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Healthy and Wealthy and Dead: Health Savings Accounts

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HEALTHY AND WEALTHY AND DEAD: HEALTH SAVINGS ACCOUNTS*

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I. INTRODUCTION

Health Savings Accounts ("HSAs") are the newest, and probably the most controversial, vehicle for providing tax-favored health benefits.[1] Proponents, including the Bush administration, claim that they will control

* James Thurber, *The Shrike and the Chipmunks*, NEW YORKER, Feb. 18, 1939 (stating "[e]arly to rise and early to bed makes a male healthy and wealthy and dead").

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1. HSAs share some similarities with other arrangements, including Health Reimbursement Arrangements (HRAs), Archer Medical Spending Accounts (MSAs) and Health Flexible Spending Accounts (Health FSAs), which are not discussed in this article. *See generally* Rev. Rul. 2004-45, 2004-1 C.B. 971 (discussing the coordination among HSAs, HRAs and FSAs, in which the I.R.S. described five factual situations and analyzed whether the individuals would be disqualified from contributing to or having contributions made on their behalf to an HSA); CONG. RESEARCH SERVS., REPORT ON TAX-ADVANTAGED ACCOUNTS FOR HEALTH CARE EXPENSES: SIDE-BY SIDE COMPARISON (2003) (discussing the similarities and differences between HRAs, MSAs, and FSAs); Greta E. Cowart & T. David Cowart, *Choosing a New Health Plan Design? Differences among HRAs, HSAs and FSAs Beyond the Basics*, 2006 A.B.A. ERISA BASICS NAT. INST. 1.

costs, reduce the number of uninsured Americans, and give consumers greater control over their health care decisions.[2] Opponents claim that they unduly benefit the wealthy, will do little or nothing to control costs or extend coverage, and provide consumers with information that is insufficient to make educated decisions.[3]

HSAs were enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[4] Section 1201(a) of the MMA added § 223 to the Internal Revenue Code (the "Code"),[5] to permit eligible individuals to establish HSAs for taxable years beginning after December 31, 2003.[6] An HSA may be set up with or without employer involvement, but if an employer makes contributions to its employees' HSAs, it must make "comparable contributions" on behalf of similarly situated employees or it will be subject to an excise tax.[7] An HSA may also be offered through a cafeteria plan.[8]

In its 2007 budget proposals, the Bush Administration proposed new tax cuts expanding HSAs, which the Treasury projected would cost $156 billion over ten years.[9]

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2. *See infra* note 162 and accompanying text.

3. *See infra* Part VI.

4. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066 (2003).

5. All references to the "Code" or "Internal Revenue Code" are to the Internal Revenue Code of 1986, as amended, codified as Title 26 of the United States Code. I.R.C. §§ 1-9833 (2006).

6. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 1201(k) (specifying the effective date for the amendments to this subsection).

7. I.R.C. § 4980G. Section 4980G was enacted by § 1201(d)(4)(A) of the MMA.

8. I.R.C. § 125(d).

9. Edwin Park, *Informing the Debate About Health Savings Accounts: An Examination of Some Misunderstood Issues*, CTR. ON BUDGET & POL'Y PRIORITIES, June 13, 2006, *available at* http://www.cbpp.org/6-13-06health2.htm. The Joint Committee on Taxation estimated the cost of the Administration's HSA proposals at only $108 billion over ten years. *Id.* at n.1.

II. WHAT IS A HEALTH SAVINGS ACCOUNT?

A. THE STATUTORY REQUIREMENTS[10]

An HSA is a trust or custodial account created or organized in the United States exclusively for the purpose of paying the "qualified medical expenses"[11] of the account beneficiary.[12] The document creating the HSA must meet all of the following requirements, which are similar to the requirements for Individual Retirement Accounts ("IRAs"):[13]

1. Except for rollover contributions,[14] all contributions must be made in cash;
2. Except in the case of a rollover contribution, the total contribution for the calendar year must not exceed the dollar limit[15] in effect for the year in question;
3. The trustee or custodian must be a bank (as defined in § 408(n) of the Code), an insurance company (as defined in § 816 of the Code), or another person approved by the Secretary of the Treasury;[16]
4. No assets may be invested in life insurance contracts. HSA assets may be invested in the same types of investments as IRA assets;[17]
5. The assets may not be commingled with other property,

10. For guidance relating to HSA's *see* Treas. Reg. §§ 54.4980G(1)-(5) (2006); I.R.S. Notice 2004-2, 2004-1 C.B. 269; I.R.S. Notice 2004-23, 2004-1 C.B. 725; Rev. Rul. 2004-38, 2004-1 C.B. 717; I.R.S. Notice 2004-25, 2004-1 C.B. 727; Rev. Rul. 2004-45, 2004-1 C.B. 971; I.R.S. Notice 2004-50, 2004-2 C.B. 196; I.R.S. Notice 2005-8, 2005-1 C.B. 368; Rev. Rul. 2005-25, 2005-1 C.B. 971; I.R.S. Notice 2005-86 2005-49 I.R.B. 1075; I.R.S. Pub. 969 (2005); Op. Dept. of Labor 2004-09A (Dec. 22, 2004); DOL Field Assistance Bulletin 2004-1 (discussing the status of HSAs under ERISA).

11. "Qualified medical expenses" is defined in § 223 of the Code. I.R.C. § 223(d)(2).

12. I.R.C. § 223(d)(1).

13. *See* I.R.C. § 408 (establishing the requirements for IRAs).

14. I.R.C. § 223(d)(1)(A)(i). Amounts can be rolled over into an HSA from another HSA or from an Archer MSA. *See generally* I.R.C. § 220; I.R.C. § 223.

15. I.R.C. § 223(b).

16. I.R.C. § 223(d)(1)(B). See § I.R.C 408(n) (defining "bank"); I.R.C § 816(a) (defining "life insurance company").

17. See I.R.C. § 408 for types of investments of IRA assets. This includes bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds. *Id.* HSA assets may not be invested in collectibles described in § 408(m) of the Code, other than bullion or coins described in § 408(m)(3). I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-65 (2004). The HSA trust or custodial agreement may restrict investments to certain types of permissible investments (e.g., particular funds). *Id.*

except in a common trust fund or common investment fund;[18] and

6. The owner's interest in the account must be nonforfeitable.[19]

Limits on the use of the funds are not allowed; the amounts in the HSA must be available for withdrawal at any time, without proof of what they are to be used for.[20] However, the trustee or custodian may place reasonable restrictions on the frequency and minimum amount of distributions.[21]

B. THE AMOUNT DEDUCTIBLE

An individual, who is an "eligible individual" for any month during the taxable year, is allowed a tax deduction equal to the aggregate amount paid in cash during the year, by or on behalf of the individual, to his or her HSAs.[22] There is no deduction for rollover contributions.[23]

The amount deductible is limited to the sum of the monthly limitations for the months that the individual is an "eligible individual".[24] The monthly limitation for any month is one-twelfth of:

1. In the case of an eligible individual who has self-only coverage under a high deductible health plan ("HDHP") as of the first day of the month, the lesser of the annual deductible, or $2,250 (indexed—the 2006 amount is $2,700),[25] or
2. In the case of an eligible individual who has family coverage[26] under an HDHP as of the first day of the month, the lesser of the annual deductible, or $4,500 (indexed—the 2006 amount is $5,450).[27]

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18. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-66 (2004).
19. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-82 (2004).
20. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-79 (2004).
21. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-79, 80 (2004).
22. I.R.C. § 223(a). A contribution made by the due date of the individual's federal income tax return, for the taxable year to which the contribution relates, is deemed to have been made on the last day of that taxable year. I.R.C. § 223(d)(4)(B), applying I.R.C. § 219(f)(3).
23. I.R.C. § 223(d)(4)(A), applying I.R.C. § 219(d)(2).
24. I.R.C. § 223(b)(1).
25. I.R.C. § 223(b)(2)(B).
26. I.R.C. § 223(b)(2)(B). Family coverage means any coverage other than self-only coverage. I.R.C. § 223(c)(4).
27. I.R.C. § 223(b)(2)(B). Section 223(g) provides for cost of living increases in the dollar amounts. I.R.C. § 223(g)(1). The limitation is zero for the first month an individual is actually enrolled in Part A or Part B of Medicare and for each month thereafter. I.R.C. § 223(b)(7); *see* I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-2 (2004). Eligibility for Medicare, without enrollment, does not terminate eligibility for an HSA. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q

If the individual has attained age fifty-five before the close of the year, the applicable annual limitation is increased by an additional contribution amount: $500 for 2004, increasing by $100 per year until it reaches $1,000 for 2009 and subsequent years.[28]

Unlike an Archer Medical Savings Account (MSA), contributions may be made on behalf of an eligible individual even if the individual has no compensation or if the contributions exceed the compensation.[29]

The deduction limitation is reduced by the sum of the following:

A. The aggregate amount paid for the year to Archer MSAs[30] of the individual, and

B. The aggregate amount of employer contributions made to HSAs of the individual which is excludable from his or her gross income under I.R.C. § 106(d). This amount is not deductible by the individual.[31]

There are special rules for married individuals; if either spouse has family coverage, both spouses are treated as having only the family coverage with the lowest deductible, and the contribution limit is divided equally between them unless they agree otherwise.[32]

No deduction is allowed to any individual who can be claimed as a dependent[33] by another taxpayer for the year in question.[34] Any excess contribution to the HSA is subject to a 6% excise tax if not timely corrected.[35] An excess contribution is any contribution (other than a rollover contribution) which is neither excludable from gross income under § 106(d) nor deductible under § 223.[36]

The deduction is an above the line deduction, so it is deductible regardless of whether the individual itemizes deductions for the year in question.[37] There is no limit on the amount that can be accumulated in the HSA.[38] An HSA may be offered as part of a cafeteria plan.[39]

&A-2 (2004).

