

A GUIDE TO HEALTH SAVINGS ACCOUNTS, AND A PLEA FOR PRACTICALITY

By Todd F. Maynes and Thomas L. Evans

Todd F. Maynes and Thomas L. Evans are partners with the law firm of Kirkland & Ellis LLP. Mr. Maynes practices from the firm's Chicago office, while Mr. Evans practices from the firm's Washington office.

In this article, the authors describe some interpretive issues raised by the newly enacted HSA rules, and make suggestions as to how these issues can be resolved by the IRS in a manner that supports the legislative goals underlying these new rules and helps ensure that HSAs will be successful. Their principal suggestion is that the IRS must interpret the HSA rules in a way that is consistent with common practice (and common sense) for health care plans. While the HSA rules clearly do require "high-deductible health plans," the HSA rules do not require that insurers and employers change the core mechanics of their health plans in ways that will make HSAs unattractive to most people. If the IRS goes beyond merely requiring an increase in deductibles and requires other changes to the way health plans operate, the authors submit that HSAs will not be broadly accepted by consumers in the marketplace and financial institutions are unlikely to even offer HSA accounts.

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A few years back, one of the major TV networks found itself without a contract to televise professional football. Fearful that it would lose the highly desirable under-30 angry sports fan demographic, the network decided to partner with the same people who brought us professional wrestling and formed the XFL. The XFL claimed that its games would be harder-hitting than a Lee Sheppard tax column. With minimal rules, elaborate end-zone dances, scantily clad cheerleaders, and Jesse Ventura calling the action in the announcer's booth, the XFL looked like a sure-fire winner. Well, in spite of having what seemed like a formula destined for success, it didn't work in practice. One year later, the XFL was defunct and the network found itself televising tractor pulls on Sunday afternoons.

In December 2003, Congress enacted and President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act).¹ While the Act has numerous significant aspects, two provisions have received the bulk of attention and controversy. First, fulfilling a campaign promise of President Bush and acting to deflect political criticism in 2004, the Act includes a prescription-drug benefit for Medicare recipients. Second, the Act authorizes so-called "health savings accounts" (HSAs).²

HSAs have received substantial publicity and have been touted as a potential catalyst for major change in how consumers fund and finance their health care purchases. *The Wall Street Journal* has described HSAs as "a revolution in American health care."³ Former House Speaker and Georgia Congressman Newt Gingrich has written that HSAs are nothing less than "the single most important change in health-care policy in 60 years."⁴ The current Speaker, Dennis Hastert of Illinois, has stated that HSAs "will revolutionize the health care market in this country, giving consumers better health care at a lower price."⁵ Martin Feldstein, former head

¹Pub. L. 108-173.

²The new provisions for health savings accounts are set forth in section 223 of the Internal Revenue Code of 1986, as amended (the code). Section references are to the code, except as otherwise noted.

³"Teddy's Nightmare," *The Wall Street Journal*, Dec. 23, 2003, p. A14.

⁴Newt Gingrich, "The Medicare Bill; A Solid Platform for Reviving Health Care," *San Diego Union-Tribune*, Dec. 7, 2003, at G1.

⁵149 *Cong. Rec.* H12881 (daily ed. Dec. 8, 2003).

of the President's Council of Economic Advisers under President Reagan, has written that the HSA provision "may well be the most important piece of legislation of 2003."⁶ And when the IRS issued its initial guidance on HSAs, Treasury Secretary John Snow expressed a belief that "millions" of Americans would soon have HSAs.⁷

HSAs can be, to put it boldly but probably accurately, the Super Bowl of tax-deferred retirement accounts.

Like the XFL, HSAs do indeed look like a great product. The tax benefits of HSAs are real and substantial. Individual taxpayers with an HSA with family coverage are permitted to contribute up to \$5,150 per year to a retirement account and deduct the contribution.⁸ The earnings in the retirement account grow on a tax-free basis.⁹ Later, the account can be withdrawn on a tax-free basis.¹⁰ In other words, tax-free on the way *in* and tax-free on the way *out*. HSAs are thus better than IRAs, Roth IRAs, and 401(k) accounts. They can be, to put it boldly but probably accurately, the Super Bowl of tax-deferred retirement accounts.

What is unclear, however, is whether HSAs will in fact become the Super Bowl of retirement accounts, or whether they will flame out like the XFL. That question turns, for the most part, on how the IRS and Treasury interpret any number of questions that the HSA statute, new section 223, presents. If these questions are resolved quickly and in a reasonable but taxpayer-friendly

fashion (which we believe Congress intended), HSAs have a real chance to take off and accomplish what the Bush administration hopes. If, however, the IRS interprets these rules in a cramped and overly literal fashion, we predict that HSAs will go the way of the XFL.

In an effort to accelerate the HSA initiative, the IRS has already issued Notice 2004-2¹¹ interpreting a number of issues regarding HSAs. It is absolutely imperative, however, that the IRS issue additional guidance, above and beyond what has already been provided, to deal with the important issues that Notice 2004-2 has either ignored or gotten wrong. Otherwise, we can look forward to the health care equivalent of tractor pulls on Sunday afternoons for the foreseeable future.

In this article, we request a practical approach to HSAs. In particular, we will focus on what we perceive as some problems with HSAs, and make suggestions as to how those problems can be resolved with guidance from the IRS in a way that is consistent with the statutory language and supportive of the legislative purpose behind HSAs. At bottom, our request is that the IRS interpret the HSA rules in a way that is consistent with common practice for health care plans. Interpreting the HSA rules in this way will make it more likely that individuals will participate in HSAs and that financial institutions will offer HSAs — both developments are vitally necessary if HSAs are to succeed. In particular, the IRS must: (i) abandon its incorrect interpretation of the deductible rules for family insurance policies which impose a significant marriage penalty on HSAs; (ii) permit high-deductible plans to continue to offer in-network fixed fee charges for certain medical services; (iii) allow prescription drugs to be covered under a co-payment plan without violating the high-deductible rules; and (iv) allow reimbursement of medical expenses from an HSA for prior years' expenses, thus allowing persons to build-up benefits tax-free inside these accounts while reducing the transaction costs that accompany frequent payments of medical expenses from HSAs.

I. Background of HSAs

The policy rationale for HSAs is to motivate consumers to scrutinize and police their spending for medical services. HSAs endeavor to accomplish this purpose by extending a significant tax benefit to consumers who agree to shoulder a larger proportion of their own health costs, with the expectation that a consumer who is paying more of his or her own costs will pay more attention to those costs. Specifically, a consumer who has a "high-deductible health plan" within the meaning of section 223(c)(2) is permitted to contribute the amount of the deductible to an HSA on a tax-deductible basis. The balance in the HSA grows tax free and may ultimately be withdrawn to pay health care costs on a tax-free basis.

