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Can Consumer-Driven Health Care, Health Reimbursement Arrangements and Health Savings Accounts Save Employer Sponsored Health Care from Ruin

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CAN CONSUMER-DRIVEN HEALTH CARE, HEALTH REIMBURSEMENT ARRANGEMENTS AND HEALTH SAVINGS ACCOUNTS SAVE EMPLOYER SPONSORED HEALTH CARE FROM RUIN?

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I. INTRODUCTION

Employer sponsored health care programs have been in crisis for over ten years because, year after year, health care costs and premiums continue to increase faster than inflation.[1] Employers have tried a number of solutions, but nothing seems to stop the trend.

Between 2000 to 2006, premiums for family health coverage increased by 87% compared with general inflation growth of 18% and wage growth of 20%.[2] Employee spending for health insurance coverage increased 126% between 2000 and 2004. Since 2001, the employees share of health insurance costs have soared 63% for single coverage and 58% for family coverage.[3] For 2006 the average annual premiums for health care coverage rose to $4,242 for single coverage and $11,480 for family coverage.[4]

A direct impact of increasing health care costs and premiums is that the percentage of employers offering health care benefits to their employees has fallen significantly, from 69% to 61%, over the last six years.[5] The percentage of small businesses offering health coverage is plunging even more sharply. Among employers with between three and nine workers, 48% offered health benefits in 2006, down from 68% in 2000.[6] For 2006, it is estimated that health care costs will continue to increase at a rate of 7% to 12%.[7]

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1. *See generally* GARY CLAXTON ET AL., THE KAISER FAMILY FOUNDATION EMPLOYER HEALTH BENEFITS SURVEY: 2006 ANNUAL SURVEY 1 (2006) http://www.kff.org/insurance/7315/upload/7315.pdf [hereinafter EHB 2006 Survey].

2. *Id.*

3. HEWITT ASSOCIATES, HEALTH CARE EXPECTATIONS: FUTURE STRATEGY AND DIRECTION 2005, Nov. 17, 2004.

4. EHB 2006 Survey, *supra* note 1, at 1.

5. *Id.*

6. *Id.*

7. TOWERS PERRIN, 2006 HEALTH CARE COST SURVEY 1, 2 (2006); THE SEGAL CO., 2006 SEGAL HEALTH PLAN COST TREND SURVEY 1 (2006). *See generally* AON CONSULTING, AON

The following discussion will review the reasons for health care cost and premium increases, the impact that these increases have had on the economy, and the ways employers have attempted to reduce health care costs while continuing to offer health care coverage to employees and dependents.

One health care delivery system that has been recently touted as being the best way to reduce health care costs is "consumer-driven health plans" ("CDHPs"). The following will examine how CDHPs work, how they reduce costs, what advantages they offer employers, and their shortcomings. A vital part of any CDHP is either a Health Reimbursement Arrangement ("HRA") or a Health Savings Account ("HSA"). Each will be examined in detail. HSAs are very important because President Bush has made their expansion the centerpiece of his administration's health reform measures. There are also several proposals in Congress to expand the use of HSAs. In examining HRAs and HSAs, this article will review how they work, their advantages, and their shortcomings, and will conclude this discussion by offering some thoughts and observations.

II. CAUSES OF THE HEALTH CARE COST INCREASES

The acceleration of health insurance premiums and costs can be attributed to a number of factors. A recent survey conducted by PriceWaterhouseCoopers identified the underlying drivers of rising healthcare costs and broke down how premium dollars were spent.[8] It estimated that general inflation accounted for 27% of the 2005 increase in premiums.[9] "Increased utilization of services accounted for an estimated 43% of the increase."[10] Meanwhile, "[p]rice increases in excess of inflation for healthcare services accounted for the remaining 30%."[11]

The major factors that drive price increases in excess of inflation include: the movement to broad-access plans, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private payers. "[T]he cost of providing care to the uninsured is estimated to add as much as 8.5% to the cost of premiums."[12] Higher-priced technologies include new prescription drugs and new imaging technologies. The cost for these

SPRING 2006 HEALTH CARE TREND SURVEY (2006).

8. *See generally* PRICEWATERHOUSECOOPERS, THE FACTORS FUELING RISING HEALTHCARE COSTS 2 (2006), http://www.mahp.org/Policy/Commercial%20Health%20Plans/2006/AHIP%20Cost%20Drivers—Power%20Point.pdf.

9. *Id.*

10. *Id.* at 10.

11. *Id.*

12. *Id.* at 9.

new technologies increased premiums by 1% in 2005.[13] Broad-access plans include plans with broader provider networks which will add to provider consolidations and reduced competition among providers. In 2005, broad-access plans contributed 1.1% to premium increases.[14]

The major factors that drive increased utilization include: increased consumer demand, new treatments, and more intensive diagnostic testing due partially to the practice of defensive medicine. The aging population and increasingly unhealthy lifestyles of people also contribute to increased utilization. It is estimated that the aging of the population in health plans has, alone, contributed to 5% of the premium increases in 2005.[15] Lifestyle challenges, including obesity, smoking, drug abuse, and physical inactivity, have contributed to 3% of the increases.[16] New treatments include new imaging technologies, biologics, and injectables for treating existing serious illnesses, as well as "lifestyle" drugs for conditions that were once not considered illnesses.[17] These new treatments made up over 11% of the premium increases in 2005.[18] It is estimated that more intensive diagnostic testing contributed to over 9% of premium increases.[19] The increase in consumer demand is fueled by factors including the proliferation of information on medical treatments and demand-pull strategies such as direct-to-consumer advertising. Increased consumer demand accounted for almost 14% of the premium increases in 2005.[20]

In addition, the PriceWaterhouseCoopers study showed that increases in the major three factors are not uniform across the different categories of healthcare services. They divided services into the following categories: "*physician spending*," "*outpatient spending*," "*hospital inpatient spending*," "*prescription drugs*" and "*other medical services*." *Physician spending* accounts for largest share of health spending (24%).[21] The increase in physician spending accounts for 22% of the increase in premiums.[22] *Outpatient spending* includes diagnostic centers and imaging centers, ambulatory surgical centers as well as hospital outpatient departments. It "is the second largest component of current health

13. *Id.* at 11.
14. *Id.*
15. *Id.* at 11.
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.* at 12.
21. *Id.* at 6.
22. *Id.* at 12.

spending (22%)" and accounts for 34% of the increases in premiums.[23] *Hospital inpatient* spending accounts for 18% of the total premium and only accounts for 15% of the increase in premium costs.[24] *Prescription drugs* account for 16% of the premium cost, but only 12% in the increase in premium cost. Lastly, *other medical services* account for 6% of the premium and only 5% of the increases in premium costs.[25]

Over the last several years, the rate of the premium increases has slowed, but is still greater than the rate of inflation. The PriceWaterhouseCoopers study indicated that one of the factors that may have contributed to the recent slowing in the rate of increase was that the number of new state mandates has decreased. In addition, the increase in prescription drug costs has slowed. Another of the major factors that contributed to this decline was the number of beneficiaries enrolled in three or four tiered prescription drug plans.[26] This indicates that litigation and provider consolidations continue to play a major factor in overall healthcare costs.[27]

The challenge for employers, health care consultants, and health care professionals is trying to find solutions to slow the growth of health care costs and premiums. Over the past several years, the pressure to find a "solution" has grown. As the next section will show, the impact of increasing costs and premiums has a dramatic effect on both employers and employees. If a solution is not found soon, it could affect the future of employer sponsored health care.

III. THE IMPACT OF RISING HEALTH CARE COSTS

A. HEALTH CARE SPENDING, A GREATER PERCENTAGE OF GDP

In 2004 (the most recent data available), total national health expenditures rose 7.9%, which amounts to more than three times the rate of inflation.[28] Total spending was $1.9 trillion in 2004, or $6,280 per person.[29] Total health care spending represented 16% of the gross domestic product

23. *Id.* at 22.
24. *Id.* at 23.
25. *Id.* at 12-15.
26. *Id.* at 17.
27. *Id.*
28. *Id.*
29. *Id.*

("GDP").[30] U.S. health care spending is expected to increase at similar levels for the next decade reaching $4 trillion in 2015, or 20% of GDP.[31]

B. THE EFFECT ON BUSINESSES

The gap between the growth in health care spending and overall economic growth over the past fifteen to twenty years, requires that both public and private employers have to devote a larger share of their resources to health care spending as opposed to other costs and services. Employers with rising health care spending may have to cut other expenses, which may include reducing wage increases, reducing health insurance benefits, or requiring employees to pay a greater share of the costs.

In the face of global competition, many American employers are reevaluating the cost of promising medical benefits to both their active and retired employees. American employers are discovering that they suffer a large disadvantage compared to many foreign competitors who do not face such a high liability, or who are being helped by governmental subsidies in providing health care to active and retiring employees. This disadvantage is especially felt by American manufacturers because, traditionally, they have offered generous pension and health benefits to both their active and retired employees. "Health-care costs are one-third higher in manufacturing than in the service sector."[32] Another factor that has affected this sector is the responsibility of these employers to pay health insurance benefits to a large number of retirees. As employers downsize, the number of retirees increases. Newer, service-sector companies, however, have not yet been burdened by these kinds of commitments to pay retiree health costs.

In an article published in the September 15, 2004, issue of Risk & Insurance, author Len Strazewski indicated that "steadily rising health benefits costs, underfunded pension plans, and increasingly costly retiree medical benefits are combining to create a new level of enterprise risk for many employers."[33] Mr. Strazewski indicated that those costs are no longer

30. C. Smith et al., *National Health Spending in 2004*, 25 HEALTH AFF. 186, 186-96 (2006).

31. C. Borger et al., Abstract, *Health Spending Projections Through 2015: Changes on the Horizon*, HEALTH AFF., (Feb. 2006) (Web Exclusive), http://healthaffairs.org (search for article by last name "Borger" in "Quick Search" box).