28. I.R.C. § 223(b)(3).
29. I.R.S. Notice 2004-2, 2004-1 C.B. 269.
30. I.R.C. § 223(b)(4)(A).
31. I.R.C. § 223(b)(4)(B).
32. I.R.C. § 223(b)(5).
33. I.R.C. § 151(c).
34. I.R.C. § 223(b)(6).
35. I.R.C. §§ 4973(a)(5), (g)(2).
36. I.R.C. § 2973(g)(1).
37. *See* I.R.C. § 62(a)(19).
38. *See* I.R.C. § 223.
39. Internal Revenue Notice 2004-50 lists requirement for health FSAs that are not

C. ELIGIBLE INDIVIDUALS

A person is an "eligible individual" for a month if:

1. he or she is covered under an HDHP as of the first day of the month,[40] and
2. is not, while covered under an HDHP, covered under any other health plan which is *not* an HDHP, and which provides coverage for any benefit which is covered under the HDHP.[41]

For this purpose, coverage for any benefit provided by "permitted insurance,"[42] and coverage for accidents, disability, dental care, vision care, or long-term care, are disregarded. If an individual is covered by both an HDHP that does not cover prescription drugs and by a separate prescription drug plan (or rider) that provides benefits before the minimum annual deductible of the HDHP has been satisfied, that individual is not an eligible individual and may not make contributions to an HSA.[43]

The fact that an individual has a choice between an HDHP and another plan that is not an HDHP does not affect eligibility; the individual is eligible as long as the only actual coverage is under the HDHP.[44] Any person may contribute to the HSA on behalf of an eligible individual.[45]

D. HIGH DEDUCTIBLE HEALTH PLAN

A "high deductible health plan" means a health plan (including a self-insured plan sponsored by an employer):[46]

1. Which has an annual deductible not less than $1,000 for self-only coverage, and $2,000 for family coverage.[47] These

applicable to HSAs. I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-57 (2004).

40. I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-11 (2004). An individual who becomes covered by an HDHP after the first of the month will not be eligible until the first day of the following month. *Id.*

41. I.R.C. § 223(c)(1)(A)(ii)(I)-(II).

42. "Permitted insurance" means (A) insurance if substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar liabilities as the Secretary may specify by regulations, (B) insurance for a specified disease or illness, and (C) insurance paying a fixed amount per day (or other period) of hospitalization. I.R.C. § 223(c)(3)(A)-(C).

43. Rev. Rul. 2004-38, 2004-1 C.B. 717. Transitional relief was provided for months prior to 2006 by the I.R.S. See I.R.S. Notice 2004-25, 2004-1 C.B. 727.

44. I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-1 (2004).

45. I.R.S. Notice 2004-2, 2004-1 C.B. 296 Q&A-11 (2004); *see also* I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-28-29 (2004).

46. I.R.S. Notice 2004-2, 2004-1 C.B. 296 Q&A-3 (2004).

47. I.R.S. Notice 2004-50, 2004-2 C.B. 196.

amounts are adjusted for inflation and are $1,050 and $2,100, respectively, for 2006;[48] and

2. The sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than premiums) for covered benefits does not exceed $5,000 for self-only coverage, and $10,000 for family coverage.[49] These amounts are adjusted for inflation and are $5,250 and $10,500, respectively, for 2006.[50]

Except as provided in regulations, an HDHP need not have a deductible for preventive care.[51] However, most employer plans do not take advantage of this rule:

> In response to concerns that high-deductible health insurance plans can discourage use of preventive benefits, HSA supporters often note that preventive services are exempt from the high deductible. It is true that under current law, high-deductible plans attached to HSAs are allowed to exempt preventive benefits from the deductible. But there is no requirement that such plans do so, and the Kaiser/HRET survey of employers found that only 30[%] of workers covered by HSA-qualified plans in 2005 were enrolled in plans that covered any preventive benefits before the deductible was met. The other 70[%] of workers covered by such plans were enrolled in plans that covered no preventive benefits before the deductible was satisfied.
>
> Even plans that do cover some preventive benefits before the deduction is met do not cover such services as primary care and various prescription drugs that can avoid more expensive services like hospitalization—because federal rules do not permit HSA-qualified plans to cover such services before the deductible is met.[52]

If the plan uses a network of providers, the plan may have a higher out of pocket limitation for out-of-network services, and the deductible for out-of-network services is not taken into account in applying the deductible limitation.[53] Certain other types of benefit limitations will not violate the out-of-pocket cap requirement.[54]

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48. *See* Rev. Proc. 2005-70, 2005-47 I.R.B. 979 § 3.22(2).

49. I.R.S. Notice 2004-2, 2004-1 C.B. 269.

50. *See* Rev. Proc. 2005-70, 2005-47 I.R.B. 979 § 3.22(2).

51. I.R.C. § 223(c)(2)(C) (2006). *See* I.R.S. Notice 2004-23, 2004-1 C.B. 725, I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A -26-27 (2004) (discussing permissible preventive care services).

52. Park, *supra* note 9. See also Edwin Park, *Health Savings Accounts Unlikely to Significantly Reduce Health Care Spending*, CTR. ON BUDGET & POL'Y PRIORITIES, June 12, 2006, *available at* http://www.cbpp.org/6-12-06health.htm.

53. I.R.C. § 223(c)(2)(D)(i)-(ii).

54. I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-14, -15, -16, -18, & -19 (2004) (lifetime limit of one million dollars on benefits, reasonable benefit restrictions, usual, customary and

The term HDHP does not include a health plan if substantially all of its coverage is coverage for any benefit provided by "permitted insurance," or for accidents, disability, dental care, vision care, or long-term care.[55]

E. QUALIFIED MEDICAL EXPENSES

The term "qualified medical expenses" means amounts paid by the account beneficiary for medical care[56] for that individual, his or her spouse, and any dependent,[57] to the extent not compensated for by insurance or otherwise.[58] Generally, this does *not* include payments for health insurance, but the account may be used to pay premiums for:

1. continuation coverage under COBRA[59] or any other Federal law,
2. a qualified long-term care insurance contract,[60]
3. a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law,[61] or
4. in the case of an account beneficiary who has attained age sixty-five, any health insurance other than a Medicare supplemental policy.[62]

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reasonable limitations, and penalties for failure to pre-certify will not violate the out-of-pocket cap requirement).

55. I.R.C. § 223(c)(1)(B)(i)-(ii).

56. As defined in I.R.C. § 213(d), for purposes of the itemized deduction for unreimbursed medical expenses.

57. I.R.C. § 152 (2006). For this purpose, "dependent" is defined in I.R.C. § 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B). *Id.*

58. I.R.C. § 223(d)(2)(A).

59. Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA) Pub. L. No. 99-272, §§ 10001-10003, 100 Stat. 82, 222-237 (1986).

60. *See* I.R.C. § 7702B (b)(1)(A)-(F).

61. *See* I.R.C. § 223(d)(2)(C).

62. *See* Social Security Act § 1882, 42 U.S.C. §1395ss (2006).

III. FEDERAL INCOME TAX TREATMENT OF HEALTH CARE EXPENSES[63]

A. IN GENERAL

Most insured Americans receive health care coverage through an employer-sponsored health benefits plan, either as an employee, as the spouse or dependent of an employee, or as a retiree. The employer's contribution toward the cost of a health plan is deductible by the employer as a business expense,[64] and is excluded from the employee's income for both income and payroll tax purposes.[65] This exclusion for employer-provided health care represents a major departure from the general income tax rule that includes compensation for services as gross income.[66] Additionally, employees participating in a cafeteria plan may pay their share of the health insurance premiums (and other medical expenses) on a pre-tax basis, through elective salary reduction; salary reduction contributions are treated as employer contributions and therefore are also excluded from income.[67] Reimbursements made by or under the employer plan for medical expenses incurred by the employee and his or her covered spouse and dependents are also generally excluded from gross income and wages.[68] There is no limit on the amount of employer-provided health coverage that is excludable and, unlike other important employee benefits,[69] there is no requirement that an insured health plan be nondiscriminatory.[70] Thus, these tax benefits are available even if the health plan covers only highly paid employees or provides more generous benefits for them than for rank and file employees.

