%20Review%20o1.

pdf. [hereinafter eHealthInsurance].

[59] KAISER COMM'N, *supra* note 42, at 1.

[60] *Id.* at 6.

[61] *Id.*

[62] *Id.*

[63] *Id.* Over a third of uninsured adults reported an inability to fill a drug prescription in the last year. One-third went without a recommended medical test or treatment due to cost. *Id.*

[64] *Id.* at 7. People with insurance are significantly more likely to have had recent mammograms, colon screenings, and pap smears. *Id.*

uninsured receive fewer services and are more likely to die in the hospital.[65] About 18,000 Americans die of treatable diseases each year because they do not have health care coverage.[66] Overall, the uninsured have meaningful access to fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services, and experience poorer outcomes.[67] More than one half of the uninsured cite cost as the main reason they do not have insurance.[68] To the extent that HSAs bridge the gap to HDHPs for those who were previously unable to afford coverage, they reduce the number of uninsured. Without question, some health insurance is better than no access to health insurance at all. For these individuals and families who can now afford health insurance through HSAs, they are a welcome alternative.

### 2. Individuals and Families with Non-Group Coverage

A number of Americans already purchase their health care coverage directly from health plans. More that twenty-five million individuals and families have non-group coverage.[69] Individuals and families may select non-group coverage for a variety of reasons. Some may select non-group coverage because they are self-employed. Others may look to the non-group market because they are detached from the employment relationship altogether. For those who can afford HSAs and HDHPs in the non-group market, these plans have certain advantages. They are an option for individuals who are either unemployed, employed by employers who do not offer coverage, employed by employers who offer coverage that is too expensive, or employed by an employer who offers affordable coverage but fail to themselves meet the employer's qualifications to be offered coverage, whether as a result of length of employment or

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[65] *Id.*

[66] Press Release, Inst. of Med., Insuring America's Health: Principles and Recommendations (Jan. 14, 2004).

[67] KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED (last updated 2003), *available at* http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PAGEID=13971.

[68] KAISER COMM'N, *supra* note 42, at 4.

[69] MILLS & BHANDARI, *supra* note 43, at 3.

part-time status.[70] HSAs are also a welcome option for a consumer who may lose a job or quit voluntarily because the cost of HDHPs is likely to be more affordable than COBRA coverage. HSAs and HDHPs create an option for a consumer whose link to employer coverage has been terminated due to a change in status, retirement, or divorce. In addition to those benefits discussed below for individuals and families with employer-based coverage, to the extent that HSAs make HDHPs purchased on the non-group market available to individuals and families, they increase access to health insurance.

### 3. Individuals and Families with Employer-Based Coverage

HSAs are designed to provide a number of benefits to individuals and families, regardless of whether they establish an HSA independently or through an employer. For the two groups of individuals and families discussed above who do not receive health care coverage through an employer, the chief advantage of HSAs is that they bridge the gap to health care coverage by making health care more affordable. In addition to their ability to increase initial coverage for the previously uninsured and purchasers of non-group insurance, HSAs offer a range of benefits for all individual and family consumers. Overall, HSAs are designed to provide greater choice and involvement in health care decisions through a portable ownership interest with premier tax advantages.

HSAs allow individuals and families greater choices in health care treatment. Traditional benefits plans may neglect to cover a variety of health care expenditures for an individual or family. This is especially true for ERISA plans that are exempt from offering state-mandated benefits.[71] For example, many traditional benefit plans may or may not cover orthodontia, eyeglasses, contact lenses, cosmetic surgery, and over-the-counter drugs. Yet all of these items and services fall within the definition of "qualified medical expenses" and would meet the requirements for tax-deductible distributions from an HSA.[72] In addition, many Americans are uninsured or underinsured with regard to their long-term care needs, which Medicare does not cover.[73] Any funds remaining in HSAs after age sixty-five, when

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[70] I.R.C. § 223(c) (West 2005).

[71] Pub. L. No. 93-409, 88 Stat. 829 (codified as amended 29 U.S.C. 1001-1461).

[72] I.R.C. § 213(d).

[73] 42 U.S.C.A. § 1395y(a)(9). Custodial care is covered under the Medicaid

long-term care needs are most likely to arise, could be used to fund the cost of this care itself, long-term care insurance, or any other post-retirement medical needs unmet by Medicare.[74] For individuals and families, greater choice in health care treatment is a significant benefit of HSAs.