32. Editorial, *Separate Health Insurance From Jobs*, DES MOINES REG., Sept. 27, 2005, at 8A.

33. Len Strazewski, *A 'Tsunami' Toward U.S. Shores: Using Sand-bags to Defend Corporations Against a Tidal Wave of Rising Benefits Expenses is Unlikely to do Much Good. More Drastic Measures are Necessary, Experts Say, and Employees Look as if They Most Likely*

just a balance sheet liability, stating that the greater the benefits liability a company incurs, the lower the level of reserve capital that will be available to fund growth and corporate opportunities.[34]

C. THE INCREASED NUMBER OF UNINSUREDS

Another direct result of rising health care costs is the increasing number of Americans who are uninsured. It is estimated that nearly two–thirds, or 64% of the decline in health coverage during the 1990's is attributable to rising health care costs.[35] As health insurance premiums increased, some employers terminated health insurance to their employees. Other employers shifted more of the premiums to workers, leading to higher prices and more workers declining offers of health insurance. Since fewer than 60% of Americans under the age of sixty-five receive health insurance coverage as an employer benefit, this result has been very dramatic.[36] While Medicare covers virtually all those who are sixty- five years or older, the nonelderly who do not have access to or cannot afford private insurance go without health coverage unless they qualify for public programs. The number of uninsured has risen from about 31 million Americans in 1987 to 45.8 million in 2004 (12.9% in 1987 to 15.7% of the total population in 2004).[37] Given the rising cost of health insurance, the number of uninsured is likely to grow in the absence of policy interventions.[38]

A good example of the current situation is to examine the nation's largest employer—Wal-Mart Stores. Even with enhancements announced in February of 2006, it only insures 46.2% (about 615,000 of 1.3 million) of its employees.[39] Overall, "75% of its workers have some form of health insurance, either through Wal-Mart, a spouse or a previous job."[40]

Will Have to Bear the Burden, RISK & INS., (Sept. 15, 2004), *available at* http://www.looksmartrealty. com/p/articles/mi_m 0BJK/ is_11_15 /ai_ n6212320.

34. *Id.*

35. Michael Chernew et al., *Increasing Health Insurance Costs and the Decline in Insurance Coverage*, 8 ECONOMIC RES. INITIATIVE IN THE UNINSURED WORKING PAPER SERVS. 17, Mar. 2005, *available at* http://www.umich.edu/eriu/pdf/wp8.pdf.

36. EHB 2006 Survey, *supra* note 1, at 40.

37. Carmen DeNavas-Walt et al., U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, U.S. Government Printing Office, Washington, DC, 60-229 (2005).

38. *Id.*

39. Michael Barbaro, *Wal-Mart to Expand Health Plan*, N.Y. TIMES, Feb. 24, 2006, *available at* http://www.nytimes.com/2006/02/24/business/24walmart.html?ei=5070&en=04c852130f9b9ce&ex=1159416000.

40. *Id.*

Likewise, "[t]he remaining 25% have no insurance."[41] Forty-six percent of the children of Wal-Mart employees are either uninsured or on Medicaid.[42]

D. EFFECT ON INDIVIDUALS

Lastly, rising health care costs will also affect an individual's household finances. Income and savings that would otherwise be used for purchasing consumer goods or put toward savings for financing future educational costs or retirement must be used to cover health care services. For less affluent households, this could result in forcing tradeoffs between health care and other normal necessities of living. For example, a 2003 survey found that 63% of families that reported problems with paying medical bills also had problems paying for other household necessities, such as food, clothing, and rent.[43]

Low-income households without access to government or private sector charity programs may be particularly impacted by rising health care costs. A recent study reported that between 2001 and 2003 the proportion of insured low-income individuals with chronic conditions that spent more than 5% of their income on health care rose from 28% to 42%.[44] Almost half of the uninsured low-income chronically ill have reported problems in paying medical bills, which has likely contributed to delaying or foregoing medical care.[45] In line with these cost-related health care choices, increased spending on health care led almost six million Americans to seek complimentary and alternative medicine ("CAM") treatments in 2002 as a more affordable option compared to traditional medical care.[46]

A lapse in health insurance coverage during the two years before an individual filed bankruptcy was a strong prediction of a medical cause for bankruptcy. Of those surveyed, nearly four-tenths (38.4%) of debtors who had a "major medical bankruptcy" had experienced a lapse of insurance

41. *Id.*

42. *Id.*

43. Jessica H. May & Peter J. Cunningham, *Tough Trade-offs: Medical Bills, Family Finance and Access to Care,* CTR. FOR STUDYING HEALTH SYS. CHANGE, Issue Brief No. 85, June 2004, *available at* http://www.hschange.com/content/689/689.pdf.

44. Ha T. Tu, *Rising Healt Costs, Medical Debt and Chronic Conditions,* CTR. FOR STUDYING HEALTH SYS. CHANGE, Issue Brief No. 88 (Sept. 2004), http://www.hschange.com/CONTENT/706/?topic=topic02.

45. *Id.*

46. Ha T. Tu & J. Lee Hargraves, *High Cost of Medical Care Prompts Consumers to Seek Alternatives,* CTR. FOR STUDYING HEALTH SYS. CHANGE, Data Bulletin No. 28 (Dec. 2004), http://www.hschange .org/CONTENT/722/.

coverage.[47] More than one quarter of those surveyed cited illness or injury as a specific reason for bankruptcy, and a similar number reported uncovered medical bills exceeding $1,000.[48]

The challenge in finding a solution to rising health care costs is finding something that will encourage employers to offer health care coverage to their employees and will encourage employees to take such coverage. For this solution to be successful it has to be reasonable in cost for coverage and administration. Such coverage has to be sufficient to cover many costs and procedures incurred by employees. As discussed in the next section, employers have tried various vehicles over the last number of years with mixed results.

IV. WAYS THAT EMPLOYERS ARE TRYING TO REDUCE HEALTH CARE COSTS

A. THE SEARCH FOR SOLUTIONS

Employers have tried various vehicles and methods to reduce health care costs over the last few years. In the 1980's and 1990's, Health Maintenance Organizations ("HMOs") were first introduced to hold down costs by shifting financial risk to the health care providers and health plans and/or demanding step discounts on services in return for an increased volume of patients. HMOs also constrained access to specialists. HMOs were successful in moderating premiums for several years, but participants complained about the limitation on their choices for care and about having to go through a gatekeeper for referrals to specialists. Preferred Provider Organizations ("PPOs") and Point-of-Service ("POS") plans were next created in the mid-to-late 1990's to reduce some of the restrictions contained in HMOs but still retained some of the managed care procedures found in HMOs.[49] In 1999, 39% of covered workers were enrolled in PPOs, 24% in POS plans and 28% in HMOs.[50] By 2005, 61% of covered workers were enrolled in PPOs, 15% in POS plans, and 21% in HMOs.[51]

47. David Himmelstein et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. (Feb. 2005) (Web Exclusive), http://content.healthaffairs.org cgi/content/full/hlthaff.w5.63/DC1.

48. *Id.*

49. EHB 2006 Survey, *supra* note 1, at 50-57.

50. *Id.* at 57.

51. *Id.*

By 2002, many employers realized that PPOs and POS plans were not containing health care costs increases. Beginning in 1999, health care premiums started to increase at an alarming rate: by 5.3% in 1999, 8.2% in 2000, 10.9% in 2001, and 12% in 2002.[52] With no end in sight, employers began to reduce benefits offered and instituted increased cost sharing for participants. In cutting benefits, employers reduced or terminated benefits for retirees, reduced or terminated coverage for spouses and dependents, and limited coverage for certain procedures. The number of employers with 200 or more employees offering retiree medical benefits dropped from 66% in 1988 to 35% in 2006. Future reductions are predicted in the coming years.[53]

In regard to cost sharing, most employers require employees to pay more of the costs by increasing their premiums and/or require higher deductibles and co-payments. Some employers require employees to pay a percentage of the actual cost of services or drugs rather than a flat co-pay amount.[54] In PPOs, the most common plan type as indicated above, has an average deductible for in-network services of $365 for single coverage and $980 for family coverage.[55] Across all plan types, average deductibles for single coverage in small firms (3–199 workers) are substantially higher than average deductibles in large firms (200 or more workers).[56]

More than half of covered workers face separate cost-sharing when they are admitted to a hospital. Twenty-five percent of covered workers face a separate deductible or co-payments for each hospital admission, with an average payment of $231. Twenty-two percent of workers face separate coinsurance when they are hospitalized, with an average coinsurance rate of 17%.[57]

The vast majority of covered workers face co-payments when they go to the doctor or fill a prescription. Among these covered workers, 60% are in plans with a co-payment of $15 or $20, and an additional 15% are in a plan with a co-payment of $25.[58]

By 2003, many employers realized that reducing health benefits and shifting costs to participants would not be enough to reduce the yearly

52. *Id.* at 17.
53. *Id.* at 1.
54. *Id.* at 76.
55. *Id.*
56. *Id.* at § 7, p. 6.
57. *Id.* at § 7, p. 1-3.
58. *Id.* at § 7, p. 2.

increases in health care costs and premiums. Premiums continued to increase, rising 13.9% in 2003 and 11.2% in 2004.[59]

Three new devices have been introduced to deal with the increases. Employers are using one or more of these devices to reduce costs. The three devices used to reduce costs are health education and wellness programs, disease management, and consumer driven health care.

B. WELLNESS PROGRAMS

An employer may provide wellness programs to simply encourage employees to lose weight or stop smoking, or include a wider number of programs to encourage employees to adopt a healthy lifestyle. According to the Centers for Disease Control, more than 75% of employer's health care costs and productivity losses are related to employee lifestyle choices.[60] In this same survey, 62% of employers offered some kind of wellness programs.[61] Wellness Council of America indicates that a $1 investment in wellness program saves $3 in health care costs.[62]

These corporate wellness programs may include the following components:

- Annual health and lifestyle assessments;
- Health results evaluation session (group workshop);
- Set individual goals, action plan;
- Referral of high-risk persons for needed care (e.g. high blood pressure, glucose levels etc.);
- Opportunity for employees to participate in risk reduction interventions and health enhancement programs consistent with individual and corporate goals, such as blood pressure reduction, weight control, fitness cholesterol reduction, and wellness campaigns;
- Monthly tracking/accountability programs to monitor progress toward goals, including: exercise logging, health

59. *Id.* at 1.