HSAs represent a significant expansion to and improvement over "Archer Medical Savings Accounts"

⁶Martin Feldstein, "Health and Taxes," *The Wall Street Journal*, Jan. 19, 2004, p. A13.

⁷Press release, *Doc 2003-26913 (3 original pages)*, 2003 TNT 246-20, accompanying Notice 2004-2, 2004-2 IRB 269, *Doc 2003-26905 (13 original pages)*, 2003 TNT 246-5.

⁸Notice 2004-2, Q&A 12, 2004-1 IRB 269. Section 223(b)(2) provides that the maximum amount that may be contributed to an HSA by an individual with family coverage is \$4,500. However, section 223(g) provides that these various amounts are increased by the same cost-of-living adjustments as are used in indexing income tax brackets in section 1. The \$5,150 figure cited in the text has been provided by the IRS in Notice 2004-2 as the index-adjusted amount for calendar year 2004.

⁹Section 223(e)(1) (providing that a HSA is exempt from tax, except for the provisions in section 511 imposing tax on unrelated business income of an otherwise tax-exempt organization).

¹⁰Section 223(f)(1) provides that amounts paid or distributed out of an HSA which are used to pay qualified medical expenses of any account beneficiary shall not be included in gross income. Section 223(d)(2) provides that this means amounts paid by the beneficiary for medical care (as defined in section 213(d)) for the individual, the spouse of that individual, and any dependent (as defined in section 152) of that individual, but only to the extent that those amounts are not compensated for by insurance or otherwise. In contrast, amounts paid or distributed out of an HSA are taxable if they are not used for qualified medical expenses, and may also be subject to an additional 10 percent tax. Sections 223(f)(2), 223(f)(4).

¹¹Note 7 *supra*.

(MSAs), which initially became available to a limited pool of taxpayers beginning January 1, 1997,¹² and which are currently provided for in section 220. MSAs were a pilot program that was touted, like HSAs, as a potentially significant change in health care policy. As a pilot program, MSAs were open only to self-employed persons and employees at companies with 50 or fewer employees. Like HSAs, MSAs required an individual to have a “high-deductible health plan” to be eligible to open an account.¹³

HSAs are a substantial improvement over MSAs, both as a far more egalitarian tax-advantaged savings vehicle, and more importantly as a potential mechanism to dramatically change the way health care is purchased and funded. At its boldest, the idea behind HSAs is to begin to change the mentality of American employees that they are entitled to receive unlimited health care at a minimal cost funded by their employer. By providing incentives for individuals to accept high-deductible health insurance plans, employees arguably will become more closely connected to the actual costs of the health care they purchase and exert greater influence on the costs of their own care.

HSAs are much more generous than the old MSAs in a number of ways, including the following: (i) although both HSAs and MSAs require a person to be covered under a “high-deductible” insurance plan, the amount of that deductible is lower for HSAs, thus allowing more people to take advantage of HSAs;¹⁴ (ii) under HSAs, both an employee and that person’s employer may contribute to an HSA on behalf of the employee — under MSAs, contributions could be made by the employee, or by that person’s employer, but not by both parties;¹⁵ (iii) HSAs are available for self-employed persons and to all persons working as employees (assuming other requirements are met) — in contrast, only self-employed persons and employees of small employers (50 employees or less) were eligible to participate in MSAs, thus excluding employees of

larger firms from being eligible to participate;¹⁶ and (iv) the maximum contribution allowed under HSAs is the full amount of the deductible under the insurance policy, whereas for MSAs the maximum annual contribution was limited to 65 percent of the annual deductible for self-coverage plans and 75 percent of the annual deductible for family coverage plans.¹⁷

II. What Is an HSA and How Does It Work?

An HSA is not health insurance. An HSA is an account and only an account, akin to an individual retirement account, a Roth IRA, or a 401(k) account. An individual who is eligible for an HSA must open an account with a bank, brokerage firm, or other provider and may then contribute money to the account on a tax-deductible basis. An HSA is thus different from a flexible spending account or a health reimbursement arrangement, since it involves an outside provider who serves as an account custodian or trustee. Moreover, the account owner may elect to invest his or her account in stocks, bonds, mutual funds or other attractive investments.

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The beauty of an HSA is in its generous tax benefits. An HSA is very much like an IRA or a section 401(k) account, only better. The participant in an HSA is entitled to claim a tax deduction for the money contributed to an HSA, as with a section 401(k) account. The money in the HSA then accumulates tax-free, as with most qualified tax-favored accounts. But unlike an IRA or section 401(k), the holder of an HSA has the ability to withdraw money from the HSA on a tax-free basis, akin to a Roth IRA.

Withdrawals from an HSA that are used to pay for the costs of health care are *not* includible in income. Recent studies indicate that Americans spend between \$5,000 and \$6,000 per person per year on health care,¹⁸ so the ability to withdraw money from a tax-favored account to pay those expenses tax-free will be a significant benefit. We know of no other retirement account that permits the dual benefit of tax-deductible contributions and tax-free withdrawals. Roth IRAs, of course, may be tax-free as they are withdrawn, but are not deductible when initially funded. Traditional IRAs are deductible when initially funded, but taxable when later withdrawn. HSAs are deductible when initially funded *and* tax-free when later withdrawn — the best of both worlds.

As noted, withdrawals from an HSA are not subject to tax from income to the extent that they are used to

¹²The provisions for MSAs were enacted in the Health Insurance Portability and Accountability Act (Pub. L. 104-91) and are set forth in section 220. For years after 2003, no new contributions can be made to MSAs except by or on behalf of individuals who previously had MSA accounts and employees who were employed by a employer participating in MSA programs.

¹³Section 220(c)(2).

¹⁴Under the new HSAs, for self-only coverage, the health plan must have an annual deductible of at least \$1,000, and for family coverage the annual deductible must be at least \$2,000. Section 223(c)(2)(A). In contrast, for MSAs the amounts are \$1,700 and \$3,350 for self and family coverage respectively. Section 220(c)(2) (as indexed for cost-of-living adjustment). For a useful discussion summarizing the tax treatment of both MSAs and HSAs, see the explanation of this legislation by the staff of the Joint Committee on Taxation, *Technical Explanation of H.R. 2596, The “Health Savings and Affordability Act of 2003,” As Passed By The House Of Representatives On June 26, 2003* (JCX-66-03), *Doc 2003-15707* (17 original pages), *2003 TNT 126-20* (Joint Committee Explanation).

¹⁵Section 220(b)(5).