63. *See* JOINT COMM. ON TAX'N, *Present Law and Analysis Relating to the Tax Treatment of Health Savings Accounts and Other Health Expenses*, JCX-27-06 (June 27, 2006) (providing a description of the present-law individual income tax provisions relating to health care expenses and a discussion of issues).

64. *Id.* See also I.R.C. § 162(a)(1).

65. JOINT COMM. ON TAX'N, *supra* note 63, at 3. See I.R.C. §§ 106(a), 3121(a)(4).

66. I.R.C. § 61(a)(1).

67. I.R.C. § 125(d)(1)(D).

68. I.R.C. § 105(b). There is a limited exception, whereby certain reimbursements made to "highly compensated individuals" under a self-insured health plan are currently taxable to the recipients under section 105. I.R.C. § 105(h).

69. *See* I.R.C. § 401(a)(4) (requiring trusts forming part of a stock bonus, pension, or profit-sharing plan of an employer to be non-discriminatory); *see also* § 79(d) (requiring group-term life insurance purchased for employees to be non-discriminatory).

70. The Tax Reform Act of 1986 added section 89, which imposed nondiscrimination requirements for health plans and other employee welfare benefits, but the section was repealed before it went into effect. *See* I.R.C. § 89.

Self-employed individuals[71] may deduct the cost of health insurance for themselves, their spouses and dependents.[72] This deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan and may not exceed the individual's net income from self-employment.[73]

An individual may claim an itemized deduction for unreimbursed medical expenses of the individual and his or her spouse and dependents, including health insurance premiums, if and to the extent that those expenses exceed 7.5% of adjusted gross income ("AGI").[74] Benefits received under personally purchased health insurance polices are also excluded from income.[75] Individuals who buy their own insurance are treated less favorably than those who receive coverage under an employer-sponsored plan: first, they receive no exclusion from payroll taxes; second, they receive a tax benefit only if they itemize deductions; third, they receive a tax benefit only if their unreimbursed expenses exceed 7.5% of AGI (even then, they receive no benefit on the expenses under the 7.5% threshold); and finally, the category of deductible medical expenses is more narrowly defined[76] than for purposes of excludable reimbursements from an employer-sponsored plan.[77]

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71. The term "self-employed individual" includes sole proprietors, partners in a partnership and members of a limited liability company that has elected not to be taxed as a corporation. I.R.C. § 401(c)(1)(B). It also includes any more-than 2% shareholders of an S corporation. *See* I.R.C. § 1372(a)-(b).

72. I.R.C. § 162*(l)*(1)(A). The deduction does not apply for self-employment tax purposes. *See* I.R.C. § 401(c)(1) (defining who is a self-employed individual for this purpose).

73. I.R.C. § 162*(l)*(l)(2).

74. I.R.C. § 213(a). The threshold is 10% (rather than 7.5%) for alternative minimum tax purposes. I.R.C. § 56(b)(1)(B). The term "medical care" is defined in section 213. I.R.C. § 213(d)(1)(A)-(D).

75. I.R.C. § 104(a)(3). Unlike employer-paid insurance, the benefits are excluded even if they exceed the amount of medical care expenses incurred, but this is rarely the case.

76. *See* I.R.C. § 213(d)(1).

77. The Joint Committee on Taxation found the following:

> For purposes of the exclusions for reimbursements under employer accident and health plans and distributions from HSAs, the limitation (applicable to the itemized deduction) that only prescription medicines or drugs and insulin are taken into account does not apply. Thus, for example, amounts paid from an FSA, HRA, or HSA to reimburse the employee for nonprescription medicines, such as sunscreen, nonprescription aspirin, allergy medicine, antacids, or pain relievers, are excludable from income; however, if the employee paid for such amounts directly (without such reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.

JOINT COMM. ON TAX'N, *supra* note 63, at 11.

B. THE TAX CREDIT

Certain individuals are eligible for a refundable income tax credit of 65% of the cost of qualified health insurance coverage, including some employer-sponsored insurance, state-based insurance, and insurance purchased in the individual market.[78] Those eligible individuals include: (1) individuals receiving a trade adjustment allowance; (2) individuals who would be eligible to receive an allowance if they had not exhausted their regular unemployment benefits; (3) individuals eligible for the alternative trade adjustment assistance program; and (4) individuals over age fifty-five receiving pension benefits from the Pension Benefit Guaranty Corporation.[79] Persons eligible for Medicare and certain other governmental health programs, or covered under certain employer-subsidized plans, or with certain other specified coverage, are not eligible for the credit.[80] There is no specific dollar limit.[81]

C. HEALTH SAVINGS ACCOUNTS

A health savings account, like an IRA, is exempt from income taxation.[82] However, as with an IRA, if a prohibited transaction occurs with respect to the HSA, it ceases to be an HSA, and the entire value of the account is treated as distributed and not used to pay qualified medical expenses.[83] An HSA is also subject to the tax on unrelated business income.[84]

Any amount paid or distributed from an HSA which is used exclusively to pay qualified medical expenses is not includable in gross income.[85] Subject to an exception for timely distributions of excess contributions, any such amount which is not used exclusively to pay qualified medical expenses is included in the gross income of the beneficiary, and is also subject to an additional income tax equal to 10% of the amount includable.[86] The additional tax does not apply if the payment

78. I.R.C. § 35(a) (2006); *see* I.R.C. § 35(e) (defining qualified health insurance).

79. I.R.C. § 35(c).

80. I.R.C. § 35(b).

81. *See generally* I.R.C. § 35.

82. I.R.C. § 223(e)(1) (2006).

83. I.R.C. § 223(e)(2). *See also* § 408(e)(2), (4) (establishing the rules of account termination made applicable to health savings accounts under § 223(e)(2)).

84. *See* I.R.C. § 511(a)(1).

85. I.R.C. § 223(f)(1).

86. I.R.C. § 223(f). An excess contribution is any contribution (other than a rollover contribution) which is neither excludable from gross income under § 106(d) nor deductible under § 223. I.R.C. § 223(f)(3)(B). In certain circumstances, taxation can be avoided if a mistaken

or distribution is made (1) after the account beneficiary becomes disabled[87] or dies, or (2) after the date on which the account beneficiary attains age sixty-five.[88]

If any amount paid or distributed from a HSA is rolled over to another HSA for the same beneficiary, the amount is not currently taxable.[89] As with IRAs, this is limited to one rollover in any one year period, but this limitation does not apply to direct trustee-to-trustee transfers.[90] An interest in an HSA may be transferred tax-free to the beneficiary's spouse or former spouse in connection with a divorce and, after the transfer, is treated as an HSA of the spouse.[91]

If the account beneficiary's surviving spouse acquires the beneficiary's interest in an HSA, as the designated beneficiary at the death of the beneficiary, the account is treated as the HSA of the spouse.[92] In any other case, the account will cease to be an HSA as of the date of death, and the account balance will then become taxable.[93]

An HSA can be established without any employer involvement.[94] Even if an employer does offer an HDHP/HSA option to its employees, the employer is not required to contribute to the HSA.[95] However, if it does so, it must make "comparable contributions" on behalf of "comparable participating employees."[96] If it fails to do so, the employer is liable for an excise tax.[97] The IRS has issued final regulations on the comparable contribution requirement[98] which are substantially similar to the proposed

distribution is timely repaid to the HSA. I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-37 (2004).

87. I.R.C. § 223(f)(4)(B). *See* I.R.C. § 72(m)(7) (defining "disabled" for purposes of distributions under employee plans).

88. I.R.C. § 223(f)(4)(C).

89. I.R.C. § 223.

90. I.R.C. § 223(f)(5)(A)-(B). *See also* I.R.S. Notice 2004-50, 2004-2 C.B. 196 Q&A-56 (2004) (providing limitation does not apply to direct trustee-to-trustee transfers).

91. I.R.C. § 223(f)(7).

92. I.R.C. § 223(f)(8)(A).

93. I.R.C. § 223(f)(8)(B)(i).

94. *See* Employer Comparable Contributions to Health Savings Accounts under Section 4980G, 71 Fed. Reg. 43,056, 43,057 (July 31, 2006) (to be codified at 26 C.F.R. pt. 54).

95. Comparable Contributions to Health Savings Accounts under Section 4980G, 71 Fed. Reg. at 43,057.

96. *Id.*

97. I.R.C. § 4980G(a). The excise tax is applicable to taxable years beginning after December 31, 2003. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201(k), 117 Stat. 2066 (2003).