60. Francis P. Alvarez & Michael J. Soltis, *Preventive Medicine, Employee Wellness Programs are Prone to Legal Maladies that Require Care Monitors*, 51 HR MAGAZINE 105 (2006), http:/www.shrm.org/ hrmagazine/articles/0106/0106legaltrends.asp [hereinafter HR MAGAZINE].

61. *Id.*

62. Tony Zook, *The ROI of Wellness*, FORBES.COM, http://www.forbes.com/ ceonetwork/2006/04/21/ wellness-programs-gold-standards-cx_tz_0424wellness.html (Apr. 26, 2006).

events, health screening, self-study projects, and wellness challenges;

- Annual health outcome reports showing changes in whole organizations.[63]

For those employers who offered wellness programs, 80% offered wellness education. This included books, newsletters, seminars and speakers on wellness topics. Other popular offerings included: health screenings (74%), health fairs (54%), subsidized flu shots (70%) and health risk assessments and subsidized or discounted off-site programs or memberships (51%).[64]

In offering wellness programs, employers have to be careful to avoid disability and privacy issues. These programs raise a number of issues regarding disability-related inquiries and medical examinations under the Americans with Disability Act (ADA):

> The ADA prohibits employers from inquiring about employees' medical conditions unless such inquiries are "job-related and consistent with business necessity." However, according to the Equal Employment Opportunity Commission's (EEOC) 2002 Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees, employers may conduct voluntary medical examinations and activities, including taking voluntary medical histories, that are part of an employee health program without having to show that they are job-related and consistent with business necessity. Medical records acquired as part of the wellness program must be kept confidential and separate from personnel records.
>
> The EEOC further explained that a wellness program is "voluntary" as long as an employer neither requires participation nor penalizes employees who do not participate. It is unclear whether compliance with HIPAA's proposed "total reward" regulation would satisfy the EEOC's requirement that a program be voluntary. As employees are required to take on an increasingly larger share of the costs of employer-sponsored health coverage, wellness programs may face challenges that premium rebates or decreased co-payments are inherently coercive and in violation of the ADA.[65]

Because of the voluntary participation requirements of wellness programs, employee participation can vary wildly. In a recent survey,

63. Corporate Wellness Program Design, WELLSOURCE, pamphlet, http://www.wellsource.com/360/pdf/CWPD_WSeminar.pdf#search=%22wellsource%20corporate%20wellness%20programs%22 (last visited Oct. 9, 2006).

64. Robert Shew, *Employers Fail to Measure Wellness-Program ROI*, CAREERJOURNAL.COM http://www.careerjournal.com/hrcenter/briefs/20060302-bna.html [hereinafter CAREER JOURNAL] (last visited Oct. 9, 2006).

65. HR MAGAZINE, *supra* note 60, at 107.

employee participation was 50% or lower for more than 80% of the respondents to the survey.[66] "[Thirty-six percent] of the respondents reported average participation in the 10% to 25% range, while 27% of the respondents reported participation in the 26% range."[67] Additionally, "[n]ineteen percent said they had participation rates of below ten percent.[68]

Employers have found that wellness programs can be an effective tool to control health care costs. But this effectiveness may be limited by the requirements for a "bona fide wellness programs" under HIPAA, the ADA concerns, and requirement that participation must be voluntary. These requirements may limit the number of employers that can adopt the programs and the number of employees and dependents that can participate in them by making these programs expensive to adopt and maintain. Relaxing some of these requirements may encourage more employers to adopt wellness programs.

C. DISEASE MANAGEMENT PROGRAMS

By the mid-1990s, most major health care carriers were offering disease management program(s) to plan sponsors as an addition to traditional utilization management services (such as case management and precertification).[69] According to the Disease Management Association of America, disease management is a "system of coordinated healthcare intervention and communications for populations in which patient self-care efforts are significant."[70] Disease management programs are designed to improve the health of persons with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations. These programs are important in reducing costs because people with chronic conditions, 44% of them non-institutionalized, account for 78% of health care expenditures in the United States.[71]

In designing a disease management program, it should:

66. CAREER JOURNAL, *supra* note 64.

67. *Id.*

68. *Id.*

69. Disease Management Programs Grow, http://www.aetna.com/producer/e.briefing/2005-1/si_disman_grown.html (last visited Oct. 9, 2006).

70. James E. Pope, M.D. et al., *Case Study of American Healthways' Diabetes Disease Management Program*, 27 HEALTH CARE FINANCING REV. 47 (Fall 2005).

71. PARTNERSHIP FOR SOLUTIONS ET AL., CHRONIC CONDITIONS: MAKING THE CASE FOR ONGOING CARE (2002).

- "Support the physician or practitioner/patient relationship and plan of care;
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
- Evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving over all [sic] health."[72]

There have been a number of examples of successful disease management programs:

- Under a diabetes management program sponsored by Medicare, participants improved many of their self-monitoring practices and used fewer inpatient services. Among 6,800 enrolled in the program, those enrolled in the program had higher number of primary care physician visits, were likely to receive eye, lipid and kidney screenings and had lower blood sugar levels, compared to those who were not enrolled in the program. It was found that enrollees made fewer visits to the hospital and emergency room than non-enrollees. Over a two-year period, the average monthly cost per enrollee -$395- was about 20% lower than per non-enrollee - $503.[73]
- In a program sponsored for Florida Medicaid beneficiaries, it was found after two years after enrolling in a disease management program for congestive heart failure that individuals were more likely to take prescription drugs to control their conditions and received an annual cholesterol screening because they were monitoring their conditions more closely and spending fewer days in the hospital. The number of days spent over the two-year period and health care expenditures for 2,500 beneficiaries decreased by 16%, a savings of $4.4 million after program costs.[74]

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72. David P. Faxon et al., *Improving Quality of Care Through Disease Management: Principles and Recommendations From the American Heart Association's Expert Panel on Disease Management*, STROKE 1527 (2004), http://stroke.ahajournals.org/cgi/content/full/35/6/1527; *see also* Disease Management Association of America, http://www.dmaa.org/definition.html.

73. J. Sidorov et al., *Does Diabetes Disease Management Save Money and Improve Outcomes*, 25(4) DIABETES CARE 684, (2002).

74. *Evaluating Coordination of Care in Medicaid: Improving Quality and Clinical Outcomes: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce,*

- Plan sponsors view disease management as an important tool that can help them lower their overall health care costs:
- J.P. Morgan conducted a survey of managed care organizations that cover a total of 110 million people. It discovered that plan sponsors generally view disease management as an important strategy to contain medical costs and are allocating additional financial resources to it.[75]
- According to the 'Mercer National Survey of Employer Health Plans,' disease management asthma programs were offered by 43% of businesses with 500 or more employees in 2003, up from 34% in 2002.[76]
- Nearly three-quarters of companies surveyed by Hewitt Associates planned to offer disease management to their employees in 2004.[77]
- Evaluations of various disease management programs found savings of $1.25 to $2.00 for every dollar spent on programs for asthma, low back pain and diabetes. Multi-condition disease management programs saved between $2.25 and $2.94 for every dollar spent.[78]
- Studies also suggest that companies that implement certain disease management programs can see a significant reduction in chronic case care after one year of implementation.[79]

The adoption of more and more plan sponsors and insurance companies of disease management services may have a long term impact on health care costs. While many programs have succeeded at reducing expenditures, the potential for long-term savings is still not known. This is because the studies that have shown savings are generally confined to a short duration of time and are typically based on the experiences for a single plan or program or are restricted to certain areas of the country. In the past, employees and their dependents with chronic conditions were given little assistance in dealing with their situations. Giving this assistance reduces costs and increases productivity by allowing more employees with chronic conditions to work. More assistance should be

108th Cong. 8 (2003) (statement of Chris Selecky, CEO, LifeMasters Supported SelfCare, Inc., on behalf of the Disease Mgmt. Ass'n of Am.).

75. Disease Management Programs Grow, *supra* note 69.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

given to employers by state and local governments to adopt these programs.

For disease management programs to be effective, they must require individuals to commit a substantial amount of time and effort to improving their health care practices. Employees and dependents must be encouraged to enroll in a program. Communication and education are very important. Beneficiaries must understand the benefits of the program. An important challenge for these programs is low patient compliance. Patient compliance ranges widely among populations with different chronic conditions. While some patients are set in their ways and find the care plans oppressive, others may not fully trust the program.[80] An employer may need to provide financial incentives to encourage participation.

D. CONSUMER DRIVEN HEALTH CARE

As more and more employers realized that managed care plans (HMOs, PPOs and POS plans) were failing to halt health premium increases, they looked for another medical delivery system that could assist in either eliminating or reducing the rate of health care costs and premium increases. Many health care consultants have touted "consumer driven health care" as a solution. They suggest that Consumer Driven Health Plans (CDHPs) potentially:

- control costs and enhance efficiency,
- increase the choices available, and
- allow for greater consumer involvement in health care.

It has been recognized that managed care plans failed to control costs because they hid the true cost of health care from both doctors and patients through the use of co-payments.[81] In fact, in many HMOs, participation was encouraged with low office co-pays and comprehensive services. In addition, many consumers rebelled against the HMO's limitations of the choice of physicians and hospitals to only those associated with the HMO, as well as against the "gatekeeper" system.[82]

80. Alin Adonmeit et al., *A New Model for Disease Management*, 4 THE MCKINSEY Q. 92-97, (2001).

81. *Health Care Dollars and Sense*, LIVING WELL (Summer 2003) at 9, *available at* http://www.ghp.com/content/items/10813/MemSum03.pdf.