Another chief benefit of HSAs is that they create for the first time a portable ownership interest in health care dollars.[75] The inherent incentives of ownership are multi-layered. First, individuals and families can effectuate immediate savings through value-based purchasing. Since balances in HSAs remain in the account until spent on medical care or withdrawn after age sixty-five, individuals and families have an inherent incentive to spend funds wisely and shop around for the best value in health care. Second, individuals and families can realize substantial long-term saving that result from HSAs' tax advantages.

Initially, HSAs encourage patients with an incentive to avoid wasteful health spending by making individuals and families responsible for managing a greater share of out-of-pocket health care costs.[76] HSAs incentivize patients to compare prices and treatments as they make decisions about their own health care.[77] HSAs also give individuals and families a reason to spend more carefully when purchasing health care services because unused amounts roll over and become available for use to cover health expenses in subsequent years.[78] This is fundamentally different from other types of insurance plans.

Under traditional health plans, an individual or family who uses less in health care benefits than the premium he or she pays does

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program if an individual meets the program's poverty-related eligibility requirements. 42 U.S.C.A. § 1396d(a)(24).

[74] I.R.C. §§ 213(c) and (f)(1). *See also* I.R.S. Notice 04-2, 2003 (describing basic examples about HSA).

[75] I.R.C. § 213(d)(1)(E).

[76] *See Health Savings Accounts and the New Medicare Law: The Face of Health Care's Future?: Hearings Before the Senate Special Comm. on Aging*, 108th Cong. 2 (2004) [hereinafter *Am. Med. Ass'n*] (statement of Am. Med. Ass'n.) (championing HSAs as a means to improve the doctor-patient relationship).

[77] *Id.*

[78] I.R.C. § 223(d)(1)(E) (West 2005). Portability is another way that HSAs are superior to FSAs and HRAs for individuals and families. While HSAs are portable, unused FSAs balances are lost each year and HRA account balances typically revert back to an employer if an employee leaves his or her job. *Id.* HSAs are more attractive to employees because the employee retains the account balance.

not receive an additional benefit the following year.[79] HSAs are innovative in that individuals and families can benefit from using fewer and less costly services though the HSA's rollover provision.[80] HSAs operate on the premise that greater consumer involvement will improve the quality of care and enhance the level of information available regarding the quality of health care provided. According to the American Medical Association ("AMA"), when individuals or families must spend their own money "patients and their physicians have a strong incentive to balance the costs of medical procedures against the potential impact on favorable health."[81] This creates an incentive to reduce health care utilization.

The second benefit of HSAs' ownership interest is its potential for long-term growth as individuals and families conserve health care dollars.[82] Take, for example, Jane, a single, relatively healthy twenty-five year old woman, who usually visits a doctor only once a year for a physical and, except for oral contraceptives ($20/month), rarely visits a pharmacy. Under a HDHP with a $1,000 deductible, she can contribute $1,000 to an HSA each year. Assuming that her annual physical is covered as preventive care under her health plan, Jane's only out-of-pocket medical expenses would be $240 for the oral contraceptives, leaving $760 in her HSA. Even if Jane only contributes to her HSA over the next five years and then chooses to switch to a more traditional health plan, that money can remain in the account and continue to accrue interest on a tax-free basis for the next thirty-five years.[83] Tables I and II appended hereafter demonstrate how these funds can accumulate.[84] While these examples assume a five percent interest per year, return on investment may, of course, be greater than these charts indicate as a result of the investment option selected by the account holder.

Similar to IRAs and 401(k) plans, depending on the level of contribution, significant savings can result over time. Although these accounts resemble more traditional retirement accounts in many

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[79] Fernandez, *supra* note 44, at 3.

[80] *Id.*

[81] *Am. Med. Ass'n.*, *supra* note 76, at 2.

[82] I.R.C. §§ 213(d)(1)(E) and (e) (West 2005).

[83] *Id.*

[84] *Benefits of Health Savings Accounts: Hearings Before the House Small Bus. Comm. Subcomm. on Workforce, Empowerment and Gov't Programs*, 108th Cong. Exhibit C (2004) (statement of Daniel B. Perrin, Executive Dir., HSA Coalition).

respects, HSAs offer a triple tax savings.[85] In general, HSA contributions, disbursements, and investment earnings are never taxed.[86] Traditional retirement accounts, in contrast, are generally subject to federal income tax when the contributions and the income attributable to them are eventually distributed to the account beneficiary.[87] This feature is particularly attractive to young individuals, like Jane, and families in good health with the capacity to regularly contribute at high levels over many years.[88] HSAs offer individuals and families with a distinct set of advantages not previously found in health-related savings accounts, which in addition to their other benefits can enable account holders to amass considerable savings.

