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Shifting Risk of Ruin to Consumers: The Role of Tax Law in American Health Policy

Timothy Stoltzfus Jost
Washington and Lee University School of Law, jostt@wlu.edu

SHIFTING RISK OF RUIN TO CONSUMERS: THE ROLE OF TAX LAW IN AMERICAN HEALTH POLICY

TIMOTHY STOLTZFUS JOST*

Of all developed countries, the United States is the one country where obtaining basic health care is most likely to result in financial ruin.[1] In most developed countries, health care is paid for by government or social insurance programs.[2] Many of these countries do impose cost-sharing obligations on patients, but those obligations are usually modest in size and capped at

* Robert Willett Family Professor, Washington and Lee University School of Law. The author also discusses consumer-driven health care in *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006). These issues will be further considered in a book by Professor Jost, OUR BROKEN HEALTH CARE SYSTEM: CAN CONSUMERS FIX IT?, to be published by Duke University Press in 2007.

1. The Commonwealth Fund has for several years been tracking access to and quality of health care in six countries (Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States). *See* KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: AN UPDATE ON THE QUALITY OF AMERICAN HEALTH CARE THROUGH THE PATIENT'S LENS (Apr. 2006). In 2005, the most recent year for which data are available, they asked both below- and above-average income "sicker adults" (those who ranked their health status as fair or poor and those who had been seriously ill or hospitalized (other than for a normal delivery) or had surgery in the preceding two years) whether they had foregone a visit to a doctor, failed to get a recommended test, treatment, or follow-up, not filled a prescription, or not received needed dental care in the past year because of cost. *Id*. at 3, 21. In each country, some below-average income adults had foregone medical care because of cost. *Id*. at 21. Averaging results from all countries other than the United States, 17% of below-average income adults had not visited a doctor, and 18.8% had not filled a prescription or had skipped doses because of cost. *Id*. In the United States, however, 44% of below-average income sicker adults had not gone to a doctor for a medical problem, and 51% had not filled a prescription or had skipped doses because of cost. *Id*. Surprisingly, 17% of above-average income adults in the United States had not gone to the doctor, and 25% had not filled a prescription or had skipped a dose because of cost. *Id*.

2. According to one survey including twelve European countries and the United States, the U.S. ranked second lowest in the percentage of health care financed publicly and third highest in percentage of costs paid out-of-pocket. Adam Wagstaff & Eddy Van Doorslaer, *Equity in Health Care Finance and Delivery*, *in* HANDBOOK OF HEALTH ECONOMICS 1804, 1821 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000). The one country in the survey that had both a lower proportion of publicly-financed health care and a higher proportion of out-of-pocket costs than the United States was Switzerland, but the data in the survey are from 1992, and in 1996 Switzerland adopted a social health insurance system, so its health care cost allocations have probably changed in the interim. *Id.*

relatively low total out-of-pocket levels; indeed, some countries excuse the poor and vulnerable entirely from cost-sharing obligations.[3]

We also, of course, have massive government health care programs in the United States. Medicare and Medicaid are the largest and best known, but we also have a host of more specifically targeted programs funded by federal, state, or local government, such as the V.A., Tricare, state mental hospitals, and municipal public hospitals. Our government programs cover tens of millions of people and account for very close to half of all health expenditures in the United States.[4]

Most Americans, however, are covered by private rather than public insurance. About 67% of Americans under the age of sixty-five are privately insured.[5] Approximately 61% are insured through their employers.[6] This is over four times the number of Americans under sixty-five who are publicly insured.[7] Although private health insurance is common throughout the world, there is no other country in which such a high percentage of the population relies primarily on private insurance for financing access to health care.

One of the reasons why so many Americans are insured through their employers is federal income tax subsidies. Federal tax law provides that money spent by employers on providing health insurance is not considered income to the employee for either income or payroll tax purposes.[8] This year, the United States will spend, according to the President's 2007 budget, nearly $133 billion in foregone tax dollars subsidizing employment-based health insurance.[9]

This tax subsidy is our third largest government health care finance program after Medicare and Medicaid; indeed it equals almost two-thirds of

3. *See* MARTIN CHALKLEY & RAY ROBINSON, THEORY AND EVIDENCE ON COST SHARING IN HEALTH CARE: AN ECONOMIC PERSPECTIVE 18–22 (1997).

4. Medicaid covers over 55 million Americans and cost $288 billion in 2004. *The Medicaid Program at a Glance*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), May 2006, *available at* http://www.kff.org/medicaid/upload/7235.pdf. Medicare covers nearly 43 million Americans at a projected cost for 2006 of $374 billion. *Medicare at a Glance*, MEDICARE FACT SHEET (Kaiser Fam. Found., Washington, D.C.), July 2006, *available at* http://www.kff.org/medicare/upload/1066-09.pdf. In total, public health expenditures accounted for about 45% of total health care spending in 2004, the most recent year for which data are available. Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFF. 186, 191 (2006).