82. A gatekeeper is a primary care physician or insurance company official who approves all referrals to specialists or hospitals. *See* http://www.rwinsurance.com/glossary.html (last visited Oct. 9, 2006) (follow the "G" hyperlink).

In developing CDHPs, health care economists and employee benefits professionals wanted to provide a health care delivery system and coverage provisions that encouraged individuals to become actively involved in making their own health care decisions, choosing their service providers, selecting health care services, and managing their own fitness and wellness. To deliver on these goals, CDHPs contain the following elements: a high deductible health plan ("HDHP"), a personal account in the form of a Health Reimbursement Arrangement ("HRA") or a Health Savings Account ("HSA") to pay for care, and a gap between the annual amount put into the account and an internet-based decision support system.

The main element of consumer driven health care is the employer's adoption of a high deductible plan. Under these plans, the deductible limit can be in the range of $1,000 to $3,000 and will result in immediately lower premiums for the employer. Depending on the size of the employer, they may allow employees to choose among various plan designs or give the employees the opportunity to tailor their premium cost by making personal choices about key design features (such as the amount of the deductible, the group of covered providers and the level of co-pays and coinsurance). In providing the employee's personal account, many employers partially fund the deductible, co-pays, and co-insurance amounts by the use of HRAs.

Two other elements of CDHPs are health information systems and wellness programs. Since under CDHPs, employees spend more of their own money, employees are given access to information through the web to allow them to make health care cost and quality comparisons.[83] At this point, the quality of information can vary by program, and some employers have problems educating employees on how to use the information to choose quality health care at a reasonable price.

One of the most important and common elements of CDHPs is a wellness program, as discussed above. Under CDHPs, this program will involve individual health risk assessments and provide education in areas such as nutrition, fitness or first-aid. As part of this program, employees will be given financial incentives for participating.

83. Jon R. Gabel et al., *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFF., Nov. 20, 2002, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.

V. ARE CONSUMER DRIVEN HEALTH PLANS A SAVIOR, OR A MATTER OF SMOKE AND MIRRORS?

A. HOW MANY EMPLOYERS HAVE ADOPTED THEM?

The universe of those employers offering consumer driven health plans (CDHPs) is still quite small, but growing. Many employers who have adopted them have done so only over the past several years. A number of recent surveys reflect this point. According to the General Accounting Office, the number of enrollees and dependents covered by a CDHP increased from 3 million to between about 5 and 6 million from January 2005 to January 2006.[84] A recent Aon Consulting/ISCEBS survey found that only 28% of the ISCEBS members responding to the survey were currently offering a consumer-driven health plan.[85] Of those who offered these plans, 75% began offering the plan in 2005 or 2006.[86] In Deloitte's 2005 Consumer-Driven Health Care Survey, 22% of respondents (up from 19% last year and 11% in 2003) have consumer-driven health plans in place.[87] Of the employers responding to the survey, 50% had adopted the plan for the first time as of January 1, 2005.[88] Among the remaining respondents, nearly one-half adopted the plan prior to 2004 and the other half adopted the plan sometime during 2004.[89]

When employers offer a CDHP, almost all also offer one or more traditional health plans to employees at the same time. Only 1% of employers offering a CDHP in 2005 did not offer one or more traditional plans.[90] When employers offered a CDHP as one of two or more options, enrollment in the CDHP was generally lower than in traditional plans. For example, data from three large multistate insurance carriers indicated that the average 2004 enrollment rates in their HRA based plans when those plans were offered alongside one or more traditional plans was 17%.[91]

84. U.S. GOV'T ACCOUNTABILITY OFFICE, CONSUMER DIRECTED HEALTH PLANS: SMALL BUT GROWING ENROLLMENT FUELED BY RISING COST OF HEALTH CARE COVERAGE, H. R. Doc. No. GAO-06-514, at 1 (2006), *available at* http://www.gao.gov/new.items/d06514.pdf. [hereinafter GAO Study].

85. Paul E. Sullivan Jr. & C. William Sharon, *Consumer-Driven Health Plans Gaining Stronger Presence*, at 1 (June 2006), http://www.aon.com/us/busi/hc_consulting/cdh_microsite/pdf/iscebs_cdh_survey_ report_ 06.pdf.

86. *Id.*

87. DELOITTE, 2005 CONSUMER-DRIVEN HEALTH CARE SURVEY 2 (2005), http://www.deloitte. com/dtt/cda/doc/content/us-consulting_cdhSynopsis_04.pdf.

88. *Id.*

89. *Id.*

90. GAO Study, *supra* note 84, at 14.

91. *Id.*

Among employers with 1000 or more workers that offered an HSA-eligible plan, 3% of employees were enrolled in the HSA eligible plan in 2005.[92]

B. HOW ARE HRAS OR HSAS USED?

In determining whether an HRA or HSA will be used in the CDHP, HRA-based plans are typically offered by large employers that self-fund their health benefits, while small employers are more likely to purchase rather than self-fund their health insurance plans and are less likely to offer HRA-based than HSA-eligible plans.[93] A recent study conducted by Buck Consultants has indicated a shift in attitude. Nearly half (46%) of the respondents said they believed that HSAs can control health care costs more effectively than HRAs, while just 13% believe that HRAs do a better job.[94] In addition, a majority of employers said they believed their employees prefer HSAs over HRAs.[95] According to the survey, 52% of the respondents believed that HSAs are favored by employees, versus 23% that view HRAs as more attractive to employees.[96]

Studies have shown that most employers contribute to their employees accounts, but there is a wide variation in the share of accounts spent by enrollees. Almost three-quarters of the HRA-based plan enrollees with single coverage and more than 95% with family coverage spent a portion of their HRAs in 2004 and the year-end balances varied.[97] The average amount of unspent HRA funds at the end 2004 was $470 for single coverage and $401 for family coverage.[98] The most common annual employer HRA contribution in 2004 ranged from about $500 to $750 for single coverage and from about $1,500 to $2,000 for family coverage. [99]

In regard to HSAs, only about 50 to 60% of eligible enrollees actually establish HSA accounts.[100] About two-thirds of employers offering HSA eligible plans made a contribution to employees' HSAs and the average

92. *Id.*

93. Gary Claxton et al., *What High-Deductible Plan Look Like: Findings from a National Survey of Employers, 2005*, HEATH AFF , Sept. 14, 2005.

94. Rupal Parekh, *HSAs Preferred Over HRAs: Study*, http://www.businessinsurance.com /cgi-bin/news.pl?newsId=8113# (last visited Sept. 27, 2006).

95. *Id.*

96. Press Release, Buck Consultants, Buck Consultants Survey Identifies Leading Success Factors In Consumer-Driven Health Care (July 27, 2006) http://www.buckconsultants. com/buckconsultants/Portals/0/Documents/PUBLICATIONS/Press_Releases/2006/pr_07_27_06 .pdf.

97. GAO Study, *supra* note 84, at 5.

98. *Id.* at 16.

99. *Id.* at 15.

100. *Id.*

employer HSA contribution to employees HSAs in 2005 was about $553 for single and $1,185 for family coverage.[101] Early experience with HSAs suggested that some individuals were and are still using their accounts to pay for medical care, while others are choosing to pay for care with other out-of-pocket sources, rather than withdrawing funds from their HSAs. Data from the IRS shows that among tax filers who claimed a deduction for an HSA contribution in 2004, the average amount was $2,100.[102] The average deduction amount generally increased with income level. [103]

C. ARE THERE REAL SAVINGS THROUGH ADOPTING CDHPS?

Recent surveys have found that CDHPs provided employers with real savings. According to The Segal/Sibson 2006 Survey of Consumer-Driven Health Plans, only a few respondents reported that costs of employers' Consumer Driven Health Plan surpassed expectations.[104] Respondents who felt that their employer's program was successful identified the following factors as having contributed to that success: employee contribution schedules and other financial incentives to enroll in the program; extensive communication and employee education; designing the right plan for the workforce; and choosing the right vendor.[105] The survey found that communication plays a vital role in the success of the program.[106] Effective communication contributed to the program's success and insufficient communication was a factor when the program was not as successful as expected.[107]

Deloitte's study, *Consumer-Driven Health Plan Cost Growth Significantly Slower Than Other Plans*, reported that the cost of consumer-driven health plans increased by an average of 2.8% from 2004 to 2005.[108] Those increases compares to an 8% increase in total premiums for HMOs, an 8.5% increase for POS plans and a 7.2% increase for PPOs.[109]

101. *Id.*
102. *Id.*
103. *Id.* at 17.
104. THE SEGAL COMPANY, SEGAL/SIBSON'S 2006 SURVEY OF CONSUMER DRIVEN HEALTH PLANS, SUMMER 2006, http://www.segalsibson.com/publications/surveysandstudies/summer 06CDHP.pdf#search=%22segal%20sibson%20consumer%20%22 [hereinafter Segal survey].
105. *Id.*
106. *Id.*
107. *Id.*
108. Press Release, Deloitte, Consumer-Driven Health Plan Cost Growth Significantly Slower Than Other Plans, (Jan. 24, 2006), http://www.deloitte.com/dtt/press _release/0,1014,sid%3 D2283 &cid%3 D107407, 00.html.
109. *Id.*

Traditional or indemnity plan costs increased 6.4% last year, according to the survey.[110] The average for all types of plans was 7.3%.[111]

The survey also found that businesses are projecting similar rates of cost growth in 2006, including 2.6% for consumer-driven health plans, 7.4% for HMOs organizations, 7.3% for POS plans, 7.5% for PPOs, and 6.6% for traditional or indemnity plans.[112] The average for all types of plans is projected to be 7.1%.[113]

In a recent Fidelity survey, the difference in costs between consumer-driven health plans and traditional comprehensive health plans among surveyed employers projected considerably lower costs for family coverage under CDHPs relative to more traditional health plan offerings in 2006, with the average coverage under a consumer driven health plan expected to cost $875 per month compared to $936 per month for a traditional health plan.[114]