¹⁶Section 220(c)(1)(A)(iii), Notice 96-53, 1996-2 C.B. 219, *Doc 96-31086* (15 pages), *96 TNT 233-1*. Section 223(c)(1). See Joint Committee Explanation, note 14 *supra*.

¹⁷Sections 220(b)(2); 223(b)(2)(A).

¹⁸Centers for Medicare & Medicaid Services press release dated January 8, 2004, available at <http://www.cms.gov>.

pay expenses that constitute medical care under section 213. Thanks to recent IRS guidance, this includes even nonprescription drugs!¹⁹ Withdrawals cannot be used, however, to pay for health insurance, except that withdrawals may be used to pay for (i) qualified long-term care insurance; (ii) COBRA health care continuation coverage; (iii) coverage when the account holder is receiving federal unemployment insurance; (iv) coverage for individuals over 65 for Medicare Part A or B, Medicare HMO, and coverage for individuals over 65 for the employee share of premiums for employer-sponsored health insurance (including premiums for employer-sponsored retiree health insurance).²⁰ However, Medicare supplemental insurance or so-called Medigap insurance is not eligible for this special rule and cannot be paid for with proceeds of an HSA.²¹

Withdrawals for medical care costs can be made tax free regardless of the age of the account holder. The account holder thus can contribute money to the account and then immediately withdraw it to pay expenses. Doing so, however, removes much of the tax benefit of HSAs, since the ability to grow money tax free in the account is obviously one of its most significant benefits.

The downside of HSAs is that they are not universally available. To open an HSA, a participant must have health insurance that meets strict requirements. Most notably, it must qualify as a 'high-deductible health plan.'

The downside of HSAs is that they are not universally available. To open an HSA, a participant must have health insurance that meets strict requirements. Most notably, the participant's health insurance must qualify as a "high-deductible health plan." A high-deductible health insurance policy is a policy that has a deductible of at least \$1,000 for a person with self-only coverage and \$2,000 for a person with family coverage.²² The policy must also have a so-called out-of-pocket maximum, which can be no greater than \$5,000 for self-only coverage and \$10,000 for family coverage.²³

¹⁹See Q&A 26, Notice 2004-2, *supra* note 8; see also Rev. Rul. 2003-102, 2003-38 IRB 559, *Doc 2003-19705 (3 original pages), 2003 TNT 171-10*.

²⁰See Q&A 27, Notice 2004-2, *supra* note 8.

²¹*Id.*

²²Section 223(c)(2)(A), Q&A 3, Notice 2004-2, *supra* note 8.

²³*Id.* The out-of-pocket maximum refers to the aggregate amount of expenses (consisting of any deductibles plus co-payments and other similar items) that the insured is required to pay under the policy. At the point in time (on an annual basis) that the insured has paid the out-of-pocket maximum, then the insurance policy must provide complete 100 percent coverage of all covered medical expenses from that point on.

The amount of the deductible determines how much money the individual can contribute to his or her HSA. In a significant improvement from the old MSA program, the amount of the permitted annual contribution to the HSA equals the amount of the deductible. Thus, if an individual with family coverage has a deductible under the policy equal to the 2004 maximum amount that may be contributed to an HSA of \$5,150 per year, then the individual can contribute \$5,150 to his HSA account and deduct that amount for tax purposes. Under the old MSA program, the amount of the deductible contribution was limited to 75 percent of the amount of the deductible. Moreover, individuals over age 55 can contribute make-up contributions to an HSA.²⁴ The make-up contribution limit is \$500 in 2004, and increases in future years by \$100 per year up to a maximum of \$1,000 in 2009.²⁵ Once an individual becomes eligible to receive Medicare benefits (usually 65), the individual can no longer make contributions to an HSA.²⁶

The tax rules for an HSA make it economically beneficial for almost any typical health insurance plan to be converted into a high-deductible health plan. For example, consider an individual who has a typical employer-provided health insurance plan with a modest \$250 deductible and an out-of-pocket limitation of \$1,500. Most plans provide for 80 percent coverage after the deductible has been satisfied, until the out-of-pocket limit is reached and coverage becomes 100 percent. If this plan were converted to a high-deductible plan with a deductible of \$1,000, but the out-of-pocket limit stayed the same, at most the employee's economic burden of the increased deductible would be \$600 (the \$750 increased deductible x 0.80 (the coverage percentage)). However, the individual would become entitled to a deductible \$1,000 contribution ("above the line" and not subject to any restrictions regarding itemized deductions) that would reduce both income taxes, employment taxes, and likely state income taxes. The individual would thus obtain a \$350 to \$400 tax benefit, leaving a worst-case scenario of a cost of around \$250 to \$300 to the employee.²⁷ In turn, however, the increase in the deductible would permit the employer or health insurer to significantly reduce the premium paid by the individual, almost certainly by more than \$250

²⁴Section 223(b)(3)(B).

²⁵*Id.*

²⁶Section 223(b)(7).

²⁷Assuming a 25 percent federal tax rate, 7.65 percent in employment taxes and 4 percent in state taxes, the tax benefit of the \$1,000 deduction would be approximately \$366. Thus, under the high-deductible alternative, the after-tax cost of paying \$1,000 in medical bills would be \$1,000 less \$366 or \$634. In comparison, under the low-deductible alternative, if a \$1,000 claim were incurred, the person would pay the \$250 deductible, and 20 percent of the excess amount of \$750, for a total of \$400. Thus, the high-deductible alternative would result in a net after-tax cost of \$634, while the low-deductible alternative would result in a net, after-tax cost of \$400, resulting in an incremental cost of \$234, *before taking into account any reduction in premiums that the increase in the deductible would surely permit.*

to \$300.²⁸ And the individual will then enjoy tax-free build-up of the cash in the account. As a result, even in a worst-case scenario where an individual incurs medical costs fully up to the higher deductible, that individual will typically be better off with a high-deductible policy. And for those individuals who either typically incur modest health care costs (and thus don't reach their deductible) or who usually hit their out-of-pocket limits, switching to a high-deductible plan has no cost whatsoever, but generates lower premiums and a generous tax benefit.

III. The Failure of MSAs

Before we discuss in depth specific issues raised by the HSA rules, we believe it would be helpful to review the history of MSAs and what we can learn from that history in dealing with the new HSA system.