5. KAISER COMM'N ON MEDICAID & UNINSURED, HEALTH INSURANCE COVERAGE IN AMERICA: 2004 DATA UPDATE 10 (2005).

6. *Id*.

7. *See id.*

8. 26 U.S.C. §§ 106(a), 3121(a)(2) (2000).

9. EXEC. OFF. OF THE PRESIDENT OF THE UNITED STATES, BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 2007—ANALYTICAL PERSPECTIVES 289 (2006) [hereinafter ANALYTICAL PERSPECTIVES], *available at* http://www.gpoaccess.gov/usbudget/fy07/pdf/spec.pdf.

the $201 billion the federal government will spend on Medicaid and the State Children's Health Insurance Program in 2007.[10] It is also by far the largest of our tax expenditures. We spend nearly twice as much in tax expenditures on subsidizing employment-related health insurance as we do on subsidizing interest payments for owner-occupied housing, our second largest tax expenditure, and two and a half times as much as we do on subsidizing pension plans, our third largest tax expenditure.[11] This generous subsidy explains in part why employment-related health insurance is so widespread in the United States.

The tax subsidy, however, is only one of several reasons why we have employment-related health insurance. It is common to see in health policy literature what I call "the myth of the accidental health insurance system." This myth is that employment-related health insurance in the United States is the unintended result of bad public policy.[12] The story begins with the National War Labor Board (NWLB), which excluded employee benefits from wage and price controls during World War II.[13] Employers, desperate to attract scarce workers, were forced by this exception to offer health insurance as a benefit in place of wage increases, creating our current system.[14] Exclusion of health benefits from taxation, also begun during World War II, assured that employers continued to offer health benefits after the war ended, leaving us with the system we have today.[15]

It is a fact that employers were allowed to increase benefits modestly during World War II in lieu of wage increases and that some did.[16] But it is also a fact that health insurance began during the 1930s, not in response to government policy, but because consumers wanted to purchase health

10. *Compare id*., *with* BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 2007—APPENDIX 441, *available at* http://www.gpoaccess.gov/usbudget/fy07/pdf/appendix/hhs.pdf.

11. We spend $79,860,000 subsidizing owner-occupied housing interest and $52,470,000 on employee pensions. ANALYTICAL PERSPECTIVES, *supra* note 9, at 288–89.

12. *See, e.g.*, MICHAEL F. CANNON & MICHAEL D. TANNER, HEALTHY COMPETITION: WHAT'S HOLDING BACK HEALTH CARE AND HOW TO FREE IT 61 (2005); JOHN F. COGAN, R. GLENN HUBBARD & DANIEL P. KESSLER, HEALTHY, WEALTHY, AND WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM 2 (2005).

13. *See generally* TIMOTHY STOLTZFUS JOST, OUR BROKEN HEALTH CARE SYSTEM: CAN CONSUMERS FIX IT? (forthcoming Duke Univ. Press 2007).

14. *Id*.

15. *See* Spec. Rul., 433 CCH 8318, ¶ 6587 (Standard Fed. Tax Serv. 1943).

16. *See* JOST, *supra* note 13; JENNIFER KLEIN, FOR ALL THESE RIGHTS: BUSINESS, LABOR, AND THE SHAPING OF AMERICA'S PUBLIC-PRIVATE WELFARE STATE 177–83 (2003); Jennifer Klein, *The Politics of Economic Security: Employee Benefits and the Privatization of New Deal Liberalism*, 16 J. POL'Y HIST. 34, 40–42 (2004).

insurance rather than to pay for medical expenses out-of-pocket.[17] Early Blue Cross and commercial health insurance plans were paid for wholly by employees without help from their employers, although they were usually purchased at the job site on a group basis with employers withholding money from wages to pay premiums.[18] Employers rarely contributed, and indeed, by the end of World War II, less than 10% of Blue Cross premiums were paid by employers.[19]

It was the efforts of the unions in the late 1940s to make health benefits the subject of collective bargaining (supported by the National Labor Relations Board and the Supreme Court) rather than tax policy that led to the explosive expansion of health benefits in the late 1940s and early 1950s.[20] By the time the Internal Revenue Code of 1954 formally recognized the tax deductibility of employee health benefits, half of the American population had at least hospital insurance, as did 70% of workers under collective bargaining agreements.[21] The availability of tax subsidies undoubtedly contributed to the spread of employee health coverage up through the 1970s and to employers increasingly picking up a larger share of premiums during the 1950s and 1960s. Tax subsidies also led to increasingly generous health insurance packages from the 1950s through the 1990s, with insurance expanding to cover not just hospitalization but also medical, and eventually pharmaceutical, dental, and vision expenses.[22] But in the end, Americans wanted health insurance; it was not forced upon them.[23]

Employment-related health insurance in the United States has, on the whole, been good for the country. Individual, non-group health insurance policies have very high transactional costs because they must be marketed and underwritten on an individual basis.[24] They are also often unavailable, or available only at very high prices, to persons in ill health who are most in need of health insurance.[25] Employment-related group health insurance policies,

17. JOST, *supra* note 13; PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 290–310 (1982).

18. S. Rep. No. 82-359, at 9, 66 (1951).

19. *Id*. at 67.