98. Employer Comparable Contributions to Health Savings Accounts under Section 4980G, 71 Fed. Reg. at 43,057.

regulations[99] issued in 2005. However, unlike the proposed regulations, the final regulations permit employers to disregard certain collectively bargained employees for purposes of the comparable contribution requirements, and generally provide more flexibility.[100]

Contributions are comparable if, for each month in a calendar year, the contributions are either the same amount or the same percentage[101] of the deductible under the HDHP for employees who are eligible individuals with the same category of coverage on the first day of that month.[102] The comparable contribution requirements do not apply to rollover contributions, after-tax employee contributions, or contributions made for non-employees (independent contractors or self-employed individuals).[103]

An employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution, or a percentage of the employee's HSA contribution (matching contributions), does not satisfy the comparable contribution requirement.[104] The regulations also do not permit the employer to make higher contributions for lower paid employees, for whom a high dollar deductible under an HDHP is obviously more burdensome than for a highly paid employee.[105]

The term "comparable participating employees" refers to employees who are eligible individuals covered by the employer's HDHP and who have the same category of coverage (i.e., self-only or family coverage).[106] The final regulations permit employers to create three subcategories of family coverage for this purpose: "self-plus-one"; "self-plus-two"; and "self–plus-three-or-more."[107]

The comparable contribution requirements apply separately to part-time and full-time employees.[108] A part-time employee is any employee who is customarily employed for less than 30 hours a week.[109]

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99. Employer Comparable Contributions to Health Savings Accounts under Section 4980G, 70 Fed. Reg. 50,233 (proposed August 26, 2005).

100. Employer Comparable Contributions to Health Savings Accounts under Section 4980G, 71 Fed. Reg. at 43,057.

101. *See* Treas. Reg. § 54.4980G-4, Q&A (7) (2006).

102. Treas. Reg. § 54.4980G-4, Q&A (1) (2006).

103. *See* Treas. Reg. § 54.4980G-2, Q&A (1)-(2) (2006); *see also* § 54.4980G-3, Q&A (1)-(3) (2006).

104. Treas. Reg. § 54.4980G-4, Q&A (8) (2006).

105. *See* Treas. Reg. § 54.4980G-1 Q&A (1) (2006).

106. *Id.*

107. Treas. Reg. § 54.4980G-1, Q&A (2) (2006).

108. Treas. Reg. § 54.4980G-3, Q&A (5)(b) (2006).

109. The Fair Labor Standards Act, Work Hours, Procedures, http://server1.fandm.edu/ depart

The final regulations also permit a distinction between collectively bargained employees and other employees;[110] employees covered by a bona fide collective bargaining agreement are not comparable participating employees if health benefits were the subject of good faith bargaining.[111]

There is also an exception to the comparability rules for employer contributions made through a cafeteria plan.[112] Employer contributions to employees' HSAs are made through the cafeteria plan if, under the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution, regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction.[113] The regulations provide examples that illustrate the application of the exception. Employers also may make HSA contributions on behalf of former employees.[114] The comparable contribution requirements apply to former employees, but they are a separate category for testing purposes.[115]

The comparable contribution requirement is tested on a calendar year basis.[116] An excise tax which equals 35% of the employer's aggregate contributions to its employees' HSAs during the calendar year is imposed on an employer that fails to make comparable contributions.[117] The final regulations provide examples of how the excise tax is computed. In the case of a failure which is due to reasonable cause and not to willful neglect, all or a portion of the excise tax imposed may be waived to the extent that payment of the tax would be excessive relative to the failure involved.[118]

The final regulations became effective July 31, 2006, and apply to employer HSA contributions made on or after January 1, 2007.[119]

D. DISCUSSION

The tax-favored treatment of health benefits is one of the largest tax expenditures in the federal budget.[120] "Estimates for personal federal

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ments/ Personnel/ policies/pay.html (last visited October 20, 2006).

110. Treas. Reg. § 54.4980G-3, Q&A (5)(b), (6)(a) (2006).
111. Treas. Reg. § 54.4980G-3, Q&A (6)(a).
112. Treas. Reg. § 54.4980G-5, Q&A (1)(a) (2006).
113. Treas. Reg. § 54.4980G-5, Q&A (1)(b).
114. Treas. Reg. § 54.4980G-3, Q&A 10(a) (2006).
115. *Id.*
116. Treas. Reg. § 54.4980G-1, Q&A (3) (2006).
117. I.R.C. § 4980G(a) (2006); *see* Treas. Reg. § 54.4980G-1, Q&A (4) (2006).
118. Treas. Reg. § 54.4980G-5, Q&A (4) (2006).
119. *See e.g.*, Treas. Reg. § 54.4980G-5 (2006).
120. *See generally* U.S. GOV'T ACCOUNTABILITY OFFICE, GOV'T PERFORMANCE AND

forgone tax revenue in 2006 related to the exclusion from individual income of employer contributions to health benefits ranged from $91 billion (Joint Committee on Taxation) to $133 billion (Office of Management and the Budget)."[121]

The enormous cost of these tax benefits, and a widespread belief that they are not equitably distributed, has given rise to an ongoing debate about whether they are appropriate and to several recent proposals for change. In 2005, a presidential advisory panel recommended limiting the tax exclusion for health benefits to $5,000 for individual coverage and $11,500 for family coverage, indexed for future cost increases.[122] In its 2007 federal budget proposals, the Bush administration sought to expand the use of HSAs and high-deductible health plans; individuals would be able to deduct the full premium for an HDHP used in conjunction with an HSA even if purchased directly from an insurer.[123] This deduction would not be allowed for a more conventional health insurance policy with a lower deductible. Under another proposal, individuals would be able to deduct all out-of-pocket health care expenses as a way to encourage more people to adopt less comprehensive coverage with more cost sharing.[124]

As the Joint Committee on Taxation recently noted:

ACCOUNTABILITY: TAX EXPENDITURES REPRESENT A SUBSTANTIAL FEDERAL COMMITMENT AND NEED TO BE REEXAMINED, *available at* http://www.gao.gov/new.items/d05690.pdf (last visited October 20, 2006).

121. Paul Fronstin & John MacDonald, *Study Says Changing Tax Preferences for Health Benefits Involves Trade-Offs Requiring Thorough Understanding*, (June 15, 2006), http://www.ebri.org, pdf/PR_741_15June06.pdf (last visited October 20, 2006). "For Federal fiscal years 2006-2010, the tax expenditure for the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums is estimated to be $534 billion." JOINT COMM. ON TAX'N, *supra* note 63, at n.22 (citing JOINT COMM. ON TAX'N, *Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010*, JCS-2-06 (Apr. 25, 2006)).

122. Report of the President's Adv. Panel on Fed. Tax Reform, Doc. 2005-22112, 2005 TAX NOTES TODAY 211-14, (Nov. 1, 2005). The dollar limits are close to the average premium for health benefits in 2005: $4,024 for employee-only coverage and $10,880 for family coverage. Fronstin & MacDonald, *supra* note 121 (citing Gabel et al., *Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues To Erode*, 24 HEALTH AFF. 5, 1273-80 (2005)).

123. FAMILIES USA, *The Bush Administration's Fiscal Year 2007 Budget: Analysis of Key Health Care Provisions* (Feb. 22, 2006), http://www.familiesusa.org/resources/publications/budget-analyses/bush-budget-fy2007.html (last visited October 20, 2006). According to the article:

> The expanded tax breaks for HSAs do not benefit low-income individuals and families. About half of uninsured Americans do not earn enough to pay taxes, so they would receive no benefit from these proposals. Other uninsured working Americans would only get help with 10 or 15 percent of the cost of their premiums—not enough to make health insurance affordable for lower-wage families.

Id.

124. Fronstin & MacDonald, *supra* note 121.

> The appropriateness of the present-law Federal tax treatment of health expenses has been the subject of much debate. . .. The present. . . treatment of employer-provided health coverage has been justified on the grounds that it encourages employees to prefer health coverage over taxable compensation, thereby increasing health insurance coverage and reducing the number of uninsured. Proponents. . . also argue that the employer market provides a natural pooling mechanism which can result in more affordable coverage. However, others argue that the. . . rules are inequitable because they do not provide a consistent tax benefit for health coverage and that the exclusion may lead to over utilization of health care.[125]

The present tax rules *are* inequitable, because they do not provide the same level of tax benefits for everyone. Those who do not have employer-provided coverage—who are more likely to be low income employees—receive less favorable treatment than those who do, in several ways: they receive a tax benefit only if they itemize deductions, and even then only if their unreimbursed medical expenses exceed 7.5% of their AGI.[126] In addition, individual health insurance policies are typically more expensive and provide less comprehensive coverage than group policies. Even for those lower income individuals who do receive a tax benefit (an exclusion or a deduction) their tax subsidy is less valuable than it is to those in a higher income tax bracket.[127]

Some economists argue that the tax benefits contribute to higher health care costs because individuals do not pay the full cost of health care.[128]

> [T]he cost of insurance or out-of-pocket expenses paid by the individual is reduced by the tax benefit received, effectively reducing the price of health care relative to other goods. In addition, some argue that the unlimited exclusion for employer-provided coverage leads to very generous insurance coverage, which further contributes to increases in health costs because individuals are not as likely to question medical treatments to the extent the cost is paid by a third party through insurance.[129]

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125. JOINT COMM. ON TAX'N, *supra* note 63, at 2.

126. *See generally* I.R.C. § 62 (2006). Medical expenses are not deductible in determining AGI. *See* § 213(a).