However, cost savings for single coverage under a CDHP is expected to be less significant. Average costs are projected at $302 per month, while more traditional health plans are expected to cost $319 per month.[115] Employee contributions toward CDHPs compared to traditional health plans seem to consistently correspond to employer cost differences, with the average consumer driven health plan coverage costing employees $58 per month for single coverage and $187 per month for family coverage.[116] The average employee cost for traditional health plans is projected at $68 per month for single coverage and $204 per month for family coverage.[117]

Many analysts are very doubtful of the long term prospects of using of high deductible plan to reduce health care costs.[118] This is because most of the nation's health care costs are for expensive procedures or treatments which often are related to major illnesses or end-of-life costs. These costs exceed the high deductibles and consequently would be paid by health

110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. Press Release, Fidelity Investments, Fidelity Study Shows Upsurge In Consumer-Driven Health Plan Offerings For 2006 Annual Enrollment (Nov. 3, 2005), http://content.members.fidelity.com/Inside_ Fidelity/fullStory/1,,6145,00.html.
115. *Id.*
116. *Id.*
117. *Id.*
118. *See generally* Alan C. Monheit, *Persistence in Health Expenditures in the Short Run: Prevalence and Consequences,* MED. CARE 41, July 2003 Supplement, (cited in Karen Davis *et al., How High Is Too High? Implications of High-Deductible Health Plans,* COMMONWEALTH FUND, April 2005).

insurance plans. One study has determined that the top 10% of health care users account for about 70% of total health expenditures, while the bottom 50% of users account for only three percent of total expenditures.[119]

Studies also show medical services below the deductibles can be effective in cost containment. These can include primary care services such as physician visits that diagnose and provide low-cost treatment of acute conditions and maintenance drugs that manage or treat chronic conditions like diabetes. While many CDHPs cover preventive care, there is no requirement that such plans actually do so.[120] In its 2005 employer survey, the Kaiser Family Foundation and the Health Research Education Trust found only 30% of workers enrolled in high-deductible plans that qualified for a HSA had some preventive benefits.[121]

D. WHAT ARE THE PROBLEMS IN OFFERING CDHPS?

In a recent survey conducted by the Employee Benefit Research Institute ("EBRI") and the Commonwealth Fund, it was found that only 42% of those employees with CDHPs are satisfied with their insurance, far below the 63% who are pleased with traditional coverage.[122] It was also found that individuals in CDHPs who have health problems or incomes under $50,000 are significantly more likely to avoid, skip, or delay health care because of costs compared to those in traditional health insurance plans.[123] About one-third of individuals in CDHPs and 31% in high deductible health plans reported delaying or avoiding care, compared with only 17% of those in traditional health plans.[124]

The EBRI survey also found that those people who do receive care are more cost-conscious than those in traditional comprehensive health plans.[125] Participants in CDHPs were significantly more likely to report

119. *Id.*

120. IRS guidance indicates that some prescription drugs may meet the preventive care definition such as cholesterol-lowering drugs taken by an individual without heart disease to prevent the future occurrence of heart disease (though it is unclear if any high-deductible health insurance plans do so), but the preventive care exemption does not encompass prescription drugs used to treat an existing illness, injury or condition. *See* Internal Revenue Service, 2004-33 I.R.B. 201.

121. Gary Claxton et al., *What High-Deductible Plans Look Like: Findings from a National Survey of Employers*, 2005, HEALTH AFF., (Sept 2005) (Web Exclusive), http://healthaffairs.org

122. Paul Fronstein & Sara R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, 288 EMPLOYEE BENEFIT RES.INST. PAGE #? (2005),

123. *Id.*

124. *Id.*

125. *Id.*

that the terms of their health plans made them consider costs when deciding to see a doctor when sick or filling a prescription.[126] Participants also reported that they had checked whether their health plan would cover their costs, as well as the price of a service, prior to receiving care, and discussed treatment options and cost of care with their doctors.[127]

The EBRI survey also found that few plans provide cost and quality information about providers to assist employees in making informed decisions about their health care.[128] In addition, the study found very low levels of trust in the information provided by health plans.[129] The Segal/Sibson 2006 Survey of Consumer-Driven Health Plans found that employees have enough information about the cost of prescriptions drugs, but employers agree that patient/consumer buying information is still lacking.[130] More than half of large employers in the survey agree that before employees can begin to make informed health care decisions they need more information, resources and tools about the following:

- Cost differences among physicians—and among hospitals,
- Performance and quality of care of physicians and hospitals, and
- Alternatives and drug therapies.[131]

The study found that 1 in 10 respondents thought there was sufficient information about provider cost.[132]

Many participants in CDHPs have found that basic data about the cost of services is generally not available. Medical providers and insurers consider this information to be highly sensitive and their contracts require that it remain secret. This leaves consumers with more financial responsibility for their care and no tools to manage these expenses. Government and insurance industry officials are moving to address the information gap. Medicare has taken a leadership role making data about the cost and quality of medical care more readily available. This spring, it started posting on the internet what it pays for 30 commonly performed hospital procedures.[133] Information regarding ambulatory surgery will be

126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*
130. SEGAL/SIBSON'S 2006 SURVEY OF CONSUMER- DRIVEN HEALTH PLANS, http://www.segalsibson.com/ publications/surveysandstudies/summer06CDHP.pdf.
131. *Id.*
132. *Id.*
133. Judith Graham, *Pricing Health Care? It's Not That Easy*, CHI. TRI., Aug. 10, 2006, at C1

published in late 2006.[134] Meanwhile 32 states have passed laws requiring hospitals to disclose what they charge for various procedures.[135] This information will only include list prices for medical procedures, not the discounted rates negotiated by insurance companies on behalf of customers.

Insurance companies are putting pressure on providers to make more information available. By the end of 2006, United Health Group will assign restaurant-style ratings to all hospitals in its networks based on their level of "cost efficiency" and "quality of care."[136] Aetna launched a pilot project a year ago that allows customers to view negotiated prices for primary care doctors and specialists.[137] Prices are listed for more than 100 procedures in Cincinnati and Dayton, Ohio and parts of Indiana and Kentucky.[138] In June 2006, Aetna expanded this initiative to South Florida; Southeast Indiana; Kansas City, Kansas and Missouri; Washington, D.C.; Pittsburgh; Las Vegas and several other markets. [139]

At this point in time, CDHPs have not shown that they are capable of reducing health care costs. Up to now only a few employers have adopted CDHPs. Before adopting CDHPs, employers have to ask:

- Is the adoption of high deductible plans by the employers the main reason for the initial reduction in health care costs?
- Will the shifting of more health care costs to employees prove costly in the long run because many will fail to obtain care because of the high costs?
- Will providing information to participants regarding providers and procedures be enough to influence the cost of health care?
- Will my employees understand CDHPs and take advantage of all the services and information offered?

134. *Id.*
135. *Id.*
136. *Id.*
137. *Id. See e.g.,* Press Release, Aetna, Aetna Pilot Site Details Fees Paid to Doctors (Aug. 19, 2005) http://www.aetna.com/presscenter/median/print_wmp_cincinnait.html.
138. Graham, *supra* note 133.
139. *Id.*

VI. HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

A. WHAT ARE THEY?

Health Reimbursement Arrangements ("HRAs") are provided under the Internal Revenue Code Section 105[140] and are authorized by the Internal Revenue Service under IRS Revenue Ruling 2002-41[141] and IRS Notice 2002-45.[142] Like Health Flexible Spending Accounts ("FSAs"),[143] an employer establishes individual accounts for participants to reimburse eligible medical expenses. Unlike FSAs, however, HRAs can only be funded by the employer, may allow unused amounts to be carried over to succeeding years, and can be used to reimburse health insurance premiums.[144] Since HRAs are funded only by employer contributions, the employer has a right to design the program to only reimburse certain medical expenses or premiums, to determine the amount of the carry-over of unused amounts, and to determine the period over which unused amounts can be carried over.[145] Although none of the cafeteria plan rules under Section 125[146] apply, nondiscrimination rules under Code Section 105(h) do apply.[147] So far, the Department of Labor has not required an employer's promise to fund these accounts. If the employer decides not to fund its obligation to provide benefits under an HRA, such obligation will be treated as a liability on the employer's balance sheet.

B. HOW ARE EMPLOYERS USING THEM?

Employers are using HRAs to reimburse health care expenses and premiums for both active and retired employees in a number of situations. First, as deductibles increase, employers may fully or partially fund medical expenses below the deductibles. Also, some employers may fund medical expenses below co-payment or co-insurance amounts provided under their health benefit plans. Other employers are using the HRAs to reimburse health expenses not provided under their insured health plans. Many smaller employers are using HRAs to reimburse employees and

140. *See generally* I.R.C. § 105 (West 2004).
141. *See generally* Rev. Rul. 2002-41, 2002-2 C.B. 75.
142. *See generally* I.R.S. Notice 2002-45, 2002-2 C.B. 93 (2004).
143. *See generally* I.R.C. § 125 (2006).
144. *See* Rev. Rul. 2002-45, 2002-2 C.B. 93.
145. *Id.*
146. *See generally I.R.C.* § 125.
147. I.R.C. § 105(h) (West 2004).

dependents for medical expenses and premiums because they cannot sponsor a group health plan.

Employers are also using HRAs to provide retiree health benefits. Some employers allow employees to carry-over unused benefits for a number of years and then allow them to use their benefits after termination of employment to reimburse expenses and premiums, even if COBRA coverage is not elected. Additionally, employers are using HRAs to determine benefit amounts during an employee's working life for use during the employee's retirement. An employee may earn a specified dollar amount for each year of employment with the employer. The employer designs the program so the promise to provide health benefits is not an open-ended promise, but rather a promise to provide this accumulated benefit. When the employee retires, the employee's total accumulated amount is available to pay health care premiums or eligible health care expenses. Unlike other types of retiree programs, the promise to provide retiree health benefits is based on a defined contribution model instead of a defined benefit model. In using this method, the employer's promise to provide a medical benefit for a retiree is no longer an unlimited promise. By defining its retiree benefit liability on this defined contribution model, an employer will better be able to honor its promise to provide retiree health benefits in the future.