20. *See* Michael K. Brown, *Bargaining for Social Rights: Unions and the Reemergence of Welfare Capitalism, 1945–1952*, 112 POL. SCI. Q. 645, 647 (1998).

21. S. Rep. No. 82-359, at 1–2 (1951); Evan Keith Rowe, *Health, Insurance, and Pension Plans in Union Contracts*, 78 MONTHLY LAB. REV. 993 (1955).

22. *See* Jon R. Gabel, *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny*, HEALTH AFF., Nov.-Dec. 1999, at 62, 63, 67.

23. This argument is developed at much greater length in my forthcoming book. *See* JOST, *supra* note 13.

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

25. SARA R. COLLINS ET AL., COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN

particularly those offered by large employers, have much lower administrative costs and permit broader risk-sharing.[26] Federal non-discrimination rules have to a large extent assured that lower as well as higher income workers who work for the same employer have access to health insurance (unless they work part-time or are temporary employees).[27] Declining employer contributions to premiums in recent years and increasing use of part-time or temporary employees have led to a declining take-up of health insurance benefits by low income employees.[28] It is clear, however, that if we did not have tax subsidies for employment-related insurance, the number of the uninsured in the U.S. would be higher.

Admiration for employment-based insurance and for the tax subsidies that undergird it is far from universal, however. One common criticism is that the tax subsidy is inequitable.[29] By one account, the average tax subsidy for health insurance for a family earning under $10,000 a year in 2004 was $102, and the average tax subsidy for a person earning more than $100,000 a year was $2,780.[30] Persons who are unemployed or whose employers do not offer health insurance receive no benefit at all from the subsidy. The tax subsidy not only disproportionately benefits the wealthy, it also probably disproportionately benefits the healthy, since on average the wealthy are healthier than the poor, and those who are employed are often more healthy than many who are not.[31]

The main complaint by conservative critics of the employee health benefit is not that it has resulted in too little insurance, however, but rather that it has resulted in too much. Since the early 1970s, conservative and libertarian advocacy groups have kept up a steady drumbeat of criticism of the tax subsidy.[32] This criticism has been steadily gaining in volume and has been

FAMILIES (Sept. 2006), http://www.cmwf.org/usr_doc/Collins_squeezedrisinghltcare costs_953.pdf; KAREN POLLITZ, RICHARD SORIAN & KATHY THOMAS, HENRY J. KAISER FAM. FOUND., HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH? 20 (2001).

26. Hyman & Hall, *supra* note 24, at 30–34.

27. *See, e.g.*, 26 U.S.C. § 105(h) (2000).

28. GARY CLAXTON ET AL., KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 40 (2005) [hereinafter KFF/HRET 2005 SURVEY].

29. John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, HEALTH AFF., Feb. 25, 2004, at W4-106, W4-109, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.

30. *Id*.

31. *See* Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, HEALTH AFF., Mar.-Apr. 2002, at 60, 61–65.

32. *See* JOST, *supra* note 13; Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts in Incremental Steps Toward Health System Reform*, HEALTH AFF., Spring 1995, at 125, 127.

getting ever more attention in recent years. The subsidy, they charge, has resulted in employers offering and employees accepting far more insurance than they would purchase without the tax subsidy, which in turn results in excess consumption and higher prices of health care.[33] The tax subsidy decreases the price of and thus increases the demand for health insurance, which in turn decreases the price of and increases the demand for health care.[34] The biggest reason why health care costs so much in the United States, they argue, is because of the tax subsidy.[35]

The obvious solution to this problem, if it is a problem, is to eliminate the tax subsidy. Urging the elimination of the biggest and one of the most popular tax subsidies in the United States, however, is not a platform on which most politicians want to run. An alternative is to replace the tax deduction and exclusion with a tax credit for employment-based insurance.[36] If this tax credit were offered to employers, it might result in more equitable insurance coverage, though the credit would probably be significantly lower than the actual cost of health insurance, and thus might still not make the purchase of health insurance viable for low-wage individuals.[37]