In all candor, MSAs were a huge disappointment. When originally enacted, Congress imposed a limit of 750,000 MSAs, and required reporting to ensure that the limit was not exceeded.²⁹ If Congress was concerned that the limit would be exceeded, its concern proved unjustified. The first report on MSAs showed that there were only about 7,500 MSAs,³⁰ and at no point did the number of plans in place come close to even 100,000, let alone the maximum number of 750,000.³¹

An even more telling fact is that we strongly believe that those using MSAs were largely affluent individuals not really in need of help in funding their health care purchases. Although our statement here is based on anecdotal evidence,³² it was our experience that MSAs were established by well-advised, high-income individuals who were able to afford the inconveniences of high-deductible insurance plans to obtain the significant tax benefits offered to MSA users. Although MSAs were, in theory, available to rank-and-file employees of small companies, in reality it was only the high-income self-employed, like partners in law firms, that had both the knowledge and the wherewithal to take advantage of the program.

²⁸An article by Martin Feldstein in *The Wall Street Journal* on January 19, 2004, note 6 *supra*, included an example from California Blue Cross that showed how dramatically lower premiums can be on a high-deductible policy. Indeed, in that example, the premium reduction was more than 100 percent of the increase in the deductible. Feldstein, note 6 *supra*.

²⁹Section 220(j).

³⁰Ann. 97-79, 1997-35 IRB 8, *Doc 97-23785* (3 pages), 97 TNT 159-5.

³¹Ann. 99-95, 1999-2 C.B. 520, *Doc 1999-31533* (3 original pages), 1999 TNT 190-8 (number of MSAs for 1998 was 32,371, and projected number for 1999 was 44,784, far short of the limit of 750,000); 2002-90, 2002-2 C.B. 684, *Doc 2002-22140* (2 original pages), 2002 TNT 189-4 (number of MSAs for 2001 was 21,079, and projected number for 2002 was 59,151, again falling far short of the numerical limit).

³²Out of those first 7,500 or so MSA accounts, we know that more than 100 of them were partners in our law firm, and we know that other law firm partners also significantly participated in the program.

One of the major reasons for the failure of MSAs to reach a mass audience was that the banking and mutual fund industry never embraced the system and never marketed these accounts on a wide, retail basis. Indeed, very few major banks or mutual fund families even permitted eligible individuals to open MSAs. The principal reasons for their reluctance were that (i) MSAs were complicated and potentially imposed significant transaction costs on MSA custodians, and (ii) the restrictions on MSAs made the potential market too small to be commercially feasible.

This is an extremely important lesson that the history of MSAs can teach us — if the mutual fund industry does not adopt and market HSAs, then HSAs will fail, much to the disappointment of the White House, IRS, and Congress. If HSAs are to catch on and become accepted by employers and employees, financial institutions such as banks and mutual funds will have to adopt and advertise them and make HSAs readily available with attractive investment choices to persons who have high-deductible health plans. In turn, the HSA rules need to be sufficiently flexible and nonpenal so that HSAs will be attractive to account custodians, advisers, and other necessary participants in the retail marketplace. This is one of the areas discussed below in which additional help from the IRS is needed.

IV. Where the HSA Rules Need Development

Regrettably, health insurance is a complicated subject, and thus it is not all that easy to recognize a “high-deductible health plan.” For that reason, converting from a low-deductible to a high-deductible health plan is not nearly as simple as it ought to be. Virtually all health insurance products have individual characteristics, with a wide array of deductibles, co-payments, wellness benefits, out-of-pocket limits, and prescription drug and vision benefits. The old MSA rules were remarkably inflexible in making concessions for these various characteristics, resulting in MSAs being unattractive because the requirements they imposed on insurance policies were unrealistic. The new HSA rules have been somewhat improved in this regard. However, as discussed below, there is still need for much more flexibility under these rules if HSAs are to become widely used. Specific areas where help is needed are discussed below.

A. The Definition of ‘High-Deductible’

Section 223 revolves around the definition of a “high-deductible health plan.” There are several significant ambiguities in the definition of what constitutes a “high-deductible health plan.” In particular, three questions need guidance: the interpretation of the amount of the family deductible when the family deductible includes a lower individual deductible; the application of the deductible when some services are covered at a discounted fixed fee within a health care network; and the application of the rules when a deductible payment in one year is allowed to carry over to the following year.

One especially important ambiguity in the existing rules is the calculation of the deductible amount (which

in turn determines eligibility for an HSA and the amount that may be contributed to an HSA) for a family insurance policy. The IRS in Notice 2004-2 sought to answer this question in part, and in doing so reached the wrong answer. To frame the issue as the IRS did in Notice 2004-2, assume an individual has family coverage with a \$2,000 family deductible. This would seem to be an eligible high-deductible health plan.³³ As is very common with family coverages, however, the coverage also provides that the deductible for to any one person in the family is \$1,000. Thus, the medical bills of any one individual in the family would be covered once that individual has incurred at least \$1,000 in costs, but if no person in the family had at least \$1,000 in costs, no amounts would be reimbursed until the entire family incurred at least \$2,000 in costs.

In Notice 2004-2, the IRS announced that this plan would not qualify as a high-deductible health plan.³⁴ That was the *wrong* answer, not required by the statute, and in so ruling the IRS created a new marriage penalty.³⁵ The statute, section 223, requires only that a family deductible be at least \$2,000. In the above example, the family deductible is \$2,000. Nothing in the statute suggests that a family deductible cannot have a lower individual deductible, and given that section 223 permits an individual policy to have a deductible of only \$1,000, this fact pattern should be HSA-eligible.

One especially important ambiguity in the existing rules is the calculation of the deductible amount (which in turn determines eligibility for an HSA and the amount that may be contributed to an HSA) for a family insurance policy.

The IRS position creates a significant marriage penalty, even as the Bush administration has sought to eliminate all marriage penalties. As President Bush recently said, “[h]eck, we want a tax code that encourages marriage, not discourages marriage. It doesn’t make sense to say, if you’re married, you get to pay more tax.”³⁶ To see how the IRS position creates a marriage penalty, consider, for example, two individuals who live together but are not married. These

³³Notice 2004-2, Q&A 3, *supra* note 8.

³⁴Notice 2004-2, Q&A 3 (Example 1), *supra* note 8.

³⁵We acknowledge that the IRS position here (which we believe to be wrong as a policy matter) seems to be the same as provided in Rev. Rul. 97-20, 1997-1 C.B. 647 (Situation 2), *Doc 97-11356 (7 pages)*, 97 *TNT* 78-6, which set forth the IRS interpretation of a “high-deductible health plan” under the MSA rules. In our view, however, the IRS was wrong in this previous revenue ruling as well. Indeed, the absolute failure of the MSA system was attributable, in part, to unreasonable IRS positions such as those taken in this revenue ruling.