HSAs offer something different to each group of consumers. For employers, HSAs and HDHPs provide a tool to control rising health care costs, allowing some to continue offering health benefits and others to offer them for the first time. For the previously uninsured and for individuals and families with non-group coverage, HSAs can help them afford HDHPs. For individuals and families who already have health care coverage through an employer, HSAs offer greater choice and involvement in health care decisions through portable ownership interest with premier tax advantages. While their long-term impact on access to health care remains to be seen, on balance HSAs offer benefits to a variety of health care consumers.

## IV. Long-Term Impact of HSAs on Health Care Access

At least initially, HSAs will increase the number of people with health insurance. Preliminary estimates show that thirty to forty

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[85] I.R.C. §§ 223(a), (e)(1), and (f)(1), (4), and (5).

[86] *Id.*

[87] *See* I.R.C. §§ 408 (establishing tax treatment of individual retirement accounts), 401(k) (establishing tax treatment of cash or deferred arrangement under qualified pension, profit-sharing and stock bonus plans), and 403(b) (establishing tax treatment of beneficiary under annuity purchased by qualified non-profit organization or public school) . Roth IRAs are taxed when contributions are made to the account in lieu of the tax upon distribution. I.R.C. § 402A.

[88] *See* I.R.C. §§ 223(e)(2) (showing a unique feature of savings through these accounts is that after the HSA account holder reaches age sixty-five the remaining balance may be withdrawn for *any* purpose and is not restricted to qualified medical expenditures, though withdrawals from HSAs after age sixty-five are subject to income tax).

percent of those opening HSAs were previously uninsured.[89] To the extent HSAs result in greater access to affordable health care, it is a step in the right direction. The Bush Administration proposes to spend more then $125.7 billion over the next ten years to expand insurance coverage in America.[90] Despite the lack of evidence as to the long-term effect, or even their early success, the Administration proposes to expand access to HSAs though a variety of tax credits[91] and tax deductions.[92] These proposals would likely add to the number

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[89] In a March 2005 study, AHIP found that 37% of individuals insured under an HSA/HDHPs were previously uninsured. *See* TERESA CHOVAN & HANNAH YOO, NUMBER OF HAS PLANS EXCEEDED ONE MILLION IN MARCH 2005, AM.'S HEALTH INS. PLANS 2, http://www.ahip.org/content/pressrelease.aspx?docid=9771 (last visited May 12, 2005). *See also* eHealthInsurance, *supra* note 58. (summarizing the HSA market as defined by HAS-eligible plans sold by eHealthInsurance to individuals and their families in their first year, Jan. 1 through Dec. 31, 2004).

[90] *President's Budget Proposals: Hearings Before the Senate Comm. on Finance*, 109th Cong. 2-3 (2005) (statement of Michael O. Leavitt, Sec'y, U.S. Dep't of Health and Human Services).

[91] In an attempt to expand access to low-income families, the White House proposes a health insurance tax credit with an HSA. *See* OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2006, ANALYTICAL PERSPECTIVES, at 283 (2005) [hereinafter OFFICE OF MANAGEMENT AND BUDGET]. This initiative would give low-income families a $1,000 contribution made directly to their HSA. *See* U.S. DEPARTMENT OF TREASURY, GENERAL EXPLANATION OF THE ADMINISTRATION'S FISCAL YEAR 2006 REVENUE PROPOSALS (Feb. 2005). It would be coupled with a $2,000 refundable tax credit to help purchase a high-deductible health plan. For example, a family of four making $25,000 or less would be able to get $1,000 deposited into their HSA. This amount could be used to pay medical expenses throughout the year, with the remainder rolling over. Low-income individuals would be eligible for a $300 contribution. Analysis of a similar proposal as part of President Bush's FY 2005 Budget found that over 10 million people would use the tax credit. *See* HENRY J. KAISER FAMILY FOUNDATION, COVERAGE AND COST IMPACTS OF THE PRESIDENT'S HEALTH INSURANCE AND TAX CREDIT DEDUCTION PROPOSALS 3 (2004) (finding that only 3.1 million of those tax credit users would be previously uninsured).