More common, however, are proposals to replace the employment-related tax exclusion and deduction with individual tax credits.[38] Critics of employment-related insurance favor individual tax credits because they would turn individuals into health insurance purchasers, arguably making them more cost-conscious.[39] This would also detach insurance from employment, making it more portable. The individual insurance market, however, presents many problems which make these proposals troubling. Some of these have already been mentioned[40]—individual insurance costs a lot more than employment-related insurance because it imposes marketing, underwriting, and other administrative costs that are much higher than those of employment-related policies and because it excludes persons who actually have health problems.[41] Tax credit proposals usually do not offer credits high enough to make

33. CANNON & TANNER, *supra* note 12, at 46; COGAN, HUBBARD & KESSLER, *supra* note 12, at 16.

34. CANNON & TANNER, *supra* note 12, at 48–49, 61–73; COGAN, HUBBARD & KESSLER, *supra* note 12, at 15–16, 27–33.

35. *See* COGAN, HUBBARD & KESSLER, *supra* note 12, at 2.

36. *See* Robert Cunningham, *Joint Custody: Bipartisan Interest Expands Scope of Tax-Credit Proposals*, HEALTH AFF., Sept. 18, 2002, at W292, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.290v1.pdf.

37. *See* BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 514–16 (5th ed. 2004).

38. *See* Pauly & Goodman, *supra* note 32, at 127.

39. *See* JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 52, 650–51 (1992).

40. Hyman & Hall, *supra* note 24, at 31–33.

41. *Id*.

insurance affordable to many of the uninsured, but would probably crowd out employment-related coverage, resulting in higher numbers of uninsured.[42]

Within the past decade, however, proposed alternatives to employment-related insurance have increasingly called not simply for tax credits to facilitate the purchase of traditional insurance, but rather for subsidies for a particular form of insurance—high-deductible insurance coupled with medical savings accounts (MSAs) or health savings accounts (HSAs).[43] The concept of individual savings accounts for health care costs surfaced briefly as an idea for expanding access in the 1920s, but was abandoned in favor of collective prepayment for health care in the 1930s.[44] In the late 1970s, however, the idea of individual savings reappeared in an article by Paul Worthington,[45] who had developed the concept together with Paul Hixson, both employees of the Social Security Administration.[46] Worthington urged the creation of accounts in which money would be invested to use against future medical expenses.[47] The holder of this account, he argued, would be cautious in purchasing medical services and would shop around before doing so for the lowest cost supplier because he would be spending his own money.[48] Worthington recognized that this solution might not work for the chronic poor, the handicapped, and the elderly, but considered it the most efficient solution on which to ground a system to pay for health care.[49]

In the 1980s and 1990s, however, the idea of medical savings accounts took on added significance, as it first gained the sponsorship of policy advocacy organizations, then became a commercial reality, and finally was recognized by first state and then federal legislation that offered tax subsidies for MSAs.[50] In the early 1980s, Hixson interested John Goodman of the recently formed National Center for Policy Analysis (NCPA) in the idea of MSAs.[51] Goodman in 1984 put forth a proposal for privatizing Medicare through medical individual retirement accounts in the *Wall Street Journal*.[52]

42. FURROW ET AL., *supra* note 37, at 515.

43. *See generally* GOODMAN & MUSGRAVE, *supra* note 39, at 231–61 (noting that low-deductible health insurance is wasteful and arguing for high-deductible insurance combined with medical savings accounts).

44. *See* JOST, *supra* note 13.

45. *See* Paul N. Worthington, *Alternatives to Prepayment Finance of Hospital Services*, 15 INQUIRY 246, 250–51 (1978).

46. Victoria Craig Bunce, *Medical Savings Accounts: Progress and Problems Under HIPAA*, POL'Y ANALYSIS, Aug. 8, 2001, at 8.

47. Worthington, *supra* note 45, at 250–51.

48. *Id*. at 251–52.

49. *Id*. at 252.

50. Bunce, *supra* note 46, at 9–11.

51. *Id*. at 8–9.

52. John Goodman & Richard W. Rahn, *Salvaging Medicare With an IRA*, WALL ST. J., Mar. 20, 1984, at 32.

At the same time, MSAs began to become available as a commercial product.[53] J. Patrick Rooney, the CEO of Golden Rule Insurance Company (Golden Rule), learned of the MSA concept from John Goodman in 1990 and became the nation's foremost policy entrepreneur promoting MSAs.[54] Rooney and Golden Rule also became major political players, contributing millions of dollars to Republicans, including Newt Gingrich.[55]

The advocacy work of Rooney, Golden Rule, Goodman, the NCPA, and their allies soon began to bear fruit, first at the state level. Missouri became in 1993 the first state to enact legislation providing state income tax subsidies for employee MSAs.[56] Over the next five years, twenty-four more states adopted legislation permitting employers, and in some instances individuals, to make tax subsidized contributions for MSAs.[57] The first attempt to provide federal tax subsidies for MSAs was introduced in May 1992 by Representatives Andy Jacobs (D-Indiana) and Bill Archer (R-Texas).[58] MSAs proved intensely controversial, however, and were strongly opposed by many Democrats who thought they would undermine employment-related group insurance.[59] A compromise creating limited tax subsidies for MSAs was finally adopted into law as part of the Health Insurance Portability and Accountability Act (HIPAA) in 1996.[60]