127. *See* JOINT COMM. ON TAX'N, *supra* note 63. As the Joint Committee on Taxation notes, the refundable tax credit provides a greater tax benefit than the exclusion. *Id.* "However, the credit is available to only limited classes of taxpayers. Less than one-half million taxpayers per year are estimated to be eligible for the credit." *Id.* at 12 n.24.

128. *Id.* at 13.

129. *Id.*

The tax benefits for HSAs raise additional issues of tax policy and fairness. "[F]or affluent individuals who do not expect to incur significant health-care costs, HSAs provide unprecedented tax-sheltering opportunities: they are the only savings accounts that feature both tax-deductible deposits *and* tax-free withdrawals."[130]

IV. HEALTH PLAN COVERAGE

For many years, most Americans with health insurance have received their coverage through an employer-sponsored plan.[131] The ever-increasing cost of health care has caused many employers to reconsider their commitment to providing comprehensive health care coverage. According to the spring 2006 Duke University/CFO magazine Business Outlook Survey, the cost of health care came second only to global competition as a concern for chief financial officers.[132]

> [T]he annual cost of coverage for a family of four is estimated by the Kaiser Family Foundation at more than $10,000. One way to look at it is to say that that's roughly what a worker earning minimum wage and working full time earns in a year. It's more than half the annual earnings of the average Wal-Mart employee.
>
> Health care costs at current levels override the incentives that have historically supported employer-based health insurance. Now that health costs loom so large, companies that provide generous benefits are in effect paying some of their workers much more than the going wage—or, more to the point, more than competitors pay similar workers. Inevitably, this creates pressure to reduce or eliminate health benefits. And companies that can't cut benefits enough to stay competitive—such as GM—find their very existence at risk.[133]

A U.S. Census Bureau report released in August, 2006, found that the number of U.S. residents without health insurance increased by 1.3 million

130. Edwin Park & Robert Greenstein, *Administration Defense of Health Savings Accounts Rests on Misleading Use of Statistics*, CTR. ON BUDGET & POL'Y PRIORITIES, Feb. 16, 2006, http://www.cbpp.org/2-16-06health.htm
(last visited October 20, 2006) (emphasis in original).

131. *See, e.g.*, David Blumenthal, *Employer-Sponsored Health Insurance in the United States–Origins and Implications*, 355 NEW. ENG. J. MED. 82 (2006); Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 405 (2004); Catherine Hoffman et al., *Holes in the Health Insurance System—Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390 (2004).

132. David M. Katz, *The Case Against Health Savings Accounts*, Mar. 17, 2006, http://www.cfo.com/printable/article/cfm/5623932?f=options.

133. Paul Krugman & Robin Wells, *The Health Care Crisis and What To Do About It*, THE N.Y. REV., 38, 39 (Mar. 23, 2006) (reviewing HENRY J AARON ET AL., CAN WE SAY NO? (2005), JULIUS RICHMOND & RASHI FEIN, THE HEALTH CARE MESS (2006), JOHN F. COGAN ET AL., HEALTHY, WEALTHY, AND WISE (2005)).

in 2005 to 46.6 million (15.9% of the U.S. population, compared to 15.6% in 2004).[134] The percentage of U.S. residents with employer-sponsored health coverage decreased from 59.8% in 2004 to 59.5% in 2005, the lowest percentage since 1993.[135] In 2001, 62.6% had employer-sponsored coverage.[136] "As the largest component of private health insurance coverage, this decline in employment-based coverage essentially explains the decrease in total private health insurance coverage, from 68.2% in 2004 to 67.7% in 2005."[137] According to another recent report, "[t]he proportion of all firms offering health care benefits fell from 69 percent in 2000 to 60 percent in 2005, causing [five] million employees to lose their insurance coverage."[138]

> Large companies that employ 1,000 or more workers are experiencing a decline in participation in employer-sponsored health plans because of increases in out-of-pocket costs, the Wall Street Journal reports. The percentage of employees at large companies who enrolled in employer-sponsored health plans declined from 87.7% to 81% between 1996 and 2004, according to a new survey by the Agency for Healthcare Research and Quality. The greatest decline in participation rates occurred at large retailers, with a drop from 83.8% to 67.3%. Although 98% of large employers offer health plans, increases in premiums, deductibles and copayments have led "many workers to forego their employers' insurance. . . ."[139]

The percentage of U.S. residents with coverage through government programs remained constant at 27.3%.[140] The percentage of children without health insurance increased to 11.2% in 2005, from 10.8% in

134. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005, 20-23 (2006), http://www.census.gov/prod/2006pubs/p60-231.pdf (last visited October 20, 2006). *See generally* Paul Fronstin, *Employment-Based Health Benefits: Trends in Access and Coverage*, (Aug. 2005), http://ebri.org/pdf/briefspdf/EBRI_IB_08-20051.pdf (last visited October 20, 2006).

135. CARMEN DENAVAS-WALT ET AL., *supra* note 134, at 21.

136. Julie Appleby, *Ranks of Uninsured Americans Grow*, USA TODAY, Aug. 29, 2006, http://www.usatoday.com/money/industries/health/2006-08-29-health-insurance-coverage_x.htm?POE=NEWISVA (last visited October 20, 2006).

137. CARMEN DENAVAS-WALT ET AL., *supra* note 134, at 23.

138. David Blumenthal, *Employer-Sponsored Health Insurance—Riding the Health Care Tiger*, 355 NEW. ENG. J. MED. 195 (2006).

139. Kaiser Daily Health Policy Report, *Percentage of Workers Enrolled in Employer-Sponsored Health Plans at Large Companies Drops, New Government Data Show* (Aug. 25, 2006), http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=39448&dr_cat=3 (last visited October 20, 2006).

140. CARMEN DENAVAS-WALT ET AL., *supra* note 134, at 21.

2004.[141] About 961,000 of the 1.3 million increase in the number of people uninsured was among full-time workers.[142]

> The likelihood of being covered by health insurance rises with income. In 2005, in households with annual incomes of less than $25,000, 75.6 percent of people had health insurance. Health insurance coverage rates increased with higher household income levels to 91.5 percent for those in households with incomes of $75,000 or more. . . . Among 18-to-64-year-olds in 2005, full-time workers were more likely to be covered by health insurance (82.3 percent) than part-time workers (76.5 percent) or nonworkers (72.7 percent). . . . The number and the percentage of part-time workers who were uninsured remained statistically unchanged in 2005 at 5.9 million and 23.5 percent, respectively.[143]

Some economists believe that the expansion of HSAs, as proposed in the President's 2007 budget proposal, would increase, not reduce, the number of uninsured Americans.

Jonathan Gruber, an MIT economist, estimates that the Administration's proposals would actually increase the number of uninsured Americans by 600,000.[144] While 3.8 million previously

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141. *Id.* at 25.

142. As the Spencer's Benefits Reports found:

> The uninsured rate for full-time workers went from 17.3% to 17.7%, and thus individuals are more likely to be uninsured in the United States if they are employed full-time than if they are unemployed. It is likely that much of the decline among full-time workers came in large firms, according to earlier research by the Agency for Healthcare Research and Quality.

You Are More Likely To Be Uninsured If You Work: Census Bureau Puts Uninsured Full-Time Worker Rate At 17.7%, SPENCER'S BENEFITS REPORTS., Sept. 1, 2006, www.aspenpublishers.com.

143. CARMEN DENAVAS-WALT ET AL., *supra* note 134, at 24 (footnote omitted).

144. Jonathan Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals*, CTR. ON BUDGET & POL'Y PRIORITIES, Feb. 15, 2006, http://www.cbpp.org/2-15-06health.html; *see* Park & Greenstein, *supra* note 130. See Paul Fronstin, *The Tax Treatment of Health Insurance and Employment-Based Health Benefits*, 2006 TAX NOTES TODAY 118-27 (2006):

> Two recent studies have examined the impact of HSAs on the number of people with insurance coverage. Glied and Remler (2005) examined the impact that the availability of HSAs would have on coverage expansion. They conclude that HSAs are not likely to be an important contributor to expanding coverage among the uninsured because most of them do not face high enough marginal tax rates to benefit from the tax deductibility of contributions to an HSA. More recently, Gruber (2006) examined the Bush administration proposal to expand health insurance coverage, and projects that the combined Bush-proposed HSA expansion and tax credit would increase the number of uninsured by about 600,000 people. However, he assumes that the proposal, as it relates to the tax treatment of premiums, would cause some employers to stop offering insurance coverage to workers. This assumption may be unrealistic for a number of reasons. . . .