Recognizing also that more than half of all the uninsured Americans are small-business employees and their families, the President proposed tax credits directed at small business. OFFICE OF MANAGEMENT AND BUDGET, *supra* note 91. To encourage HSAs among small employers and their employees, the White House would offer a rebate to small employers contributing to their employees' HSAs. This would take shape as a refundable tax credit for a portion of these contributions, up to $500 per employee with family coverage and $200 per employee with individual coverage. *Id.*

[92] For middle-income families, President Bush proposes an above-the-line

of newly insured resulting from HSAs. Though initial estimates demonstrate that these accounts are alleviating the health care access issue for some Americans, a number of underlying policy questions remain relevant. Part IV *infra* will examine important questions regarding HSAs, including their ability to contain health care spending, their impact on the long-term destabilization of employer-based health care coverage, and their impact on low-income Americans.

### A. Will HSAs Contain Health Care Spending?

Underpinning the success of HSAs is their ability to increase health care efficiency. Proponents assert that greater cost-sharing borne by individual and family consumers will encourage more cost-efficient health care choices, decreasing utilization and thereby reducing overall health care costs.[93] The direct effects of HSAs on health care costs may, however, be small because they fail to address the true driver of cost. According to recent research, ten percent of the population accounts for sixty-nine percent of total health care spending.[94] Opponents of HSAs argue that:

> [M]ost medical spending occurs during high-cost episodes

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deduction for premiums associated with high-deductible health plans. OFFICE OF MANAGEMENT AND BUDGET, *supra* note 91. Under current law, an individual may take an itemized deduction for non-group health insurance only if he or she has unreimbursed medical expenses that exceed 7.5% of his or her income. *Id.* This proposal would permit individuals who purchase a high-deductible, non-group health plan in conjunction with an HSA to deduct 100% of the amount of the health plan's premium from their taxable income. *Id.* The deduction would be permissible without regard to the 7.5% threshold and without itemizing deductions. *Id.* It would put individually purchased high deductible plans on equal footing with employer purchased plans. *Id.*

Opponents contend that the proposal could also result in new inequities in the private non-group insurance market, biasing incentives for individuals to purchase high.deductible policies relative to more comprehensive policies in the non-group market and leaving those with high costs and low incomes with the most to lose if coverage shifts to the non-group market. Statement of Blumberg, *supra* note 48. In addition, opponents argue that this subsidy would extend the problems of adverse selection already associated with HSAs and ignore the impact on insurance pools. *Id.* Most states allow non-group insurers to charge lower premiums for those in good health and to exclude from coverage those with pre-existing conditions. *Id.*

[93] *Health Savings Accounts: Hearings Before the Senate Comm. on Special Aging*, 108th Cong. 2 (2004) (statement of John C. Goodman, President, Nat'l Ctr. for Policy Analysis) [hereinafter Statement of Goodman].

[94] Statement of Greenstein, *supra* note 52, at 5.

> in which the total cost of care charged to patients greatly exceeds the limits of any high-deductible plan . . . . Once patients enter the stop-loss range of their insurance, they would, by definition, be as free from financial discipline to attend to health costs as they are under low-deductible insurance.[95]

Thus, even under HSAs, the vast majority of health care spending will still continue unchecked. While some efficiency will be realized initially, it is unlikely that HSAs will have a significant, long-term impact on the increases in health care spending.

Even if HSAs could be somehow redesigned to contain costs, consumers do not have the appropriate tools and information to make the efficient choices necessary for HSAs to succeed. To begin, individuals and families lack understanding about how HSAs and HDHPs work. Health insurance policies are complicated. Patients must appreciate the policy's parameters, like annual deductibles, coinsurance rates, and maximum out-of-pocket limits. Equally important for patients are the items excluded from the benefit package or those subject to separate deductibles. A recent study revealed that "while two-thirds of respondents were interested in the idea of controlling their own tax-free health savings account, less than half of them were informed about the details."[96] It is less likely that individuals and families understand how these components work together. Even if individuals and families understand the complexities of an HSA and HDHPs package, they may be unable to discern how this new alternative compares with their current plan coverage.

Even proponents of HSAs agree that consumers do not have enough information. According to the U.S. Chamber of Commerce, "[t]o work most effectively, all health system consumers, but especially those with Health Savings Accounts and other plan designs which encourage active consumer behavior, must have far better information about the medical delivery system than that which exists today."[97] Increased sharing of information regarding provider

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[95] Henry Aaron, *HSAs—The 'Sleeper' in the Drug Bill*, 102 TAX NOTES TODAY 1025 (Feb. 23, 2004).