HIPAA established a demonstration project allowing tax deductions for money contributed to and income earned on MSAs established by small employers and the self-employed where the MSA was coupled with High-Deductible Health Plans (HDHPs).[61] The demonstration project, however, was limited to four years and to 750,000 participants.[62] Though the expiration date of the project was extended several times, the HIPAA MSA never caught on,

53. *A Brief History of Health Savings Accounts*, BRIEF ANALYSIS (Nat'l Ctr. for Pol'y Analysis, Dallas, Tex.), Aug. 13, 2004, *available at* http://www.ncpa.org/pub/ba/ba481/ba481.pdf.

54. Robert Dreyfuss & Peter H. Stone, *MediKill*, MOTHER JONES, Jan.-Feb. 1996, at 27.

55. *Id*. at 23, 27; Michael Scherer, *Medicare's Hidden Bonanza*, MOTHER JONES, Mar.-Apr. 2004, at 23.

56. William R. Bowen, Jr., Policy Innovation and Health Insurance Reform in the American States: An Event History Analysis of State Medical Savings Account Adoptions (1993–1996), at 32–33 (Spring 2005) (unpublished Ph.D. dissertation, Florida State University) (on file with author).

57. *Id*. at 33; Bunce, *supra* note 46, at 10.

58. Bunce, *supra* note 46, at 10.

59. *See generally* Dreyfuss & Stone, *supra* note 54 (arguing that MSAs would destroy Medicare).

60. Pub. L. No. 104-191 § 301, 110 Stat. 1936, 2037 (1996).

61. 26 U.S.C. § 220(c)(1) (2000).

62. *Id*. § 220(i)–(j).

and only about 40,000 to 50,000 MSAs were established in any one year under the program.[63]

Although the results of the HIPAA demonstration project were disappointing, MSA advocates contended that the problem was not with the MSA concept, but rather with the restrictions imposed on MSAs by HIPAA.[64] They repeatedly called for dropping those limits[65] and finally achieved success in 2003 through the Medicare Modernization Act (MMA).[66]

The MMA offers tax exclusion to employers and a deduction to employees for funds contributed by the employer or employee to an HSA.[67] The HSA must, however, be coupled with a high-deductible health insurance policy, which must have a deductible of at least $1,100 a year for a single individual or $2,200 a year for family coverage (in 2007).[68] The out-of-pocket maximum may not exceed $5,500 for individuals or $11,000 for families for 2007.[69] The tax subsidies for contributions to the HSA are subject to an absolute limit adjusted annually for inflation, which for 2007 is $2,850 for individual coverage and $5,650 for family coverage.[70]

The HSA was also accompanied by another new health savings device, the Health Reimbursement Arrangements (HRA).[71] The HRA was created not by a statute but rather by the I.R.S. In 2002, the I.R.S. determined that existing legislation authorized the offer of tax subsidies for employer contributions to health savings vehicles fully funded by employers.[72] The HRA has proved attractive to employers because the accounts can be held as notional accounts and need not be fully funded and because the funds in them also need not go with the employee if he or she leaves employment.[73]

63. Bunce, *supra* note 46, at 13.

64. *A Brief History of Health Savings Accounts*, *supra* note 53, at 2.

65. *Id*.

66. Pub. L. No. 108-173 § 1201, 117 Stat. 2066, 2469 (2003).

67. 26 U.S.C. §§ 62(a)(19), 106(d)(1), 223, 3231(e)(11), 3306(b)(18), 3401(a)(22) (2000 & Supp. III 2005). For a description of the law that governs HSAs and the tax issues it raises, see Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005).

68. Rev. Proc. 2006-53, 2006-48 I.R.B. 996.

69. *Id*.

70. *Id*.

71. Under an HRA, employees are reimbursed for qualified medical expenses. I.R.S. Notice 2002-45, 2002-2 C.B. 93, *available at* http://www.irs.gov/pub/irs-drop/n-02-45.pdf; Haneefa T. Saleem, U.S. Dept. of Labor Bureau of Labor Statistics, *Health Spending Accounts*, Dec. 19, 2003, http://www.bls.gov/opub/cwc/cm20031022ar01p1.htm.

72. Rev. Rul. 2002-45, 2002-2 C.B. 93; Rev. Rul. 2002-41, 2002-2 C.B. 75.

73. Saleem, *supra* note 71.

HSAs have grown very rapidly since the MMA. Whereas roughly 438,000 individuals were covered by HSAs in 2004,[74] today the number stands at over 3.2 million.[75] Over $1 billion has been invested in HSAs.[76] According to America's Health Insurance Plans (AHIP), 31% of the individuals covered by HSA insurance plans were previously uninsured, 33% work for small businesses not previously offering coverage, and nearly 50% are aged 40 and over.[77] Even more people may be covered by HRAs.