Id.

uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would respond to the equal tax treatment of some policies in the individual market by dropping coverage.[145] Consequently, Gruber estimates that 8.9 million people would lose their employer-based health insurance.[146] While some people who lose their coverage would buy insurance in the individual market, about 4.4 million would become uninsured.[147]

V. OUT OF POCKET MEDICAL EXPENSES

Health care costs have increased at several times the rate of general inflation, and are expected to continue to outpace growth in the economy.[148] According to one study, the estimated 2004-2005 premium increase was 8.8% (general inflation accounted for 2.4%, healthcare price increases in excess of inflation for 2.6% and increased utilization for 3.8%).[149] The average annual cost of family coverage in employer-sponsored health plans was more than $10,880 in 2005,[150] more than the average yearly earnings of a full-time worker earning the minimum wage. By way of contrast, according to America's Health Insurance Plans, an advocate for HDHPs, the average annual premium for the best selling HDHP product in the small group market was $2,772 for single coverage and $6,955 for family coverage.[151] For the best selling HDHP product in the large group market, the average annual premium was $2,745 for single coverage and $6,715 for family coverage.[152]

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145. Park & Greenstein, *supra* note 130.

146. Gruber, *supra* note 144.

147. Park & Greenstein, *supra* note 130.

148. *See, e.g.*, Stephen Heffler et al., *U.S. Health Spending Projections for 2004-2014*, HEALTH AFFS., Feb. 23, 2005, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.74; Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFFS. 186 (2006).

149. PRICEWATERHOUSE COOPERS, THE FACTORS FUELING RISING HEALTHCARE COSTS (2006), http://www.pwc.com/extweb/pwcpublications.nsf/docid/E4C0FC004429297A852571090065A70B/$File/ahip-factors_fueling_rising_hc-costs.pdf.

150. KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 SUMMARY OF FINDINGS, (2005), http://www.kff.org/insurance/7315/sections/upload/7316.pdf (last visited Oct. 20, 2006).

151. America's Health Ins. Plans, *January 2006 Census Shows 3.2 Million People Covered by HSA Plans*, 2006 http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf (last visited Oct. 20, 2006).

152. *Id.* According to Duncan Moore:

> In the New York region served by Empire Blue Cross Blue Shield, a health savings account with a $5,000 deductible and 100 percent coinsurance would cost $197 a

Many employers, particularly small companies, are coping with the problem by passing on more of the cost to employees or by eliminating coverage.[153] A Commonwealth Fund survey released on August 17, 2006, found that 48% of adults in middle-income families with gross annual income between $35,000 and $50,000 reported serious problems paying for health care and health insurance.[154]

> Between 1999 and 2005, workers' average monthly contribution to family coverage increased from $129 to $226 (although the proportion of the premium paid by workers—26 percent—did not change, on average). . . . Between 2003 and 2005, the proportion of all firms offering health plans with high deductibles increased from 5 percentto 20 percent (and to 33 percent among large firms with more than 5000 employees). . . . The proportion of all firms offering health care benefits fell from 69 percent in 2000 to 60 percent in 2005, causing 5 million employees to lose their insurance coverage.[155]

One question is whether employers that offer HDHPs and HSAs to their employees contribute to the HSAs in order to help the employees pay the higher out-of-pocket costs resulting from the high deductibles. A 2006 survey found that more than one-third of large employers made no contribution.[156] Among firms that did, the median contribution was only $100 a year, though the median deductible was $1,200.[157] Another survey

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> month for an individual. A plan with a $1,250 deductible and 80[%] coinsurance would run $315 a month. A conventional Empire health maintenance organization in the same market would cost about $391 for an individual.
>
> A person enrolled in the Empire HMO would pay an annual premium of $4,692, and any medical costs would be entirely covered by the health maintenance organization in the network. If the person switched to the $5,000-deductible plan, he or she would pay an annual premium of $2,364, and be on the hook for medical expenses of as much as $5,000.
>
> While this consumer would pay less in premiums than for the HMO, the total outlay could run as high as $7,364 before the insurance kicks in, according to WellPoint figures.

Duncan Moore, *Shifting Health Care Costs to Users: Marketing Push Offers Higher Deductibles to Curb Consumption*, ALBANY TIMES UNION, Aug. 23, 2006, at E3.

153. *See generally*, Jon Gabel et al., *Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode*, 24 HEALTH AFFS. 1273 (2005).

154. CATHY SCHOEN ET AL., COMMONWEALTH FUND, PUBLIC VIEWS ON SHAPING THE FUTURE OF THE U.S. HEALTH CARE SYSTEM 1, 7 (2006), http://www.cmwf.org/publications/publications_show.htm?doc_id=394606.

155. David Blumenthal, *supra* note 138. "Employee contributions toward family premiums increased by 27 percent between 2002 and 2005, and many employers have imposed similar increases in coinsurance and copayment levels." MARK MERLIS ET AL., THE COMMONWEALTH FUND, RISING OUT-OF-POCKET SPENDING FOR MEDICAL CARE: A GROWING STRAIN ON FAMILY BUDGETS (2006), http://www.cmwf.org/publications/ publications_ show.htm?doc_id=347500 (last visited October 20, 2006).

156. Park, *supra* note 9.

157. *Id.*

found that in 2005, 35% of employers offering HDHPs that qualified for an HSA made no contribution to their workers' accounts.[158] The average contribution by firms that made a contribution was $553 for individual coverage and $1,185 for family coverage, significantly lower than the average deductible of $1,901 for individual coverage and $4,070 for family coverage.[159]

In addition to the 46 million uninsured, another 16 million people could be considered "underinsured" as a result of their high out-of-pocket costs relative to income.[160]

> Americans already pay far more out-of-pocket for their health care than citizens do in any other industrialized country. Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s. Higher spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their earnings on medical costs. A Commonwealth Fund report by Mark Merlis found that the percentage of households spending 10 percent or more of their income on out-of-pocket costs rose from 8 percent during the years 1996–97 to 11 percent in 2001–02. Including premiums, 18 percent of all families spent more than 10 percent of income on health care.[161]

Proponents of HDHPs argue that, by requiring consumers to pay more from their own funds in order to obtain health care, consumers become better informed and are less likely to over-spend. The President's rationale for encouraging increased use of HDHPs is that, if consumers have "skin in the game," they will be more prudent purchasers of health care.[162] However, there is another side to this question:

> Other studies have shown that, instead of a decline in over-utilization of services, high out-of-pocket expenses lead to: delays in care, medical debt, and bankruptcy. One study found that half of those surveyed with an annual deductible of $500 had problems with medical bills and medical debt (HSAs require an annual deductible of $1000 for individuals and $2000 for families). In fact, medical bills are the leading cause of personal bankruptcies in the U.S.[163]

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158. *Id.*

159. *Id.*

160. Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, 24 HEALTH AFF. 272 (2005).

161. *Health Savings Accounts: Why They Won't Cure What Ails U.S. Health Care: Hearing on Health Savings Accounts before the Comm. on Ways and Means, of the U.S. House of Rep.* (2006) (invited testimony of Sara R. Collins, Ph.D., Assistant Vice President, The Commonwealth Fund) (footnotes omitted).

162. FAMILIES USA, *supra*, note 123.

163. Mila Kofman, *HSAs: A Great Tax Shelter for Wealthy, Healthy People but Little Help to*

There is also evidence that higher out of pocket expenses cause patients to forego needed care:

> The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care. Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs, and it increased the risk of adverse health events. In addition, a review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population. Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all.[164]

A 2005 survey found the costs of HSA/HDHP plans to employers are lower than other plans, but the costs to employees are higher:

> The EBRI/Commonwealth Fund survey found that two-thirds of adults who are enrolled in [an] HDHP with an HSA or HRA and who have incomes of less than $50,000 spent 5 percent or more of their income on out-of-pocket costs and premiums-twice the rate of those with similar incomes in more comprehensive plans. People with health problems in HSA-eligible HDHPs, both with and without accounts, were also vulnerable to spending large shares of their income on out-of-pocket costs and premiums: more than half (53%) of those in HDHPs without accounts and 38 percent of those in HDHPs with an account spent 5 percent or more of their income on out-of-pocket costs. People with health problems in comprehensive plans were much better

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the Uninsured, Underinsured, And People with Medical Needs, ETHICS J. AM. MED. ASS'N. (2005), http://www.ama-assn.org/ama/pub/category/15262.html (footnotes omitted).

164. *Health Savings Accounts, supra* note 161 (footnotes omitted). See also MERLIS, *supra* note 155. Sara R. Collins, in her invited testimony in front of the Committee on Ways and Means, stated the following:

> The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay, avoid, or skip health care. The EBRI/Commonwealth Fund survey found that one-third of those in HDHPs with and without accounts had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans. People with health problems or incomes under $50,000 reported particularly high rates of avoiding care. Nearly half of adults in HDHP/HSAs with incomes of less than $50,000 reported delaying or avoiding care; this was nearly twice the rate of people in the same income group in more comprehensive plans. People enrolled in HSA-eligible HDHPs without accounts were more likely to skip doses of their medications, in order to make them last longer, or to not fill their prescriptions at all. The rates of skipped medication were highest among people with health problems.

Health Savings Accounts, supra note 161, at 10.