[96] SCOTT SPIKER, HEALTH SAVINGS ACCOUNTS: REALIZING THE PROMISE REQUIRES EDUCATED CONSUMERS, AHIP COVERAGE, (Am.'s Health Ins. Plans, Washington, D.C, July-Aug. 2004), *at* http://www.ahip.net/content/default.aspx?bc=31|130|136|2278|2281.

[97] *Health Savings Accounts: Hearings Before the Senate Comm. on Special*

performance grounded in evidence-based medicine is critical to better health care decision-making. Patients need more information about the cost of items and services in order to compare prices relative to health care benefits. Until these measures are in place, it will be difficult for patients to discern which providers are dedicated to quality improvement, and thereby impossible for patients to become more savvy health care consumers.

If individuals and families do not have the appropriate tools to make health care purchasing decisions, efficiency will not increase and health care costs will continue to climb. If costs remain unchecked, HSAs will just be a cost-shifting mechanism and not one to effectuate cost-containment. For HSAs to succeed, all types of consumers need access to better information and decision-support tools. The Institute of Medicine recently reported that ninety million Americans have difficulty understanding and using health information, and that patients with low health literacy often forgo preventive treatment.[98] At the point where HSAs result in poorer health care outcomes due to market imperfections, poorly executed economic policy becomes antithetical to the expansion of health care access.

### B. Will HSAs Lead to the Destabilization of Employer-Based Health Care?

The level of employer interest in HSAs has important ramifications for individuals and families with employer-based health coverage. Many small and mid-sized employers plan to offer HSAs to their employees for the first time this year.[99] Among those surveyed, "[s]ome employers indicate that they will include HSAs in the health insurance options available to their employees, while others say they will completely replace their current coverage" with defined contribution plans.[100] The majority of large employers are interested in HSAs because "[t]hey think this may be a once in a lifetime opportunity to change the paradigm."[101]

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*Aging*, 108th Cong. 8-9 (2004) (statement of Kate Sullivan, Executive Dir., Health Care Policy, U.S. Chamber of Commerce).

[98] INSTITUTE OF MEDICINE, HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION REPORT BRIEF (2004).

[99] Rabinowitz, *supra* note 57.

[100] *Id.*

[101] Janet Novack, *Don't Bank on Health Savings Accounts*, FORBES (Mar. 17, 2004), *at* http://www.forbes.com/2004/03/17/cz_jn_0317beltway_print.html (last

HSAs are a landmark tool in the employer health insurance market. They allow a feasible shift from defined benefit plans, where employers bear the risk of rising health care costs, to a defined contribution approach that transfers risk to individuals and families.[102] Defined contribution health plans, along with HSAs, mark a fundamental shift in the financing of health care in the United States.[103] Today, defined contribution health plans, like HSAs, represent about two percent of the health plan market.[104] As employers are increasingly under pressure to curtail spending on health insurance premiums, HSAs will likely develop as an important tool for those who wish to shift from offering defined benefit plans to defined contribution plans. This year, eighty-nine percent of HMO's and PPO's will offer a defined contribution plan to employers—up from twenty-nine percent just one year ago.[105]

According to their proponents, HSAs aim to slow the growth in medical costs by providing participants with educational resources, decision-making tools and financial incentives that will lead them to make more efficient health care decisions.[106] But, many critics disagree, believing that they may hasten many employers to drop

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visited May 12, 2005) (quoting Joseph Martingale, national leader for health care strategy at benefits consultants Watson Wyatt).

[102] *See generally* Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451, 508-509 (2004) (discussing that under a defined-benefit model, employers promise to cover one or more fixed sets of health care services in the amount and manner determined by the employer). Under these plans, employees bear minimal risk with regard to their health care expenses. Fernandez, *supra* note 44, at 18. As an alternative to defined benefit plans, employers can take a defined-contribution approach. *Id.* These plans redirect the risk of rising health care costs from employers to employees. *Id.* Under a defined contribution plan, an employer promises to provide a specific contribution that employees can use to purchase the plan of their choice. *Id.* The employer contribution is generally intended for immediate health care expenses—not a catastrophic event—which are provided under an accompanying insurance component, like HDHPs. *Id.* In contrast to the more traditional defined benefit plans, in defined contribution plans employees bear the risk of a funding shortfall under a defined contribution plan. *Id.*

[103] *See* Weismantel, *supra* note 55 (discussing consumer driven health care as new model for provision of health benefits).