³⁶Remarks by President Bush in a conversation on the economy with women who own small businesses, January 9, 2004, available at <http://www.whitehouse.gov/news/releases>.

two individuals have self-only insurance coverage, with a \$1,000 deductible. Under section 223, this couple would be permitted to contribute \$1,000 each to an HSA, for a total annual contribution of \$2,000. If, however, the couple were to get married and adopt family coverage, they would have family coverage with a \$2,000 family deductible (but with a \$1,000 per person deductible within the \$2,000 family deductible). Their health insurance coverage and limitations would, as an economic matter, be absolutely unchanged, but now, because of their marriage, the IRS says that they are ineligible for any HSA contribution. This IRS position is unreasonable and ignores the economic substance of this family health plan — nothing in the statute or the legislative history requires such a position.

How should the rules apply in this situation? In the above example, the couple should be permitted to make a \$2,000 HSA contribution, the amount of their family deductible and the amount they could have contributed if they had remained unmarried.

Determining the amount of the deductible for purposes of section 223 becomes somewhat more complicated when the family includes children, and thus we assume a slightly different fact pattern to illustrate that situation. Assume that a family consists of two adults and a child, with a \$5,000 family deductible and an individual deductible within the family policy of \$2,000 per person.³⁷ It is quite possible that up to \$5,000 in medical expenses will be incurred by the family without any insurance benefits whatsoever being available to offset this cost.³⁸ Based on this point, to allow a contribution of \$5,000 to the HSA would be consistent with the congressional intent of section 223 — amounts would be contributed for any one year up to the total amount of the deductible under the policy for that same year in question.

Notice 2004-2 does not state whether the permitted HSA contribution in this example would be \$2,000 or \$5,000, but the strong implication of Q&A 3 is that the limit would be \$2,000. Again, that would be the wrong answer and would impose a penalty on families. We would propose that for family coverage, the limit for annual HSA contributions should be the lesser of (i) the overall family deductible; or (ii) the number of people in the family multiplied by the individual amount deductible. Such a result is entirely rational and consistent with the goals of the HSA system, and it encourages the use of HSAs by families — a vitally important development if HSAs are to be successful.

The fact that the IRS position on this issue is out of step with good policy can be seen in a *Wall Street Journal* editorial on January 19, 2004, by Martin Feldstein, former Chair of the Council of Economic Advisers

³⁷Notice 2004-2, Q&A 3 (Example 2), *supra* note 8. It is not clear in this example set forth in Notice 2004-2 what the contribution limit is to this plan under the IRS interpretation of the rules.

³⁸This would be the case, for example, if the medical expenses were evenly spread among members of the family, as opposed to being concentrated in one individual.

under President Reagan. Feldstein lays out an example of how HSAs work and how HSAs can benefit consumers. Unfortunately, however, Feldstein assumes that the IRS would not interpret the HSA rules in such an anti-taxpayer manner. In Feldstein's example, a married couple have a high-deductible policy from California Blue Cross with a \$5,000 deductible, but not more than \$2,500 per individual. Feldstein assumes that the couple could contribute up to \$5,000 to an HSA.³⁹ However, under the IRS interpretation, the maximum contribution would be \$2,500. Surely it would come as a surprise to Dr. Feldstein that the couple in his example could contribute only \$2,500 to an HSA when the family clearly has a high-deductible policy with a \$5,000 deductible.

Surely it would come as a surprise to Dr. Feldstein that the couple in his example could contribute only \$2,500 to an HSA when the family clearly has a high-deductible policy with a \$5,000 deductible.

There are other significant open issues in determining whether a plan is a "high deductible" plan. In today's typical health insurance plan, the plan will have in-network and out-of-network providers. Section 223(c)(2)(D) recognizes the fact that a higher deductible or out-of-pocket limit for out-of-network usage should not be relevant to determining whether a plan is a high-deductible health plan. But the statute does not address what happens when services within the network are charged at a low fixed cost because of agreements between health care providers and health care networks. For example, many health plans provide that in-network doctor's visits have a fixed cost at well-below market rates. These rates are often negotiated in long-term agreements and represent a price that is well below what a person would pay if he or she purchased this service without health insurance. The question then becomes whether the ability to purchase health services at a discounted price causes the plan to fail to be a high-deductible health plan. We would urge the IRS to clarify that the existence of such in-network fixed pricing does not cause a failure of the high-deductible test. Without this clarification, it will be extremely difficult for most employers to modify their plans to make those plans HSA-eligible, and employees will not want such plans.

Another issue relates to the timing of deductibles. Many plans provide that if an individual incurs costs at the end of a plan year, those costs can be applied to the deductible for the following year. The reason for this is quite clear and is supported by a strong public policy. Put simply, a person who feels chest pains in

³⁹In Feldstein's example, he assumes that the married couple could contribute the amount of their premium savings, \$4,524, to their HSA. Feldstein, note 6 *supra*.

December should feel no economic compulsion to defer medical care until January 1.⁴⁰ To avoid imposing that type of economic compulsion, health plans commonly permit medical costs at the end of one year to be applied to the deductible for the subsequent year. The IRS should clarify that the rules for determining whether a health plan has a "high-deductible" should be consistent with standard practice, and that a provision that permits medical bills at the end of a year to be applied to the following year's deductible should not cause the plan to fail the high-deductible test.

B. 'Permitted' and 'Preventive' Insurance

Section 223(c)(1)(A)(ii) states that a person with a high-deductible policy is an eligible HSA holder only if the holder does not have other insurance that overlaps in some way with the high-deductible insurance and the other insurance is not high-deductible insurance. In applying this rule, the statute excludes some "permitted insurance" and other types of policies.⁴¹ In other words, a person is allowed to have permitted insurance and other types of policies, with no deductible or a very low deductible, without that fact disqualifying the person from having a policy that is treated as a high-deductible policy that is eligible for an HSA. It is extremely important that, in defining specific details of permitted insurance and the other policies in question, the IRS is flexible and reasonable.

"Permitted insurance" is insurance under which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (such as automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.⁴² The other types of policies that a person is allowed to have consist of coverage for accidents, disabilities, dental care, vision care, and/or long-term care.⁴³ Ironically, although these types of plans will not prevent a person from having another plan that itself is treated as a high-deductible plan, if a plan that is intended to qualify as a high-deductible plan is one in which substantially all of the coverage is through permitted insurance or other allowed coverage, that plan is not a high-deductible plan.⁴⁴ Presumably, this encourages a system in which a person obtains coverage of permitted insurance and other allowed coverage through low-deductible plans, while retaining a high-

⁴⁰Unfortunately, such economic compulsion may be present if the person knows that the medical cost, if incurred in December of Year 1, will not be reimbursed under the health plan because that cost (along with other health costs incurred in Year 1) will not exceed the deductible for that year, whereas if the medical cost is incurred in January of Year 2 at least it will count against the deductible for Year 2 and will not be "wasted."