One of the reasons why HSAs have proved so popular is that they are very attractive as tax-sheltered investment vehicles.[78] According to one scenario, a family who invests the maximum amount in an HSA over a forty year period, paying for their medical expenses out of pocket rather than from the HSA, could accumulate nearly $1.5 million that could be withdrawn at retirement.[79] If instead they used the account to cover $1,250 in medical expenses each year, they would still end up with $1.12 million.[80] HSAs are not subject to the income limits that apply to IRAs[81] and are thus very attractive to high-income individuals.[82] Even more importantly, the income placed in an HSA, unlike the income placed in an IRA, will never be taxed if it is used for qualified medical expenses—it is a completely tax free means to shelter income for retirement.[83]

HSAs are also very popular with banks.[84] One way of understanding HSAs is that they represent a massive transfer of capital from the insurance industry to the banking industry.[85] Banks have been starved for capital in recent years as the demand for borrowing has been high while deposits in banks have been minimal,[86] and the HSA has been a godsend for banks. The

74. U.S. DEP'T OF TREASURY, FACT SHEET: DRAMATIC GROWTH OF HEALTH SAVINGS ACCOUNTS (HSAS), http://www.ustreas.gov/offices/public-affairs/hsa/pdf/fact-sheet-dramatic-growth.pdf (last visited Jan. 22, 2007).

75. *Id.*; *January 2006 Census Shows 3.2 Million People Covered by HSA Plans* (Ctr. for Pol'y & Res., Washington, D.C.), 2006, at 1, *available at* http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf [hereinafter *January 2006 Census*].

76. U.S. DEP'T OF TREASURY, *supra* note 74.

77. *January 2006 Census*, *supra* note 75, at 1.

78. Edwin Park & Robert Greenstein, *GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals* (Ctr. on Budget Pol'y Priorities, Washington, D.C.), Sept. 20, 2006, at 1, *available at* http://www.cbpp.org/9-20-06health.pdf.

79. *See* Consumer Directed Health Care, Inc., *HSA Deferred Versus Immediate Reimbursement*, http://www.cdhcinc.com/_private/Excel/HSA%20Value%20Projector.xls (last visited Jan. 22, 2007).

80. *Id*.

81. Park & Greenstein, *supra* note 78, at 6.

82. *Id*.

83. 26 U.S.C. § 223(d)(2) (2000 & Supp. III 2005).

84. James G. Knight, *What HSAs Mean for Banks*, AM. BANKER, Apr. 29, 2005, at 11.

85. *See id*.

86. *Id*.

larger insurance companies have tried to protect their income by buying or partnering with banks, but the net result has still been more money for banks.[87]

HSAs are popular with some doctors, tired of struggling with managed care companies.[88] They are also popular with some employers, who see them as a way to move from defined-benefit to defined-contribution health plans and then to cut their own contributions.[89]

Are HSAs a good deal for consumers or for the country, however? A first question is whether they will actually decrease health care expenses. Money contributed to an HSA can be spent for "qualified medical expenses," which are broadly defined to include many things not covered by traditional health insurance, such as nursing home care and transportation or lodging while away from home to receive medical care.[90] HSA custodians and trustees have no responsibility for assuring that expenditures are for qualified medical expenses.[91] That is the responsibility of the HSA owner, subject to normal I.R.S. audit procedures. HSA expenditures will be limited only by the imagination, on the one hand, and good faith, on the other, of their owners. One possibility, therefore, is that some Americans, who are after all not known to be a particularly thrifty people, will spend rather than save their HSAs, driving up health care costs.

A second issue is whether persons with chronic diseases will see a benefit from HSAs. It is quite possible that they will run through their HSAs each year at great expense to themselves and will not be able to carry over money in the HSA from year to year, but will need to keep refilling it each year.[92] Not all persons with chronic illnesses stand to lose from HSAs. Some who previously had traditional policies with high coinsurance amounts and high out-of-pocket limits may see a reduction in expenses.

Once consumers reach the limits of their deductibles, their incentives to reduce consumption of health care or pay attention to its price are diminished, and once they reach the out-of-pocket limit, all remaining incentives to do so

87. *Id*.

88. *See* Brandi White, *How Consumer-Driven Health Plans Will Affect Your Practice*, FAM. PRAC. MGMT., Mar. 2006, at 71, 72.

89. According to one recent survey, 35% of employers are holding onto some of the savings from reduced premiums for HDHPs rather than contributing the full amount of their savings to employee HSAs. NAT'L ASSOC. OF HEALTH UNDERWRITERS, 2006 BENEFIT BUYING TRENDS STUDY CHARTPACK, June 2006, at 16.