[104] Rabinowitz, *supra* note 57.

[105] Press Release, Milliman Consultants and Actuaries, Milliman 2004 Group Health Insurance Survey Sees Surge in Consumer Driver Products (Oct. 14, 2005), *at* http://www.milliman.com/press_releases/2004%20CDH%20Press%20Release.pdf .

[106] Statement of Goodman, *supra* note 93.

coverage. They argue that: "[a]s costs rise, and as coverage consequently falls, more costs are going to be shifted to employers."[107] Critics fear that "[u]ltimately, those costs will be passed along to employees in the form of lower wage increases, reduced benefits, or higher out-of-pocket costs."[108] In addition, they contend that "this inequitable cost-shift will force more employers to drop or cut health insurance or go to defined contributions, and the erosion of the employment-based system will increase."[109] To the extent that HSAs fail to turn the tide of increasing costs, they exacerbate an already worsening situation in terms of access to employment-based health coverage.

Due to the inability to contain health care costs over time, the promulgation of HSAs may actually increase the number of uninsured. HSAs are primarily attractive to young, healthy workers who would be willing to bear the risk of high-deductible, less comprehensive health plans. The attractiveness of HSAs may drive these individuals out of employer-based plans, which will increase the percentage of the pool made up of older, sicker individuals. This adverse selection would result in even greater increases in the cost of traditional health insurance—the problem that is driving employers away from defined benefit plans in the first place. At the point where employers drop coverage entirely or employees are unable to bear the burdens of these increased premiums, they will become uninsured or underinsured.

### C. Will Low-Income Americans Be Disproportionately Burdened by the Ripple Effects of HSAs?

HSA-supporters contend that these accounts will result in a reduced health care spending, in part because they are based on increased cost-sharing. Even if this were true, perhaps the important policy question is whether HSAs will disproportionately

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[107] HENRY E. SIMMONS, RAISING THE DEBATE: THE NATURE AND IMPACT OF THE HEALTH CARE CRISIS AND REFORMS WHICH WILL BE NECESSARY, ADDRESS AT THE NAT'L CONFERENCE ON PUBLIC EMPLOYEE RETIREMENT SYSTEMS (May 5, 2004); PRESIDENT, NAT'L COALITION ON HEALTH CARE (2001), *at* http://www.nchc.org/materials/speeches/NCPERS%20speech.pdf (last visited May 12, 2005).

[108] National Coalition on Health Care, *Health Insurance* Coverage (2001), *at* http://www.nchc.org/facts/coverage.shtml (last visited May 12, 2005) (statement of Henry E. Simmons, President, National Coalition on Health Care).

[109] *Id.*

disadvantage low-income individuals and families.[110] Cost-sharing is still just a blunt instrument in the attempt to contain costs. Among low-income individuals, increased cost-sharing can discourage utilization of both necessary and unnecessary services.[111] According to a Commonwealth Fund survey, patients with individual insurance were twice as likely as patients with employer coverage to skip medical tests, treatment, or follow-up, or forgo seeing a doctor altogether because of cost concerns.[112] This indicates that patients were not getting the care they needed when they needed it. More than likely, the HDHPs required under HSAs could result in the same selective behaviors.

HSAs have limited applicability for uninsured and underinsured Americans because more that half of such Americans are considered low-income. Sixty-six percent of the uninsured live below 200% of the poverty level, which is $37,700 for a family of four.[113] The promise of greater affordability and increased savings is merely a fiction for low-income Americans.[114] For the working poor who do not have tax liability, HSAs provide no benefit whatsoever. Table III, produced by the U.S. Treasury Department and appended hereafter, demonstrates how low-income Americans derive few benefits from the tax-incentives offered through HSAs. [115]

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[110] MILLS & BHANDARI, *supra* note 43, at 5 (finding this as a particularly troubling social policy in light of the fact the race, ethnicity, and national origin are significant indicators of income in the U.S.).

[111] Statement of Blumberg, *supra* note 48.

[112] Elisabeth Simantov, Cathy Schoen, & Stephanie Bruegman, *Market Failure? Individual Insurance Markets for Older Americans*, HEALTH AFFAIRS, at 144 (July-Aug. 2001) (analyzing Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70).

[113] KAISER COMM'N, *supra* note 42, at 2.