⁴¹Section 223(c)(1)(B).

⁴²Section 223(c)(3), Q&A 6, Notice 2004-2, *supra* note 8. This definition was borrowed from the MSA rules, which provide for the same types of permitted insurance. Section 220(c)(3).

⁴³Q&A 6, Notice 2004-2.

⁴⁴*Id.*

deductible plan that provides coverage for other illnesses or medical problems, thus avoiding overlapping coverage and undermining somewhat the purpose of the HSA system.

In a provision that is far more important than perhaps even Congress realized, the HSA rules say that a health care policy does not fail to be a high-deductible policy merely because the policy has no deductible for "preventive care."⁴⁵ The statute then states that preventive care shall be defined based on rules under section 1871 of the Social Security Act, and the IRS has the authority to promulgate rules to expand and define preventive care.⁴⁶ It is difficult to find the definition of preventive care that is incorporated in the HSA system, and the reference to section 1871 of the Social Security Act appears to be a typographical error. Notice 2004-2 does not provide any detailed description of that care, and the authors (and colleagues at other firms that we spoke with) were able to locate the definition only after significant efforts. *This is not a good sign.* The IRS needs to do everything in its power to encourage the use of HSAs, and the fact that the IRS did not even bother to provide a meaningful definition of an important component of the rules does not bode well for the future of the HSA regime.

The fact that the IRS did not even bother to provide a meaningful definition of an important component of the rules does not bode well for the future of the HSA regime.

Based on section 1861 of the Social Security Act (42 U.S.C. section 1395x), as amended by Pub. L. 108-173 (which we believe is the cross-reference that Congress intended), "preventive services" appear to include (i) an initial preventive physical examination; (ii) a cardiovascular screening blood test; (iii) a diabetes screening test; and (iv) some mammography services. The definition of initial preventive physical examination, in turn, includes physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described below, but does not include clinical laboratory tests.

The screening and other preventive services noted above, which are included in preventive care, include the following: (a) pneumococcal, influenza, and hepatitis B vaccine and administration; (b) screening mammography; (c) screening pap smear and screening

⁴⁵Section 223(c)(2)(C). IRS Notice 2004-2, *supra* note 8, pays very little attention to preventive care, which is a major mistake by the agency. Q&A 3 notes that a high-deductible plan may provide for preventive care without any deductible being required. The IRS does not define a preventive care policy.

⁴⁶*Id.*

pelvic exam; (d) prostate cancer screening tests; (e) colorectal cancer screening tests; (f) diabetes outpatient self-management training services; (g) bone mass measurement; (h) screening for glaucoma; and (i) medical nutrition therapy services.

There is a very strong rationale for allowing persons to have health coverage for preventive care without any deductible (or with low deductibles), while at the same time qualifying to participate in an HSA. Congress should encourage the use of preventive-care medicine, such as immunizations for children, mammograms for women, and a yearly physical examination with accompanying lab tests. Routine preventive care is essential to rein in health care costs, because what really causes health care costs to spiral out of control are occasional high-expense cases. In an effort to identify the special problems and severe cases, and at the same time reduce their frequency, it has become extremely common for health care insurance, regardless of the amount of the deductible, to include so-called "wellness benefits." These permit participants to enjoy a limited amount of preventive care with no deductible and perhaps only a small co-pay. Wellness benefits are extremely popular with employees, and any change to health insurance that does not include a wellness benefit is unlikely to be widely adopted by employee participants.

The IRS needs to articulate a definition of preventive care. It would be absurd for IRS auditors to pore over an individual's health plan documents to determine whether the plan had an appropriate definition of preventive care. We would recommend that the IRS promulgate regulations providing that preventive care be defined in accordance with common practice in the health care industry, and the IRS should announce that it will not disqualify an individual's HSA retroactively merely because the individual's employer offered an overly generous definition of preventive care. In that regard, the IRS needs to state definitively what does *not* constitute preventive care, and should do so prospectively so that employers and health care insurance companies can adapt their plans if necessary.

C. Prescription Drugs Coverage

There is no issue more important under the HSA rules than the treatment of prescription drugs. What is missing from the definition of a "high-deductible health plan," and what threatens to derail the expansion of HSAs, are specific rules for dealing with prescription drugs.

In general, most employer-paid policies treat prescription drugs as a separate item. Rather than being subject to deductibles, employer-sponsored health plans typically treat prescription drugs as a separate item subject to co-payments, with a more modest co-payment for generic drugs and a larger co-payment for branded pharmaceuticals. Many plans offer special rates for mail-order prescription drugs. Most employers have been steadily increasing their co-payments for prescription drugs, hoping to ensure that their employees act as wise consumers of those drugs.

The HSA rules do not contemplate an exclusion for prescription drugs from the high-deductible definition, and

it thus may appear that any health insurance policy that does not subject the purchase of pharmaceuticals to the deductible would fail to qualify as a high-deductible plan. If this turns out to be the IRS's position on this matter, then the Bush administration can say "good-bye" to any hope that HSAs will be adopted by "millions" of participants as Treasury Secretary John Snow has stated.⁴⁷ This aspect of the high-deductible rules will make high-deductible plans much less attractive to individuals who currently participate in an employer-sponsored plan, will make the adoption of new high-deductible plans more of a bureaucratic headache for employers and administrators, and will make it impossible to adopt HSA-eligible plans for employers whose employees are subject to collective bargaining in which the collective bargaining agreement calls for co-payments for prescription drugs.

The reason that most health insurance policies adopt a co-payment, as opposed to a deductible, for prescription drugs is that (i) the consumption of prescription drugs tends not to be discretionary, and (ii) prescription drugs are in many ways a form of preventive care. Employers therefore have no desire to create unreasonable incentives for employees to restrict their consumption, since nonuse of prescription drugs will raise costs in the long term. For example, imagine an employee who catches a virus and obtains a prescription for an expensive drug to treat it. If the employee has a high-deductible plan, the employee may choose to just wait out the illness rather than spend a significant amount of money on the drug. The employee may then be delayed in returning to work, or worse yet, may return to work and infect other employees. Similarly, anticholesterol medications are very expensive. Such medicines, however, play an important role in controlling long-term health care costs. No employer wants to create incentives to stop using those medications.