90. *See* I.R.S. Pub. 502 (2005), at 5–13, *available at* http://www.irs.gov/pub/irs-pdf/p502.pdf.

91. BOB LYKE, CONG. RES. SERV., HEALTH SAVINGS ACCOUNTS: OVERVIEW OF RULES FOR 2006 10 (2006).

92. *See generally* John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531 (2005) (discussing the implications of HSAs for the chronically ill).

cease.[93] Because of the skewed nature of health care, most health care costs are attributable to persons who would exceed their deductible in any given year, so most health care expenses would not be any more subject to market discipline under HSAs than they are now.[94] The fact that high-deductible health insurance policies do not cost dramatically less than standard policies is easily understandable given the fact that most medical costs are incurred by those whose costs exceed the deductible.[95]

The success of consumer-driven health care, moreover, ultimately depends on making patients into consumers.[96] This in turn depends on getting consumers the information they need to make purchasing decisions.[97] Consumers need to know when to seek out professional help, which professionals and providers offer the best quality care, how to find the least expensive professionals and providers, and which products and services recommended by treating professionals are in fact the best and offer the best value for money.[98] Although consumer-driven health care advocates see great promise in the internet to solve all of these problems, someone will have to create the information that will go on the internet and put it there, and it is not clear who that someone will be.[99]

One real advantage of HSAs is that they should lower administrative costs, as health insurance plans will be freed from processing many small claims.[100] The cost does not, in a sense, go away entirely, however, but is rather transferred to the HSA owner, who must now pay and keep track of all of the bills to eventually justify claiming insurance coverage once the deductible is met (and to satisfy the I.R.S. in the eventuality of an audit).[101] Since expenses that qualify for coverage from the HSA are not necessarily the same as those

93. Stephen Parente, Roger Feldman & Jon B. Christianson, *Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting*, 39 HEALTH SERVS. RES. 1091, 1093–94 (2004).

94. In any given year, 1% of the population accounts for around 27% of health care costs and 10% of the population accounts for 69%. Marc Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.-Apr. 2001, at 9, 12.

95. *See* James Maxwell et al., *Are California's Large Employers Moving to Catastrophic Health Insurance Coverage?*, HEALTH AFF., May 17, 2005, at W5-233, W5-237 (noting that high-deductible policies cost only 15% to 20% less than traditional managed care policies), http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.233v1.pdf.

96. JUDITH HIBBARD, ET AL., AARP, DECISION MAKING IN CONSUMER-DIRECTED HEALTH PLANS 1 (2003), *available at* http://assets.aarp.org/rgcenter/health/2003_05_cdp.pdf.

97. *Id*. at 2.

98. *Id*. at 7.

99. *Id*. at 1–2 (exploring these issues).

100. Stephen Parente, Roger R. Feldman & Jon Christianson, *Evaluation of the Effects of a Consumer Choice Health Plan on Medical Expenditures and Utilization*, 39 HEALTH SERVS. RES. 1189, 1192 (2004).

101. KAREN DAVIS ET AL., COMMONWEALTH FUND, HOW HIGH IS TOO HIGH? IMPLICATIONS OF HIGH-DEDUCTIBLE HEALTH PLANS 5 (2005).

that will qualify for the deductible,[102] qualifying for insurance coverage once the deductible is met is bound to cause problems for many insured.[103] This is, of course, always an issue for persons who must meet an insurance deductible, but will be more of an issue with high-deductible plans, since more bills will need to be paid and documented to prove that the higher deductible has been met.

We are steadily gaining more experience with HSAs, and evidence as to their performance is accumulating.[104] That evidence, however, is not yet conclusive.[105] HSA advocates and insurers who offer HSAs claim that HSA-linked insurance products are dramatically decreasing health care cost increases.[106] Some of this may be attributable, however, to favorable selection. It is easy to hold down health care costs if you insure predominantly healthy persons. There is some evidence that persons who enroll in consumer-driven products have a history of low health care costs, though the matter is far from settled.[107] It is also possible that much of the cost-savings attributable to consumer-driven products are in fact cost-shifts to the insured. For example, average deductibles have been rising in HSA-linked plans as premiums have been falling.[108] Finally, it is possible that savings are real but temporary. One study, for example, found that costs fell in the first year of a consumer-driven plan, but by the third year hospitalization rates in the plan exceeded those in a traditionally-managed care plan.[109] It is simply too early to tell whether HSAs will live up to their cost-saving potential.[110]

The most important question is what effect high-deductible plans will have on the health and economic well-being of consumers. The evidence here is

102. U.S. GOV'T ACCOUNTABILITY OFF., CONSUMER-DIRECTED HEALTH PLANS: SMALL BUT GROWING ENROLLMENT FUELED BY RISING COST OF HEALTH CARE COVERAGE 24 (2006) [hereinafter GAO].