[114] More than half of uninsured adults have no income tax liability. *Total HSA Enrollment Tops 1 Million, Insurance Industry Survey Reports*, BNA'S HEALTH CARE DAILY REPORT (May 5, 2005) (citing the Commonwealth Fund). Low-income individuals derive little or no benefit from the tax benefits of HSAs and generally lack the income or resources to make substantial contributions to them. HSAs cannot be both a savings vehicle and a spending tool. These concepts are mutually exclusive. If individuals and families utilize their savings to pay for ongoing out-of-pocket medical costs, then they cannot be used for retirement savings. And, if the account is used to accumulate savings, then it cannot be used for put-of-pocket medical costs.

[115] U.S.TREAS., REDUCTION IN FEDERAL INCOME TAX FROM HSA CONTRIBUTIONS IN 2005 (Nov. 16, 2004), *at* http://www.ustreas.gov/offices/public-affairs/hsa/pdf/hsa-examples.pdf (last visited May 12, 2005).

Not surprisingly, early survey results indicate that HSAs are purchased overwhelmingly by those with the highest incomes.[116] In 2004, sixty percent of HSA-eligible plans were purchased by people with annual incomes greater than $50,000.[117] The nation's median household income was $43,318 last year.[118] Perhaps the Administration should entertain some additional proposals to make HSAs a viable option for the uninsured and underinsured despite their relative incomes.[119]

## IV. Conclusion

It is possible that the positive public policy implications of HSAs will ultimately outweigh the concerns regarding their disproportionate tax advantages. Perhaps the empowerment of consumers to engage more actively in their health care decision-making will encourage greater individual awareness of health risks,

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[116] eHealthInsurance, *supra* note 58, at 10.

[117] *Id.* at 10.

[118] DENAVAS-WALT ET AL., *supra* note 1, at 2.

[119] *See, e.g.*, Interview by Susie Gharib with Uwe Reinhardt, Professor, Princeton Univ. (Feb. 21, 2005) (finding that several proposals could change the face of HSAs to make them more equitable for low-income individuals and families). These ideas might take shape through a variety of changes to the current structure of HSAs. *Id.* Two changes could make HDHPs more affordable. *Id.* First, the amount of deductible required for a qualifying HDHP might be tied to income level. *Id.* For example, an HSA-eligible HDHP must have an annual deductible of at least $2,000 for families. For a family of four living at 200% of the poverty level, a $2,000 deductible is more than half of one month's income. If the amount of deductible could be instead be tied to income, the level of deductible could be reduced, for example, to $500 for families at 200% of the poverty level, $1,000 for families at 300% of the poverty level, but remain higher for those families who are most able to afford the high deductibles. To make HSAs affordable in another way, the maximum out-of-pocket amount could be established as a percentage of annual income. *Id.*

To standardize the tax advantages, the deductibility could be fixed regardless of income and designed as a refundable tax credit for those with no tax liability. The Congressional Budget Office estimated that HSAs would cost more than $6 billion over the next ten years. *See* Letter from Douglas Holtz-Eakin, Congressional Budget Office, to Hon. William Thomas, Chairman, Committee on Ways and Means, U.S. House of Representatives (Nov. 20, 2003), *available at* http://www.cbo.gov/ftpdocs/48xx/doc4808/11-20-MedicareLetter.pdf (discussing that if the advantages for higher tax brackets were scaled back slightly to fund a tax credit for low-income Americans and families, a more equitable benefit could be established at no additional cost to taxpayers).

increase communication between patients and physicians about treatment options and costs, and ultimately provide significant market incentives for the development of new treatments, technologies, and delivery modalities designed to better meet the needs of consumers. But those advantages will only be available to those who can still afford coverage. To the extent that HSAs facilitate a broad movement for employer's to switch from offering defined benefit plans to defined contribution plans, HSAs are likely leave the most vulnerable populations to bear an even greater burden of their health expenses. When HSAs create a perverse incentive to forgo necessary acute and preventive health care, they not only risk increasing spending over time but also fail to expand health care access to all Americans. Their ability to significantly reduce the forty-five million uninsured Americans remains to be seen.