C. WHAT ARE THE PROS AND CONS OF HRAS FOR BOTH EMPLOYERS AND EMPLOYEES?

Many employers prefer HRAs over HSAs because they can design the program to fit their needs and can control how employees spend the benefits. As was indicated above, an employer can provide in the HRA that if an employee leaves his/her employment, the employee loses the benefits under the HRA. In addition, many employers design their HRAs to be flexible, so if they are unable to make a contribution for any year, they can skip years and provide contributions in future years.

With this control comes responsibility for employers. They must be involved in the design and administration of the benefits under the HRA. They also must monitor the usage of these benefits to be able to make changes in the future. In addition, the employer should educate employees in which expenses can be reimbursed under the HRA.

On the other hand, participation in HRAs has a downside for employees. An employee may lose the right to any benefits under the program if he or she terminates employment before retirement or before s/he becomes eligible for benefits under the program. Since the employer

controls the terms of the HRA, it could change the terms for benefits before the employee becomes entitled to benefits or it could terminate the program entirely. The employee has little or no recourse in forcing the employer to provide benefits.

HRAs are good short term solutions for many smaller employers because they allow employers to soften the blow of increasing deductibles, co-payments and co-insurance. HRAs introduce consumerism to participants without putting them at risk. In order to function properly, employers must understand which health care expenses are not paid through their insured health plan in order to fund them. Employers have to be careful not to completely shield their employees from the true cost of health care. By exposing employees to some risk, employees will be forced to use their health care dollars under the HRA more wisely.

VII. HEALTH SAVINGS ACCOUNTS (HSAS)

A. HEALTH SAVINGS ACCOUNTS, AN IMPORTANT ELEMENT IN CDHPS

Health Savings accounts ("HSAs") have become an important element in providing CDHP. In 2005, the majority of the large employers offering a CDHP used an HRA (62%), while the majority of small employers offering a CDHP used an HSA (76%).[148] For 2006, HSA-based plans are likely to gain some ground. Large employers who said they were very likely to offer a CDHP in 2006 were split nearly down the middle in terms of HRAs and HSAs.[149] According to the preliminary results of a new study by America's Health Insurance Plans ("AHIP"), at least three million consumers currently receive health coverage through high-deductible health insurance plans offered in conjunction with HSAs.[150] Current projections estimate enrollment could grow to 3.6 million by January 2007.[151] According to the study, enrollment in the new insurance policies eligible for HSAs has roughly tripled from March 2005 to January 2006, when a similar AHIP survey found that 1,031,000 people were covered by

148. Press release, Mercer Human Resource Consulting, *Beyond the Early Adopters: Consumerism at Work in the Workplace*, http://www.mercerhr.us/common/printer friendlypage.jhtml;jsessionid=NHK2JNWYQJHWECTGOUGCHPQKMZ0QUJLW? indContentType=100&idContent=1209030&indBodyType=D&reference= (last visited Oct. 9, 2006).

149. *Id.*

150. Hannah Yoo & Teresa Chovan, *January Consensus Shows 3.2 Million People Covered by HSA Plans*, (2006), http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf.

151. *HSAs Growing Apace To Reach 3.6 Million Accounts By January, 2007*, http://www.hsafinder.com/08-06_02.shtml (last visited Oct. 9, 2006).

HSA-compatible insurance policies.[152] In addition, President Bush urged expansion of HSAs and increased portability of health coverage to make health care more affordable in his State of the Union Address in January 2006. [153]

B. EXPANDED HSAS PROPOSED

Under the President's proposal, premiums for HDHP policies purchased independently of employment would be deductible from income taxes.[154] In addition, the President supports an income tax credit to make up for payroll tax savings that employees enjoy when they pay pre-tax health insurance premiums through employers.[155]

Additional tax incentives would be extended to HSA account holders as well. President Bush's plan would permit employees and their employers to make deductible HSA contributions up to their out-of-pocket costs under the HDHP, and not just the annual deductible pursuant to current law.[156] Employees who do not contribute through a cafeteria plan would also receive a credit for payroll taxes paid on HSA contributions.[157]

Moreover, enhanced HSAs would be created for those dealing with low incomes or chronic illness. Families of four with an annual income of $25,000 or less would be allowed a refundable tax credit of $3,000 to assist in the purchase of HDHP policies to cover major medical expenses.[158] Up to $1,000 would be allowed in an HSA to cover routine costs.[159] For those with chronic illness, employers would be allowed to make higher contributions to HSAs to assist in funding out-of-pocket expenses.[160]

In pushing for greater use of HSAs, the Bush Administration has argued that the accounts will make people more judicious about their health-care spending. "The [accounts] can grow tax-free, which is an encouragement for people to make wise decisions about how they treat

152. Yoo & Chovan, *supra* note 150.

153. President's Address before a Joint Session of the Congress on the State of the Union, 42 WEEKLY COMP. PRES. DOC. 145, 150 (Feb. 6, 2006).

154. *State of the Union: Affordable and Accessible Health Care*, http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html (last visited Oct. 9, 2006) [hereinafter *State of the Union*].

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

their body," the President said.[161] "The proposal to increase the amount a person can put into an HSA each year is intended to make the accounts a more useful savings vehicle and more palatable for people with high out-of-pocket medical spending."[162] The proposal to increase the deposit threshold to the annual out-of-pocket spending limit for HSA plans would allow people to save a few thousand dollars more each year tax-free. "That would certainly help people with chronic conditions that use up the money each year," Paul Fronstin, director of the Washington nonpartisan group Health Research and Education Program at the Employee Benefit Research Institute, told the Wall Street Journal.[163] "The other benefit is it allows you to accumulate more, faster. If you're using this account to save money for medical expenses in retirement, that would be valuable," he said.[164]

Legislation has been introduced in Congress that incorporates some aspects of the administration's HSA proposals and makes other HSA changes.[165] Some of the bills are targeted as specific proposals, such as increasing the HSA contribution limits, while others take a more comprehensive approach.[166]

The Tax Free Health Savings Act (H.R.5262) includes many of the administration's recommendations. For Example, it would:

- Increase the maximum HSA deduction to the lesser of the sum of the HDHP deductible and other out-of-pocket expenses (except for premiums) or the statutory out-of-pocket limit for the year;
- Allow coordination between HSAs, HRAs and FSAs by permitting individuals covered by FSAs and HRAs to also participate in HSAs. The bill would establish a combined limit for contributions and credits to HSAs, FSAs and HRAs and allow a limited, one-time rollover of certain FSA or HSA balances into an HSA;
- Allow employers to contribute more to the HSAs of chronically ill employees;
- Treat medical expenses incurred after an individual joined an

161. Sarah Lueck, *Bush to Seek Bigger Health-Savings Tax Break*, WALL ST. J., Jan. 21, 2006, at A3, *available at* http://www.gahealthplans.org/index.php?Module=pagesetter&func=viewpub&tid=3&pid=246.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Legislation Aims to Make HSAs More Attractive*, INSIDER, July 2006, at 12, *available at* http://www. watsonwyatt. com /us/pubs/Insider/showarticle.asp?ArticleID=16350.

166. *Id.*

HDHP but before he or she established an HSA as qualified medical expenses;

- Allow individuals to pay non-group HDHP premiums from their HSAs.
- Provide tax deductions and credits for those who purchase HDHP coverage and contribute to HSAs outside of an employer-sponsored group health care plan.
- Increase the penalties for distributions that were not used for qualified medical expenses.[167]

Another bill introduced is the Expanded Health Access, Portability, and Ownership Act (S.3488).[168] Several of its provisions are similar or identical to provisions to the Tax Free Health Savings Act. This bill would increase the limit on HSA contributions to the lesser of the plan's annual deductible plus other out-of-pocket expenses for the year or the statutory out-of-pocket limit.[169] "It would allow employers to contribute more to the HSAs of chronically ill individuals."[170] Furthermore, "[i]t would permit a one-time rollover of HRA balances to an HSA and establish tax deductions and other tax breaks to help equalize the tax treatment between employer-sponsored coverage and non-group coverage."[171] Additionally, "S.3488 includes provisions aimed at establishing more portable HDHPs - coverage that individuals can retain if they change jobs or leave the workforce."[172]

Targeted HSA bills have also been introduced in both the House and the Senate. For example, legislation (S.2424) "would increase the annual deductible contribution limits for HSAs - similar to the increase in the Tax Free Health Savings Act and the Expanded Health Access, Portability and Ownership Act."[173] In addition, legislation (S.2494) "would allow people to deduct their HDHP premiums and provide a tax credit to individual purchasers of HDHPs who pay their premiums with after-payroll-tax dollars."[174] Lastly, separate bills have been introduced to allow individuals and families to pay non-group HDHP premiums from HSAs.[175]

167. *Id.* at 12-13.
168. *Id.* at 13.
169. *Id.*
170. *Id.*
171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.*
175. *See id.*

C. TAX RELIEF AND HEALTH CARE ACT OF 2006 ENACTED

On December 20, 2006, the President signed into law, the Tax Relief and Health Care Act of 2006 (H.R. 6111) (the "Act").[176] The Act makes many important changes to Health Savings Accounts. These changes include:

- Allowing an eligible individual a one time right to rollover his or her Health Flexible Savings account balance or his or her Health Reimbursement account balances into his or her Health Savings Account.[177]
- Allowing an eligible individual a one time right to rollover a certain portain of his or her Individual Retirement Account balance to his or her Health Savings Account.[178]
- Allowing an eligible individual to contribute the full amount to his or her Health Savings Account for a tax year if he or she participates in a high deductible health plan for any part of a tax year if certain conditions are met.[179]
- Allowing an eligible individual to contribute the full amount no matter what amount of his or her deductible under the high deductible health plan was for the taxable year.[180]
- Ignoring an eligible individual coverage in a health flexible spending account during the tax year if certain requirements are met.[181]

All of the above changes are effective for tax years beginning after 2006. Their purpose is to make it easier for eligible individuals to make full contributions to their HSAs for the taxable year. The following discussion will fully explain each of these changes.

176. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 1 Note (to be codified as amended at IRC (2007)). Details as to how specific sections of the law affect specific sections of the I.R.C. statute are explained in detail within this section of the article. We thank the author for providing this analysis in a timely manner, immediately after the passage of the Act. *Eds.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

D. WHAT ARE HEALTH SAVINGS ACCOUNTS?

Because Health Savings Accounts are being used as a foundation for health care reform proposals, it is important to understand the requirements that apply to HSAs, and its advantages and disadvantages.

HSAs provide eligible individuals with a tax-free basis for paying current medical expenses as well as an ability to save on a tax-favored basis for future medical expenses.[182] HSAs are provided for under Internal Revenue Code Section 223[183] and have been available since January 1, 2004. HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of an employee, and those of his/her spouse and dependents, that are subject to rules similar to those applicable to individual retirement arrangements or accounts ("IRAs").[184]

Eligibility to contribute to an HSA program is determined on a month-by-month basis. For any month, an individual is eligible to contribute to an HSA under I.R.C. § 223(c)(1)(A) if he or she:

- is covered only by a high-deductible health plan ("HDHP") as of the first day of such month;
- is not also covered by any other health plan that is not a HDHP (with certain exceptions for plans providing certain limited types of coverage);
- is not enrolled in benefits under Medicare; and
- is not claimed as a dependent on another person's tax return.[185]

Under Internal Revenue Code Section 223(c)(2)(A), a HDHP is an insured or self-insured health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses.[186] In the case of individual coverage, the plan must have an annual deductible of not less than $1,050 for 2006 and $1,100 for 2007, and in the case of family coverage, the plan must have an annual deductible of not less than $2,100 for 2006 and $2,200 for 2007.[187] In addition, the plan's annual deductible for out-of-network services is not taken into account in determining the annual contribution limit. Rather, the annual contribution limit is

182. I.R.C. § 223 (2005).
183. *Id.*
184. *Id.*
185. I.R.C. § 223(c)(1)(A) (2005).
186. *Id.*
187. *Id.*

determined by reference to the deductible for services within the network.[188]

There is also a maximum out-of-pocket expense limit on covered expenses that cannot exceed $5,250 for 2006 and $5,500 for 2007 in the case of individual coverage and $10,500 for 2006 and $11,000 for 2007 in the case of family coverage under Internal Revenue Code Section 223(c)(2)(A)(ii).[189] Out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the plan.

Within limits, contributions to HSAs are deductible if made by or for an eligible individual and are excludable from such individual's income and wages for employment tax purposes if made by the employer of an eligible individual or if made by the employee in the form of pre-tax salary deferral contributions under a cafeteria plan.[190] The maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility, and health plan coverage as of the first day of the month for tax years beginning before 2007.[191] Any individual who begins HDHP coverage in mid-month would not be eligible to make an HSA contribution until the beginning of the following month, as provided in IRS Notice 2004-50, Q&A-11.[192]

The maximum monthly contribution for eligible individuals with individual coverage under an HDHP, as provided in Code Section 223(b)(2), is one-twelfth of the lesser of 100% of the annual deductible under the HDHP (minimum of $1,050 for 2006), but not more than $2,700 for 2006 for tax years beginning before 2007.[193] For eligible individuals with family coverage under an HDHP, the maximum monthly contribution, as provided in Code Section 223(b)(2)(B), is one-twelfth of the lesser of 100% of the annual deductible under the HDHP (minimum of $2,100 for 2006), but not more than $5,450 for 2006.[194]

For tax years beginning in 2007, the Section 303 of the Act repeals the requirement limiting HSA contributions under Code Section 223(b)(2) to the lesser of specified dollar amount or the annual deductible under the HDHP. With these changes, the maximum aggregate annual contribution that an individual can make to an HSA is $2,850 for 2007 in the case of

188. I.R.C. § 223(c)(2)(D) (2005).
189. I.R.C. § 223(c)(2)(A)(ii) (2005).
190. *See generally* I.R.C. § 223.
191. I.R.C. § 223(b)(2).
192. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-11 (2004).
193. I.R.C. § 223(b)(2).
194. I.R.C. § 223(b)(2)(B).

individual coverage and $5,650 for 2007 in the case of family coverage. The individual's deductible is not considered in determining the amount of his or her contribution.

For tax years beginning in 2007, Section 305 the Act adds Code Section 223(b)(8) which provides that an individual, who becomes covered under an HDHP in a month other than January, may make a full deductible HSA contribution for the year if certain conditions are met. If an individual does not remain an eligible individual during the testing period, the amount of the contributions attributable to months preceding the month in which the individual was not an eligible individual which could have not have been made but for the provision, will be includible in the individual's gross income. The testing period is the period beginning with the last month of the taxable year and ending on the last day of 12th month following such month. The amount is includible for the taxable year of the first day during the testing period that the individual was not an eligible individual. A 10-percent additional tax also applies to the amount includible. An exception applies if the individual ceases to be an eligible individual by reason of death or disability.

Example: An individual enrolls in an HDHP in December of 2007 and is otherwise an eligible individual in that month. The individual is not an eligible individual in any other month in 2007. The individual can make an HSA contribution for 2007 as if he or she had been enrolled in the HDHP for all of 2007. If the individual ceases to be an eligible individual (e.g., if he or she ceases to be covered under an HDHP) in June 2008, an amount equal to the HSA deduction attributable to treating the individual as an eligible individual for January through November 2007 is included in the individual's income in 2008.

In addition to the maximum contribution amount, catch-up contributions are also provided for under Code Section 223(b)(3).[195] If an employee has reached age fifty-five by the end of the taxable year, the HSA annual contribution limit is increased by $700 in 2006.[196] As with the annual contribution limit, the catch-up contribution is also computed on a monthly basis for taxable years beginning before 2007. Like the annual contribution limit discussed above, Act Section 305 adds Code Section 223(b)(8) providing that the monthly limit requirements are waived for catch-up contributions if certain conditions are met.[197]

195. I.R.C. § 223(b)(3).
196. I.R.C. § 223(b)(3).
197. *Id.*

Under Code Section 223(f)(2)[198] and IRS Notice 2004-2, Q&As 25-26,[199] distributions from an HSA for "qualified medical expenses" of the individual and his or her spouse or other dependents generally are excludable from gross income and can be made at anytime.[200] In general, amounts in an HSA can be used for "qualified medical expenses" even if the individual is not currently eligible for contributions to an HSA, as long as the expense is incurred after the HSA was established, as provided in IRS Notice 2004-2, Q&As-25 and 26. [201]

Under Internal Revenue Code Section 223(f)(1),[202] distributions from an HSA that are not used to pay medical care expenses are includible in the employee's gross income.[203] Distributions includible in gross income are also subject to an additional 10% tax unless made after death, disability, or if the individual attains the age of Medicare eligibility (i.e., age 65), as provided in Code Section 223(f)(4).[204]

If the HSA account holder's surviving spouse is the named beneficiary of the HSA, then, after the death of the HSA account holder, the HSA becomes the HSA of the surviving spouse and the amount of the HSA balance may be deducted when computing the decedent's taxable estate, pursuant to the estate tax marital deduction, as provided in Code Section 223(f)(8).[205] In IRS Notice 2004-2, Q&A-31, the IRS provides that the surviving spouse is not required to include any amount in gross income as a result of the death; the general rules applicable to the HSA apply to the surviving spouse's HSA (e.g., the surviving spouse is subject to income tax only on distributions from the HSA for nonqualified expenses).[206] The surviving spouse can exclude from gross income amounts withdrawn from the HSA for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.[207]

If, upon death, the HSA passes to a named beneficiary other than the decedent's surviving spouse, then Code Section 223(f)(8) provides that the HSA ceases to be an HSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of HSA assets (as of

198. I.R.C. § 223(f)(2).
199. I.R.S. Notice 2004-2, 2004-1 C.B. 269, Q&A-25-26 (2004).
200. *Id.*
201. *Id.*
202. I.R.C. § 223(f)(1).
203. *Id.*
204. I.R.C. § 223(f)(4).
205. I.R.C. § 223(f)(8).
206. I.R.S. Notice 2004-2, 2004-1 C.B. 269, Q&A-31 (2004).
207. I.R.C. § 223(f)(8)(ii)(I).

the date of death) in gross income for the taxable year that includes the date of death.[208] The amount includible in income is reduced by the amount of the HSA used, within one year after death, to pay qualified medical expenses incurred by the decedent prior to the death.[209] As is the case with other HSA distributions, whether the expenses are qualified medical expenses is determined at the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the federal estate tax on the decedent's estate that was attributable to the amount of the HSA balance.

If there is no named beneficiary of the decedent's HSA, the HSA ceases to be an HSA as of the date of death, and the fair market value of the assets in the HSA at such date is includible in the decedent's gross income for the year of the death.[210] This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the rights to the HSA assets (*e.g.*, if the surviving spouse is the sole beneficiary of the decedent's estate).[211]

No amount can be rolled over from Health Flexible Spending Accounts (Health FSAs) or HRAs into HSAs for tax years beginning before 2007 under Code Section 223(f)(5).

For distributions and contributions made after December 31, 2006 and before January 1, 2012, Section 302 the Act amends Code Section 106(e) by allowing certain amounts in a Health FSA or HRA to be distributed and contributed through a direct transfer to an HSA without violating the otherwise applicable requirements for such arrangements. The amount that can be distributed from the Health FSA or HRA may not exceed an amount equal to the lesser of (i) the balance in the Health FSA or HRA as of September 21, 2006, or (ii) the balance in the Health FSA or HRA as of the date of the distribution. The balance in the Health FSA or HRA as of any date is determined on a cash basis (i.e., expenses incurred that have not been reimbursed as of the date the determination is made are not taken into account).