Although the public policy behind high-deductible plans is to make individuals more cost-conscious of what they spend, the typical co-payment accomplishes the same purpose with respect to prescription drugs. That is, the objective of a high-deductible health plan is to make individuals more cost-conscious in making health care decisions, and to provide them incentives to work with their health care providers to make correct choices — both economically and medically — in determining the amount of health care to purchase. The existence of reasonable co-payments generally serves as an effective deterrent to overconsumption of prescription drugs. As a result, requiring employers and employees to completely change the way they treat prescription drugs in their health plans to qualify them as high-deductible health plans is a very unwise approach for the government to take.

The IRS should apply the HSA rules in such a way that will permit health-insurance plans to continue to treat prescription drugs as they have done historically.

Doing so would not violate the language of section 223. The IRS can state explicitly that the definition of a "high-deductible" plan shall be made in accordance with common practice. Thus, a plan with a \$2,000 family deductible would not fail to be a high-deductible plan merely because prescription drugs can be purchased from the outset at a fixed co-payment, as is the case with the vast majority of health plans.

Alternatively, the IRS could conclude that the prescription drug component of a health plan should be treated as a separate plan. According to the statutory language, an individual is eligible to have an HSA if the individual has a high-deductible health insurance plan. An employee is not permitted to have any health insurance that is not a high-deductible health plan if it provides any coverage that is also covered by the high-deductible health plan.⁴⁸ As a result, the IRS could treat a health plan that has prescription drug coverage based on reasonable co-payments as being divided into two plans, a prescription-drug plan and a medical insurance plan. The medical insurance plan could be a high-deductible plan while the prescription-drug plan would be a no-deductible, co-pay plan. The individual would thus still be eligible for an HSA even though there was no deductible for the prescription drugs.

D. Dual Health Plans

The analysis above with respect to the possibility of dual plans to deal with the prescription drug program leads to an interesting question. Could an employer divide his health plan into two plans altogether? One plan would be a low-deductible plan that would include standard health care, including preventive care, doctors' visits for illnesses, prescription drugs, and the like. The second plan would be akin to a major medical plan, and would cover traumatic illnesses and disease, including surgical procedures, hospital stays, and other expensive treatment. The major medical plan would be a high-deductible plan, while the other plan would not. As long as the two plans were structured so as to not overlap in their coverage⁴⁹ and the plans themselves were kept separate, it would appear that an individual even with both plans would be eligible for an HSA because of the existence of the high-deductible plan.

The benefit of this two-plan or dual-plan approach is that many employees will resist a high-deductible health plan, even if it results in lower premiums and the ability to make a deductible HSA contribution, if they perceive the high deductible as being too onerous. If, however, the high-deductible plan relates only to charges that employees typically do not expect to incur, the high-deductible plan will be more warmly received. Is it abusive or contrary to legislative intent for an employer to offer dual plans? The authors contend that a dual plan system is implicit in the separate treatment for permitted insurance and preventive care under the HSA rules. It is logical and reasonable to

⁴⁷Press release of December 22, 2003, announcing Notice 2004-2 available at <http://www.ustreas.gov>.

⁴⁸Section 223(c)(1)(A)(ii)(II).

⁴⁹See section 223(c)(1)(A)(ii)(II).

expand this concept in a way that will remain consistent with the goals of the HSA system.

For years, the federal government has effectively acknowledged that prescription drugs are a different market than regular health care, since prescription drugs have generally been excluded from Medicare coverage until now. Many employers have separate plans for vision, for dental, for long-term care, etc. A compelling argument can be made that the fundamental purpose of health insurance is to cover major medical items, and that individuals ought to be personally responsible for their more routine expenses. Consequently, the existence of a separate policy for major medical coverage would not appear to be purely tax-motivated.

E. Reimbursement of Medical Expenses

As mentioned above, one of the largest failures of the MSA program was the fact that practically no retail market developed for MSAs. Place a call to Schwab or Vanguard or Fidelity and tell them you would like to open an MSA, and you will have a very short conversation. Why have these types of firms not offered MSAs? First and foremost, the last thing third-party custodians want is scores of government-regulated accounts with small balances and high transaction costs. Since MSAs (and now HSAs) at least in part are designed to permit individuals to use such accounts to pay their health care bills, third-party custodians see a significant risk that these accounts will be used principally as IRS-monitored checking accounts with money constantly flowing in and out. In other words, small-balance accounts with high transaction costs.

The IRS should do all it can to facilitate the marketing of HSAs by third-party custodians.

The IRS should do all it can to facilitate the marketing of HSAs by third-party custodians. To that end, the IRS already does not require custodians to determine whether withdrawals are for qualified medical costs. However, beyond that, individuals with HSAs should be permitted to accumulate funds in their HSAs and retain records of health care expenditures incurred while they have a high-deductible health plan, and then make withdrawals at some later time from the account to reimburse themselves for those costs. By permitting this, the mutual fund families, insurance companies, banks, and the like could prescribe rules that could limit the number and size of withdrawals from HSAs, to minimize their potential transaction costs. It would also make it much more plausible that HSA balances will grow large enough that the accounts could become a profit source for HSA custodians.

We see no reason why there should be any time limit for the use of funds from an HSA to reimburse health care expenses incurred when the individual was HSA-eligible. As long as an individual retains adequate proof of actual health care expenses, an individual should be permitted to make a withdrawal from an HSA well after an expense is incurred and that with-

drawal should be tax free. No public policy is protected by compelling prompt withdrawal of funds to pay expenses. At a minimum, withdrawals made on or before April 15 of the year following the year in which the medical expense is incurred should qualify for tax-free status. If the IRS does not permit at least this measure of flexibility, we believe that most mutual fund families and other third-party custodians will find it disadvantageous to even consider entering the HSA market.

V. The Potential for HSAs

While most of the media attention on HSAs has focused on the benefits of HSAs to employees and individuals, employers will benefit substantially from offering high-deductible health plans that will make their employees HSA-eligible. The benefits to the employer are at least twofold. First, the notion of health insurance is typically misunderstood by employees. Most large employers self-insure, which means that a health insurance company administers the plan but the medical costs are entirely passed through to the employer. This means that any increase in the deductible will translate directly into cost savings for the employer. Every dollar that employees either pay for their health care or do not spend at all translates dollar-for-dollar into employer cost savings. Thus, to the extent that the deduction for HSA contributions permits the employer to raise its deductible, the employer wins. Second, the HSA rules permit the employer to offer HSAs as a salary reduction benefit. The amount that the employee contributes to the HSA will reduce the employee's taxable compensation, and such amounts would not be subject to employment taxes for either the employee or the employer. The HSA contribution, potentially up to \$5,650 per employee (including make-up contributions for persons over age 55), would thus not be subject to the employer portion of FICA. An employer could save up to approximately \$400 per employee per year.