# Table I

**Possible Build-Up of Savings For Families With An HSA Under Different Time and Medical Expense Scenarios.**

| **Account Balance After X Years** | **Age of Head of Household Starting at 30** | Health Savings Account Balances (Assumes a $4,000 Deductible and Deposit Each Yr) | | |
|---|---|---|---|---|
| | | **After Family Medical Expenses of $1,000 Each Year** | **After Family Medical Expenses of $500 Each Year** | **Zero Family Medical Expenses** |
| 5 Years | 35 | $17,406 | $20,307 | $23,208 |
| 10 Years | 40 | $39,620 | $46,224 | $52,827 |
| 15 Years | 45 | $67,972 | $79,301 | $90,630 |
| 20 Years | 50 | $104,158 | $121,517 | $138,877 |
| 25 Years | 55 | $150,340 | $175,397 | $200,454 |
| 30 Years | 60 | $209,282 | $244,163 | $279,043 |
| 35 Years | 65 | $284,509 | $331,927 | $379,345 |

# Table II

## Possible Build-Up of Savings For Individual With An HAS Under Different Time and Medical Expense Scenarios

| **Account Balance After X Years** | **Age of Individual Starting at 25** | Health Savings Account Balances (Assumes a $4,000 Deductible and Deposit Each Year) | | |
|---|---|---|---|---|
| | | **After Family Medical Expenses of $1,000 Each Year** | **After Family Medical Expenses of $500 Each Year** | **Zero Individual Medical Expenses** |
| 5 Years | 30 | $5,802 | $8,703 | $11,604 |
| 10 Years | 35 | $13,207 | $19,810 | $26,414 |
| 15 Years | 40 | $22,657 | $33,986 | $45,315 |
| 20 Years | 45 | $34,719 | $52,079 | $69,439 |
| 25 Years | 50 | $50,113 | $75,170 | $100,227 |
| 30 Years | 55 | $69,761 | $104,641 | $139,522 |
| 35 Years | 60 | $94,836 | $142,254 | $189,673 |
| 40 Years | 65 | $126,840 | $190,260 | $253,680 |

# Table III

## Reduction in Federal Income Tax from HSA Contributions in 2005—Illustrative Examples

| HSA | Income | | | | | |
|---|---|---|---|---|---|---|
| **Contribution** | **$20,000** | **$40,000** | **$60,000** | **$80,000** | **$100,000** | **$120,000** |
| **Single Taxpayer** | | | | | | |
| $500 | 75 | 75 | 125 | 125 | 140 | 140 |
| $1,000 | 150 | 150 | 250 | 250 | 280 | 280 |
| $1,500 | 225 | 225 | 375 | 375 | 420 | 420 |
| $2,000 | 300 | 300 | 500 | 500 | 560 | 560 |
| $2,500 | 375 | 375 | 625 | 625 | 700 | 700 |
| $2,650 1/ | 397 | 397 | 662 | 662 | 742 | 742 |
| Head of Household with 1 Dependent Child | | | | | | |
| $1,000 | 100 | 150 | 250 | 300 | 250 | 350 |
| $2,000 | 200 | 300 | 500 | 600 | 500 | 500 |
| $3,000 | 300 | 450 | 750 | 900 | 750 | 750 |
| $4,000 | 400 | 600 | 900 | 1,200 | 1,000 | 1,000 |
| $5,000 | 500 | 750 | 1,050 | 1,500 | 1,250 | 1,250 |
| $5,250 1/ | 525 | 788 | 1,088 | 1,563 | 1,313 | 1,313 |
| Married Couple with No Dependents | | | | | | |
| $1,000 | 100 | 150 | 150 | 150 | 250 | 350 |
| $2,000 | 200 | 300 | 300 | 300 | 500 | 500 |
| $3,000 | 300 | 450 | 450 | 450 | 750 | 750 |
| $4,000 | 360 | 600 | 600 | 600 | 1,000 | 1,000 |
| $5,000 | 360 | 750 | 750 | 750 | 1,250 | 1,250 |
| $5,250 1/ | 360 | 787 | 787 | 787 | 1,312 | 1,312 |
| Married Couple with 2 Dependent Children | | | | | | |
| $1,000 | 0 | 150 | 150 | 150 | 250 | 300 |
| $2,000 | 0 | 300 | 300 | 300 | 500 | 600 |
| $3,000 | 0 | 430 | 450 | 450 | 750 | 900 |
| $4,000 | 0 | 530 | 600 | 600 | 1,000 | 1,200 |
| $5,000 | 0 | 630 | 750 | 750 | 1,250 | 1,500 |
| $5,250 1/ | 0 | 655 | 787 | 787 | 1,312 | 1,562 |

1/ Maximum contribution generally allowable.

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