> protected by comparison: 17 percent spent 5 percent or more of their income on out-of-pocket costs.[165]

In addition, "[t]he majority of those in HDHPs have deductibles substantially above the level required for HSA eligibility."[166]

> According to the EBRI/Commonwealth Fund survey, nearly three of five adults (59%) who had individual HDHPs with accounts had deductibles of $2,000 or more. Among those with family coverage in HDHPs with accounts, two-thirds (67%) reported a deductible of $3,000 or more; 24 percent had a deductible of at least $5,000.[167]

VI. OTHER ISSUES

Some critics of HSAs have argued that they will be used by some higher-income individuals as tax shelters. According to the Center on Budget and Policy Priorities:

> [A] recent report from the GAO indicates that some individuals with HSAs, tend to be people who view their HSAs more as investment vehicles than as a way to help pay out-of-pocket medical costs. The GAO reported that "some account holders are primarily using HSAs as a tax-advantaged savings vehicle" and that such individuals "tend to be highly compensated individuals, [and] pay for care from other, out-of-pocket sources, rather than withdraw funds from their HSA. . .."[168]

One study estimates that fewer than one million currently uninsured people are expected to gain coverage as a result of HSAs, primarily because 71% of uninsured Americans are in a 10% or lower income tax

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165. *Health Savings Accounts, supra* note 161, at 9. *See also* Paul Fronstin & Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, 2005, http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2005.pdf.

166. *Health Savings Accounts, supra* note 161, at 9.

167. *Id.* at 9-10 (footnotes omitted). According to America's Health Insurance Plans, for the best selling HDHP product in the small group market, the average annual deductible and out of pocket limit were $2,143 and $3,381 for single coverage and $4,311 and $6,575 for family coverage. America's Health Ins. Plans, *supra* note 151. For the best selling HDHP product in the large group market, the average annual deductible and out of pocket limit were $1,754 and $3,330 for single coverage and $3,494 and $6,385 for family coverage. *Id.*

168. Park, *supra* note 9 ("Industry representatives indicated that while most HSA account holders withdrew a portion of their account funds in 2005, some account holders used other, out-of-pocket funds, rather than their HSAs, to pay for medical care") (citing GEN. ACCOUNTABILITY OFFICE, CONSUMER-DIRECTED HEALTH PLANS: SMALL BUT GROWING ENROLLMENT FUELED BY RISING COST OF HEALTH CARE COVERAGE, GAO-05-514 (2006)). For a summary of why HSAs are likely to be used as tax shelters, *see* Edwin Park & Robert Greenstein, *Latest Enrollment Data Still Fail to Dispel Concerns About Health Savings Accounts* (2006), http://www.cbpp.org/10-26-05health2.htm.

bracket, and so would get little or no benefit from the tax savings associated with HSAs.[169]

Second, critics argue that, given the realities of health care utilization, HSAs cannot and will not deliver the claimed savings for society as a whole:

> HSA advocates forget the core fact that governs the world of health insurance: 50% of the healthiest people use 3% of the health care dollar; 10% of the sickest people use 70% of the health care dollar. To take money out of the health care insurance system (i.e., spend less on high deductible catastrophic insurance policies) and give that cash to the healthy half of the population to put into savings accounts means that the money will not be there for the very sick who need intensive, expensive care.[170]

One recent study found that, because of the tax subsidies account holders receive, HSAs may actually lower effective out-of-pocket costs for some enrollees:

> In "How Much More Cost-Sharing Will Health Savings Accounts Bring?". . . Dahlia K. Remler, Ph.D., a professor at Baruch College School of Public Affairs, and Sherry A. Glied, Ph.D., chair of the department of health policy and management at Columbia University, evaluate consumer cost-sharing under traditional health policies compared with cost-sharing incurred under HSAs coupled with high-deductible health plans.
>
> Remler and Glied find that HSA/high-deductible health plans actually reduce cost-sharing for people who spend the least and the most on health care, while increasing cost-sharing for individuals in the

169. *Health Savings Accounts, supra* note 161, at 3.

170. *Hearing on Health Savings Accounts before the Committee on Ways and Means of the U.S. House of Rep.* (2006) (statement for the record by Gail Shearer, Director of Health Policy Analysis & William Vaughan, Senior Policy Analyst). See Linda Blumberg & Leonard E. Burman, *Most Households' Medical Expenses Exceed HSA Deductibles*, 104 TAX NOTES 759 (Aug. 16, 2004), stating in part:

> The idea behind HSAs is that they will discourage unnecessary medical spending since people will be more careful if they, rather than an insurer, are paying for care. HSAs' effectiveness thus depends on how much care is purchased by people with expenses below the HSA deductibles. The answer is: not much. Although it is true that more than half of working-aged singles and nearly a third of families spent less than the HSA deductible in 2004 according to our estimates, they accounted for only a tiny fraction of medical spending. People who spent less than the deductible accounted for less than 6 percent of expenditures by singles and 4 percent of families' expenditures. Put differently, more than 95 percent of medical expenditures by insured working-aged households were made by those who spent above the HSA deductibles.

Id. "[Advocates] believe that Americans have too much health insurance . . . . Excessive consumption of [low cost items] don't account for a major share of medical costs." Krugman & Wells, *supra* note 133.

> midrange of spending. In particular, those patients responsible for half of all medical spending—7.7 percent of the population—would see no change, or even a decline, in cost-sharing under HSAs.[171]

One recent study found that only 16% of employers contribute more than the amount they are saving on insurance premiums to HRA or HSA plans.[172] One possible explanation is that "as employers have increased deductibles for more traditional managed care plans, the premium savings for high-deductible account-based CDH plans—versus those for traditional plans—are no longer as significant as they once seemed. . . ."[173]

Third, there is the risk that HSAs will appeal primarily to younger, healthier individuals, resulting in adverse selection as the older and sicker individuals are left in the more traditional health plans.[174]

> Adverse selection occurs when healthy people and less-healthy people separate into different health insurance arrangements, and the cost of insurance for the less healthy consequently rises and places such individuals at greater risk of becoming uninsured or underinsured. Numerous health policy experts and economists have expressed concern that high-deductible plans attached to HSAs pose a significant risk of adverse selection, because such plans are likely to be disproportionately attractive to healthier individuals who do not need much in the way of health care and who consequently are less concerned about the higher out-of-pocket costs required under a high-deductible plan. If healthier individuals move to high-deductible plans attached to HSAs in large numbers over time while less healthy individuals remain in lower-deductible, comprehensive plans, then significant adverse selection will result and drive up health insurance premiums for the comprehensive plans.[175]

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171. DAHLIA K. REMLER & SHERRY A. GLIED, THE COMMONWEALTH FUND, HOW MUCH MORE COST-SHARING WILL HEALTH SAVINGS ACCOUNTS BRING? (2006), http://content.healthaffairs.org/cgi/content/full/25/4/1070?ijkey=AdY/Rg2fCWWZY&keytype=ref&siteid=healthaff. See also Park, *supra* note 52:

> This brief analysis indicates, however, that HSAs are unlikely to reduce overall health care expenditures to any significant extent. The analysis also finds that to the limited extent HSAs may cause some modest reduction in health care spending, any such reduction is likely to result in no small part from individuals—particularly those with lower incomes—forgoing cost-effective medical services including primary care, prescription drugs, and preventive services.

Id.

172. Steve Davis & Jim Gutman, *Study: Health Plans Not Doing Enough to Educate Employers on Consumer-Directed Health Plans* (2006), http://www.aishealth.com/Bnow090606c.html.

173. *Id.*

174. Park, *supra* note 9.

175. *Id.*

Fourth, one of the basic premises urged by advocates of HSAs, and other forms of "consumer-directed health care," is that, given information and financial incentives, consumers will make better health care purchasing decisions.[176] However, most experts agree that the information currently available to patients is woefully inadequate:

> The theory most central to the consumerism in health care movement is that prudent choices in the use of health care will drive the health services market to look more like markets for other goods and services, lowering costs and improving quality as providers compete for patients. But patients' ability to make informed choices is dependent on the extent to which they have access to useful information.
>
> The EBRI/Commonwealth Fund survey finds that Americans, regardless of the health plan they are in, continue to encounter a yawning gap between the information needed to make decisions based on cost and quality and the information that is actually available. Just 14 to 16 percent of insured adults—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their [health] plan on the quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.[177]

And, as many commentators have pointed out, buying health care is not as straightforward as buying typical consumer goods and services:

> Proponents assume that individuals can make informed medical decisions about their medical care and will, if forced to spend their own money. However, this assumption may not be realistic given the low rate of medical literacy in the U.S. There are nearly 90 million adults who have difficulty understanding and acting on health information. Those who *are* capable of making decisions soon discover a disconnect between the information they need to make informed decisions and what is available (eg, it is difficult to compare the cost and benefits of various procedures because that information is not available from health plans or physicians). Even if better information were available, it would not necessarily be helpful for patients with serious illnesses. A cancer patient undergoing radiation or chemotherapy, for example, may have an hour of energy per day to take care of life's needs—cooking, cleaning, paying bills. It is unlikely there would be time to research the cheapest labs or physicians, nor would the patient always opt for the cheapest. A key premise underlining HSAs is that consumers will choose the "cheapest" options. But medical care is not like milk; if you need heart surgery,

176. Fronstin & Collins, *supra* note 165, at 18.

177. *Health Savings Accounts*, *supra* note 161, at 14-15. *See also* Davis & Gutman, *supra* note 172.