103. *Id*.

104. Press Release, United Health Group, Three-Year Study Shows Consumer-Driven Health Plans Continue to Stimulate Positive Changes in Consumer Health Behavior, July 13, 2006, http://benefitslink.com/pr/detail.php?id=39892.

105. *Id*.

106. DELOITTE CTR. FOR HEALTH SOLUTIONS, SURVEY: CONSUMER-DRIVEN HEALTH PLAN COST GROWTH SIGNIFICANTLY SLOWER THAN OTHER PLANS (Jan. 24, 2006); KFF/HRET 2005 SURVEY, *supra* note 28, at 92; United Health Group, *supra* note 104, at 2.

107. *See* Anthony T. Lo Sasso, et al., *Tales from the Frontier: Pioneers Experience with Consumer-Driven Health Care*, 39 HEALTH SERVS. RES. 1071, 1079, 1082 (2004).

108. A report from eHealthInsurance on experience with high-deductible plans in late 2005 noted that premiums had decreased (17% for individuals and 6% for families) compared to 2004, but also noted that consumers were moving dramatically to higher deductible plans, which should cost less. EHEALTHINSURANCE, HEALTH SAVINGS ACCOUNTS: JANUARY 2005—DECEMBER 2005 (May 10, 2006), *available at* http://www.ehealthinsurance.com/content/ReportNew/2005HSAFullYearReport-05-10-06F.pdf.

109. Parente, Feldman & Christianson, *supra* note 100, at 1201.

110. DAVIS ET AL., *supra* note 101, at 4–5.

also decidedly mixed. One study found that persons with high-deductible health insurance plans were significantly less likely than privately-insured persons with lower deductibles to see a doctor for a specific medical problem, fill a prescription given by a doctor, or get needed specialist care, and significantly more likely to not make a follow-up visit recommended by a doctor.[111] Insured adults with high deductibles are also much more likely to be unable to pay medical bills, be contacted by a collection agency, or have to change their way of life to pay medical bills.[112] Of course, if an employer funds the HSA, these effects will be mitigated, but studies of consumer-driven plans are finding continuing problems.[113] One study, for example, found that persons with consumer-driven health plans "were significantly more likely to report that they had avoided, skipped, or delayed health care because of costs than were those with comprehensive insurance, with problems particularly pronounced among those with health problems or incomes under $50,000."[114]

There is also disturbing evidence that consumer-driven health plans in fact are being marketed in two rather different markets. One market consists of higher income individuals and families, who disproportionately choose HSA-linked high-deductible plans.[115] Some of these higher income insureds use their HSAs solely as tax shelters paying for their health care from other sources.[116] Many seem to behave as intelligent consumers, using comparative information to shop carefully for health care and getting good deals for themselves.[117]

The other market consists of many persons insured through HSA qualified high-deductible health plans who are not receiving contributions from their employers for HSAs.[118] One study found that one in three employers contribute nothing to their employees' HSAs.[119] Many of these individuals are also not themselves contributing to HSAs or building up HSA balances that they carry over from year to year.[120] These lower-income employees are in fact ending up simply with high-deductible policies, not with HSAs.[121] Many

111. *Id.* at 9.

112. *Id*. at 11.

113. *Id*. at 19.

114. PAUL FRONSTIN & SARA R. COLLINS, EMP. BENEFIT RES. INST., EARLY EXPERIENCE WITH HIGH-DEDUCTIBLE AND CONSUMER-DRIVEN HEALTH PLANS: FINDINGS FROM THE EBRI/COMMONWEALTH FUND CONSUMERISM IN HEALTH CARE SURVEY 1, 15 (2005).

115. *See* Lo Sasso, et al., *supra* note 107, at 1075–76.

116. *Id*.

117. *Id*.

118. GAO, *supra* note 102, at 5, 17.

119. KFF/HRET 2005 SURVEY, *supra* note 28, at 6.

120. GAO, *supra* note 102, at 17–18.

121. *Id*. at 17.

of these individuals and families earn little and have little margin.[122] When they become ill, therefore, they will face financial ruin.[123]

Only time will tell whether HSAs in fact will save the American health care system, or whether they will be just one more failed panacea, like health planning in the 1970s or HMOs in the 1980s and 1990s. One thing that we can confidently predict, however, is that health policy in the United States will continue to be tax policy and that the tax laws will continue to be used in efforts to save the health care system. We can also predict that tax policies that end up shifting more and more risk to individual Americans, and particularly lower income Americans, will leave more and more of these Americans in financial ruin.[124]

122. *See* Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 314 (1993).

123. DAVIS ET AL., *supra* note 101, at 19–20.

124. Stone, *supra* note 122, at 308, 314.