Whether employees will respond favorably to a high-deductible health plan depends on a number of factors and on the total package of benefits that the employer offers to induce employees to accept a higher deductible. The key factors appear to be (i) the existence and amount of the current deductible, (ii) the impact that the change will have on the employee portion of premiums, (iii) the total package of benefits that the employer now includes in its health insurance plans, (iv) whether the employer subsidizes the contribution to the HSA, and (v) whether the employer offers retiree medical insurance.

From our experience with MSAs, we can say that most individuals will tend to undervalue future tax benefits. That is, while business lawyers and accountants may understand the benefit of tax-free build-up in an HSA and the miracle of tax-free compounding, others will not. Thus, the fact that HSAs accumulate income tax free that can then be withdrawn tax free in retirement will not generally be viewed as a substantial benefit by most employees. What employees will understand, however, is the current arithmetic, that is, whether the benefit of the immediate tax deduction and

the reduction in premiums will offset the increase in deductible. Thus, for example, assume an employee currently has a family deductible of \$1,000 per year and pays \$2,000 per year in premiums. If the employer raises the deductible to \$2,000, most employees will perceive that change as a \$1,000 cost, regardless of whether the employee typically hits the deductible. As a result, the combination of the tax deduction for the contribution plus the reduction in the after-tax cost of the premiums will have to exceed the potential cost of the increased deductible, or the employee is likely to be skeptical of the proposed change.

That being said, the potential upside to an employee from a high-deductible plan can be quite substantial, and a savvy employer will endeavor to modify its health plans to the maximum extent possible to make the high-deductible option attractive for employees. For example, a higher-income employee taxed in the 33 percent or 35 percent bracket could save up to \$2,000 per year in federal and state income taxes and employment taxes with a \$5,000 deductible health plan. The typical premium for a policy with a \$5,000 deductible would also likely be dramatically reduced. Assuming the employee currently pays approximately \$2,000 per year in premiums, the employee would surely save at least \$1,000. If the employee is reasonably healthy and does not expect to have significant uncovered health care costs on an annual basis (keeping in mind that preventive care can be excluded from the deductible), the individual easily could see annual cash savings in the neighborhood of \$3,000.

As a result of the interaction of these tax rules, there is a powerful incentive for individuals to purchase as much health insurance as possible and then to consume health care without concern for incremental costs.

Logically, an employer might believe that the optimal proposal is to offer employees two different deductibles: a traditional low-deductible plan with higher premiums, and then a high-deductible plan with lower premiums designed to maximize an employee's ability to make a tax-deductible HSA contribution. This approach is ideal for employees. From an employer perspective, however, this structure may not be so attractive, because it might actually increase an employer's total costs by creating a significant risk of self-selection by employees (the "adverse selection" problem). That is, it is inevitable that some employees will incur significant health care costs on an annual basis, either because of a recurring medical condition or because of their personal habits. Other employees are of the type that rarely incur any significant medical expenses. When the employer offers low-deductible and high-deductible health plans with widely varying premiums, one would expect that an employee who typically incurs high costs would remain with the low-deductible plan, while an employee who typically incurs fewer costs would switch to the high-deductible

plan and pay the lower premiums. In that case, because the latter employee would not have hit the deductible in any event, there has been little or no change in overall employer costs, but the amount of premiums collected by the employer will have been reduced.

For that reason, it may be that the most attractive way for an employer to induce its workforce to accept a high-deductible health plan would be to structure the plan in such a way as to maximize the total package of benefits for employees. For example, HSAs permit preventive care to be offered with no deductible, and also require a fairly low out-of-pocket maximum. The employer could thus offer a plan with a higher deductible but also with generous preventive care provisions and a low out-of-pocket maximum. The employer might also consider matching some portion of the HSA contribution. The combination of preventive care and the low out-of-pocket limitation may offset the higher deductible, thereby making all parties better off.

At a minimum, all employers ought to now take a long, hard look at their health plans. The tax benefits of the HSA are so significant, and the potential for dramatic change in health care behavior so dramatic, that employers ought to revisit the terms of their health plan and determine whether now is the time for a fairly significant restructuring of these plans.

VI. Will HSAs Be Successful?

The public policy behind HSAs is relatively self-evident. The amount of health care that an individual purchases will obviously be inversely related to the cost of that health care. In turn, this means that an individual with a relatively low-deductible policy would be expected to purchase more health care and to be relatively price-insensitive to the cost of that health care. By offering an economic incentive to a consumer to adopt a high-deductible policy, the hope is that consumers will become more price conscious in purchasing health care and therefore finally bring some rationality to the health-care consumption process.

Whether these goals will be accomplished is anyone's guess, but at a minimum the HSA initiative helps to remedy a questionable policy judgment in the taxation of health care. The costs of purchasing health insurance for both the employer and the employee generally are tax-deductible. Employers deduct their costs as business expenses under section 162, while employees who pay premiums may treat those premiums as expenses under a cafeteria plan and thus pay no tax on the portion of their salary dedicated to those premiums. Beginning in 2003, self-employed persons became eligible to receive a 100 percent deduction for health insurance premiums. The combination of these rules effectively means that health insurance premiums are almost always 100 percent deductible. In contrast, the costs of health care itself are effectively not deductible. That is, while health care costs in excess of 7.5 percent of an individual's gross income are deductible under section 213(a), that limit is so high that as a practical matter, few if any individuals ever reach it. The only individual who would reach this amount is a relatively low-income individual who suffers a

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major calamity and who has no insurance. While these persons are no doubt more prevalent than we all would like, it is also the case that these persons are not likely to be taxpayers, and are less likely to be taxpayers who claim itemized deductions — thus in effect there are few taxpayers who see any tax benefit for actual unreimbursed health care costs.

As a result of the interaction of these tax rules, there is a powerful incentive for individuals to purchase as much health insurance as possible and then to consume health care without concern for incremental costs. Between a low-deductible policy (with a relatively high premium) and a high-deductible policy (with a relatively low premium), the low-deductible policy, with its incentives to consume, was clearly tax-preferable, before HSAs were enacted. Indeed, a person would typically choose a high-deductible policy only if the individual expected not to consume any material amount of health care whatsoever.

By providing a tax incentive for choosing the high-deductible policy, Congress has begun to remedy somewhat this fairly absurd tax result. And in doing so, Congress has taken a stab at remedying a serious public policy problem — the dramatic increase in health care costs. Having taken this step, however, the IRS should take those additional steps necessary to ensure that HSAs have a chance to succeed in the marketplace, including dealing with items such as the definition of preventive care, eliminating the marriage penalty in Notice 2004-2, and permitting the exclusion of prescription drugs from the deductible in a high-deductible policy when there is a reasonable co-payment in place.