> you do not shop for the "cheapest" heart surgeon but for the best one.[178]

The Institute of Medicine concluded in 2004 that "nearly one-half of all adult Americans were health illiterate."[179]

Another problem, based on the relatively brief experience to date with HDHPs, is customer satisfaction:

> Few Americans who are currently enrolled in HDHP/HSA plans are satisfied with them. The EBRI/Commonwealth Fund survey found that people with HDHPs, both with and without accounts, were far more likely than people in more comprehensive plans to report dissatisfaction with quality of care, out-of-pocket costs, and overall satisfaction with their plans. More than half of those in the plans were not satisfied with their out-of-pocket costs. Moreover, one-third of those in the plans would change plans if they had the opportunity to do so, and only one-third or less would recommend the plan to a friend or co-worker.[180]

According to industry estimates, in January, 2006, there were about 3.2 million HDHPs that qualified for an HSA.[181]

> It is unclear, however, how many of these people actually have a HSA or have contributed to one; these industry estimates do not indicate to what extent people enrolled in an HSA-eligible health insurance plan actually have established HSAs. The Government Accountability Office (GAO) reports that industry officials believe that up to half of enrollees in high-deductible plans eligible for a HSA have not opened and contributed to a HSA.[182]

"If enacted, Bush's reforms would raise the projected number of HSA participants in 2010 from 14 million to 21 million, according to a fact sheet released by the White House."[183]

How prevalent are employer sponsored HDHP/HSA plans?

> It has been estimated that 20 percent of employers are already offering some form of CDHP or HDHP, with large employers (with 5,000 or more employees) leading the way with one-third offering them, and that approximately 2.4 million workers were covered by an HSA or HRA plan in 2005. It is expected that in 2007 an additional 33 percent

178. Kofman, *supra* note 163 (footnotes omitted).
179. Fronstin & MacDonald, *supra* note 121.
180. *Health Savings Accounts*, *supra* note 161 (footnotes omitted).
181. Park, *supra* note 9, at 2.
182. *Id.* (emphasis omitted).
183. Allen Kenney, *Questions Arise over HSAs' Effectiveness*, 110 TAX NOTES TODAY 26-3 (Feb. 7, 2006).

of employers will adopt a CDHP, and that by 2010, CDHPs could account for 24 percent of the market.[184]

VII. CONCLUSION

Assessing the advantages and disadvantages of HSAs is difficult; actual experience is very short, and the commentators on both sides of the argument tend to be true believers who see the issues in black and white terms. One of the few relatively objective sources is the General Accountability Office (GAO), which in April, 2006 reported that:

> According to industry officials and experts, the primary factor responsible for the growth of CDHPs is the rising cost of health care coverage. Prompting the growth of enrollment among individuals is the desire to lower premiums and accumulate tax-advantaged savings, according to the officials. Experts noted that employers would be more likely to offer a CDHP if the plans demonstrate the ability to restrain rising costs, and employees would be more likely to enroll in a CDHP if employers offered more comprehensive CDHP benefits coupled with education about the plans.[185]

The most recent GAO report, issued in August, 2006, included the following concluding observations:

> We found that enrollees who use little health care could incur lower costs under HSA-eligible plans than under traditional plans, while those who use more extensive health care services could incur higher costs under HSA-eligible plans. Thus, when individuals are given a choice between HSA-eligible and traditional plans–as in the individual market and with employers offering multiple health plans–HSA-eligible plans may attract healthier individuals who use less health care or, as we found, higher-income individuals with the means to pay higher deductibles and the desire to accrue tax-free savings. While patterns evident during the first few years of HSA-eligible plan enrollment may not predict future trends and enrollment will depend on the particular choices available, it will be important to monitor enrollment trends and assess their implications for the cost of health care coverage for all HSA eligible and traditional plan enrollees.
>
> Contrary to the hopes of CDHP proponents, few of the HSA-eligible plan enrollees who participated in our focus groups researched cost before obtaining health care services. According to proponents, an increase in such health care consumerism is central to cost reductions that may occur under the plans. Any increase in consumerism that

184. Fronstin, *supra* note 144, at 18.

185. U.S. GEN. ACCOUNTABILITY OFFICE, CONSUMER-DIRECTED HEALTH PLANS: SMALL BUT GROWING ENROLLMENT FUELED BY RISING COST OF HEALTH CARE COVERAGE, GAO-05-514 (2006).

> may be exhibited by CDHP enrollees will likely require time, education, and improved decision support tools that provide enrollees with more information about the cost and quality of health care providers and services.
>
> Finally, while HSA-eligible plan enrollees we spoke with were generally satisfied with their plan, it is notable that these enrollees each had a choice of health plans and voluntarily selected the HSA-eligible plan. Their caution that HSA-eligible plans may not be appropriate for everyone and the views of traditional plan enrollees who opted not to elect an HSA-eligible plan suggest that satisfaction may be lower when employees are not given a choice or when employer contributions to premiums or accounts do not sufficiently offset the potentially greater costs faced by CDHP enrollees.[186]

HSAs and similar arrangements are almost certainly here to stay, but based on the GAO's report on experience to date, Senator Max Baucus, ranking minority member of the Senate Finance Committee, was correct to conclude that "I would have to caution against counting on HSAs to advance real health care reform."[187]

The following summarizes the major developments that have occurred since this article was written.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006.[188] Title III of Division A of the Act, sections 301 through 307, contains provisions relating to HSAs:

- A one-time transfer may be made into an HSA, from a flexible spending account (FSA) or health reimbursement arrangement (HRA), before January 1, 2012;[189]
- The maximum annual HSA contribution for 2007 is $2,850 for an individual with self-only coverage and $5,650 for an individual with family coverage, even if this exceeds the

186. *Id.*

187. Max Baucus, *Baucus Says GAO Report Shows Expanding HSAs Might Not Have Desired Effects*, 2006 TAX NOTES TODAY 176-127 (2006).

188. The House Ways and Means Committee web site has links to various resources, including the text of the Act, a technical description and revenue estimate prepared by the Joint Committee on Taxation, and the Congressional Budget office score of the Act. *See* www.waysandmeans.house.gov/ResourceKits.asp?section=2544. *See also* Press Release, President Bush Signs Bill to Make Health Care More Affordable, Accessible, (Dec. 20,. 2006) *available at* www.benefitslink.com/pr/detail.php?id=40252.

189. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922 (to be codified at I.R.C. § 302 (2006)).

applicable deductible.[190] For a newly eligible individual, who becomes eligible after January 1 of the year, the annual maximum need no longer be prorated for the number of months of participation in the initial year;[191]

- Certain FSA coverage is disregarded in determining the allowable HSA contribution;[192]
- The dollar amounts will continue to be indexed for inflation The Act requires the Secretary of Treasury to announce the HSA cost of living adjustments by June 1, effective for tax years beginning after 2007;[193]
- The Act allows a one-time trustee-to-trustee transfer from an IRA to an HSA;[194] and
- The Act modifies the comparability rules to allow employer contributions for non-highly compensated employees that are higher amounts, or higher percentages of the applicable deductible, than the amounts contributed for highly compensated employees.[195]

The National Conference of State Legislatures has issued an updated summary of State legislation on HSAs and consumer-directed health plans.[196]

The U.S. Department of Labor has issued additional answers to questions on the applicability of ERISA to HSAs offered by employers.[197]

In November, 2006, the DOL's Bureau of Labor Statistics reported that, in 2006, 6% of private sector workers had access to an HSA, an increase from 5% in 2005.[198]

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190. Tax Relief and Health Care Act § 303 (to be codified at I.R.C. § 303 (2006)). For the rules under prior law, see *supra* text accompanying notes 25-27.

191. Tax Relief and Health Care Act § 305 (to be codified at I.R.C. § 305 (2006)). For the rules under prior law, see *supra* text accompanying note 24.

192. Tax Relief and Health Care Act § 302(b) (to be codified at I.R.C. § 302(b) (2006)).

193. Tax Relief and Health Care Act § 304 (to be codified at I.R.C. § 304 (2006)).

194. Tax Relief and Health Care Act § 307 (to be codified at I.R.C. § 307 (2006)).

195. Tax Relief and Health Care Act § 306 (to be codified at I.R.C. § 306 (2006)). For the rules under prior law, see *supra* text accompanying notes 101-105.

196. National Conference of State Legislatures, 2004-2006 State Legislation on Health Savings Accounts and Consumer-Directed Health Plans, Sept. 26, 2006, www.ncsl.org/programs/health/hsa.htm.

197. DOL Field Assistance Bulletin 2006-02, Oct. 27, 2006, *available at* www.dol.gov/ebsa/regs/fab_2006-2.html.

198. U.S. Department of Labor, Bureau of Labor Statistics, Health Savings Accounts in National Compensation Survey Data, Nov. 29, 2006, *available at* www.bls.gov/opub/cwc/cm20061127ar01p1.htm.