Any amounts contributed to the HSA are excluded from the employee's income for income and employment tax purposes and are not taken into account in applying the maximum deduction limitation for HSA contributions. This provision is limited to one distribution with respect to each Health FSA or HRA of the individual.

208. I.R.C. § 223(f)(8)(i)(II).
209. I.R.C. § 223(f)(8)(ii)(I).
210. I.R.C. § 223(f)(8)(b)(i).
211. I.R.C. § 223(f)(8)(b).

Example: An individual has a balance in his or her Health FSA as of September 21, 2006 of $2,000 and the balance in his or account as of January 1, 2008 is $3,000. Under the new changes, the individual may distribute an amount not to exceed $2,000 from his or her Health FSA to his or her HSA. If the individual ceases to be an eligible individual as of June 1, 2008, the $2,000 contribution amount is included in his or her gross income and subject to a 10-percent additional tax. If instead, the distribution and contribution are made as of June 30, 2008 when the balance in the Health FSA is $1,500, the amount of the distribution and contribution is limited to $1,500.

If the individual does not remain an eligible individual during the testing period, the amount of the distribution and contribution is includible in the individual's gross income.[212] The testing period is the period beginning with the month of the contribution and ending on the last day of the 12th month following such month. The amount is includible for the taxable year of the first day during the testing period that the individual is not an eligible individual.[213] A 10-percent additional tax also applies to the amount includible. An exception applies if the individual ceases to be an eligible individual by reason of death or disability.[214]

No amounts can be rolled over into an HSA from an IRA, as provided under Code Section 223(f)(5) for taxable year beginning before 2007. Rollovers need not be made in cash. Amounts transferred from another HSA taken into account under the annual contribution limits.

For tax years beginning in 2007, the Section 307 of Act amends Code Section 408(d) by allowing an individual to make a one-time contribution to an HSA of an amount distributed from his or her IRA. The contribution must be made in a direct trustee-to trustee transfer. Amounts distributed from the IRA are not includible in the individual's income to the extent that the distribution would otherwise be includible in income. Such distributions are not subject to the 10-percent additional tax on early distributions.

In determining the extent to which amounts distributed from the IRA would otherwise be includible in an individual's income, the aggregate amount distributed from the IRA is treated as includible in an individual's income to the extent of the aggregate amount which would have been includible in the individual's income if all amounts were distributed from

212. Tax Relief and Health Care Act § 106(e)(3).
213. *Id.* at § 106(e)(4).
214. *Id.*

all of the individual's IRAs of the same type (i.e., in the case of a traditional IRA, there is no pro-rata distribution of basis).

The amount that can be distributed from the IRA and contributed to an HSA is limited to the otherwise maximum deductible contribution to the HSA computed on the basis of the type of coverage under the HDHP at the time of the contribution. The amount that can otherwise be contributed to the HSA for the year of the contribution from the IRA is reduced by the amount contributed from the IRA. No deduction is allowed from the amount contributed from an IRA to an HSA.

An individual is allowed only one distribution and contribution during his or her lifetime, except that if a distribution and contribution are made during a month in which an individual has individual coverage as of the first day of the month, an additional distribution and contribution may be made during a subsequent month within the taxable year in which the individual has family coverage. The limit applies to the combination of both contributions.

If the individual does not remain an eligible individual during the testing period, the amount of the distribution and contribution is includible in the individual's gross income. The testing period is the period beginning with the month of the contribution and ending on the last day of the 12th month following such month. The amount is includible for the taxable year of the first day during the testing period that the individual is not an eligible individual. A 10-percent additional tax also applies to the amount includible. An exception applies if the individual ceases to be an eligible individual by reason of death or disability.

These changes do not apply to simplified employee pensions ("SEPs") or to SIMPLE retirement plans.

E. WHAT ARE ITS ADVANTAGES?

The establishment of, and participation in, HSAs brings many advantages to both the employer and employee. They include:

- Lowering of health care premiums under the HDHP for coverage for employees;
- Lowering the employer's administrative costs;
- Providing employees an opportunity to contribute to the HSA for future health care expenses incurred by the employee or their dependents;
- Providing any employee who contributes to an HSA with a

tax deduction and/or an income tax and payroll tax free contribution;

- The inability of the employer to forfeit any contributions made by or for the employee to an HSA;
- Providing an employer with an opportunity to contribute to eligible employees at any time and at any amount up to statutory limits;
- Giving employees immediate access to their HSAs for any reason;
- Providing for tax-free distributions at any time for health care expenses incurred after the HSA has been established if the expense was neither reimbursed from any other source nor deducted by the employee;
- Providing for reimbursement of health care expenses after an employee's death, if he or she names the spouse as the beneficiary under the HSA;
- Providing either a trust or custodial account that accumulates earnings on a tax free basis;
- Relieving the employer of the duty of substantiating health care claims;
- Avoiding the requirements of ERISA (and COBRA and HIPAA) if the employer does not make participation in the HSA mandatory; and
- Giving the employees who participate in an HSA complete portability in transferring their accounts at any time.
- Allowing amounts in Health FSAs, HRAs and IRAs to be rolled over to HSAs

F. WHAT ARE ITS DISADVANTAGES?

At the same time that HSAs offer many advantages, they also come with a number of disadvantages that should be explained to both employers and employees before they establish HSAs. HSAs are very complex and, if not administered properly, can cause adverse tax consequences to employees. The following will discuss these complexities and disadvantages of HSAs so as to provide a complete picture of the account:

Administration of the HSA - When an employer participates in an HSA program, the responsibility for administering the account is transferred to the employee. It is the employee who decides:

- Whether he or she is eligible to make contributions to an HSA;
- The amount of the eligible contribution to the HSA for any calendar year;
- The withdrawal of any excess contributions;
- How funds in his or her HSA will be spent; and
- Whether the distributions are taxable or nontaxable.

Employees are prohibited from delegating any of the above responsibilities to either the employer or the HSA trustee or custodian.[215] Since the employee is in control of the HSA, he or she is responsible for reporting all contributions and distributions to the IRS on his or her Form 1040, using Form 8889.[216] If the employee makes any errors, he or she must pay any additional tax or penalties to the IRS.

Eligibility to Participate - If an employee is covered under a spouse's health plan, that coverage can affect the employee's ability to contribute to an HSA.[217] This coverage also includes reimbursements under a spouse's Health Flexible Spending Account ("FSA").[218] For any month that a spouse could submit an employee's expenses for reimbursement, the employee is ineligible to make a contribution to an HSA.[219] Since a spouse's coverage could change at any time during a calendar year, it is the employee's responsibility to determine eligibility to make a contribution to an HSA.[220] Neither the employer nor the HSA trustee or custodian can make that determination for the employee.[221] As discussed below, if an employee makes a contribution to an HSA when ineligible, the entire contribution is considered to be an excess contribution and the employee will be penalized for this contribution.

Amount of Contribution - In the case of married couples, if either spouse has family coverage, then both are treated as having family coverage, unless they do not cover each other and cover other dependents, as provided in Revenue Ruling 2005-25.[222] If each spouse has family coverage under a separate health plan, then both spouses are treated as

215. *See* Instructions to I.R.S. Form 8889 (2005), http://www.irs.gov/instructions/i8889/ch01.html#d0e27.
216. I.R.S. Form 8889 (2005).
217. *See* Instructions to I.R.S. Form 8889 (2005), http://www.irs.gov/instructions/i8889/ch01.html#d0e27.
218. *Id.*
219. *Id.*
220. *Id.*
221. *Id.*
222. Rev. Rul. 2005-25, 2005-18 I.R.B. 971 (2005).

covered under the plan with the lowest deductible, if they cover each other as provided in IRS Notice 2004-2, Q&A-15.[223] The contribution limit for the spouses is the lowest amount, divided equally between the spouses unless they agree on a different division.[224]

The determination of an individual's proper HSA contribution is a complex calculation. Since only the employee will have the information needed to determine the proper amount, neither the employer nor the HSA trustee or custodian can help in the determination. After the end of the calendar year, the employee should seek proper tax assistance to make the determination or the employee will have to pay the consequences.

Excess Contributions - If an employee contributes more than the stated limits for the taxable year, these contributions are not deductible under Code Section 223(a).[225] Contributions made by an employer over the limits are included in the employee's income.

In addition, an excise tax applies to contributions in excess of the maximum contribution amount, as provided in Code Section 223(f)(3).[226] The excise tax is generally equal to 6% of the cumulative amount of excess contributions that are not distributed from the HSA to the contributor, as provided under Code Section 4973(g).[227]

However, if the excess contributions for a taxable year and the net income attributable to such excess contributions are paid to the individual before the last day prescribed by law (including extensions) for filing the individual's federal income tax return for the taxable year, then the net income attributable to the excess contributions is included in the individual's gross income for the taxable year in which the distribution is received, but the excise tax is not imposed on the excess contribution and the distribution of the excess contribution is not taxed.[228] If the eligible individual is under age sixty-five and is not dead or disabled, he or she will be subject to the 10% tax penalty on earnings, as provided in Code Section 223(f)(3).[229]

Remember, it is the employee who must report and pay the penalty or withdraw the excess to avoid the penalty. Neither the employer nor the HSA trustee or custodian can be involved in the determination of the

223. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 271, Q&A-15 (2004).
224. *Id.*
225. I.R.C. § 223(a) (2005).
226. I.R.C. § 223(f)(3).
227. I.R.C. § 4973(g) (2005).
228. I.R.C. § 4973(g).
229. I.R.C. § 223(f)(4).

excess or withdrawal of the excess. It is the employee who must initiate the process.

Distributions - Since employees cannot forfeit HSA contributions, it is the employee who controls when and for what purpose HSA withdrawals can be made. In Notice 2004-2, Q&A-24, the IRS indicates that an employee is permitted to receive distributions from an HSA at any time.[230] In IRS 2004-50, Q&A-79, the IRS further states that trust or custodial agreements are prohibited from containing provisions restricting distributions made only for an employee's qualified medical expenses, and confirms that the employee is entitled to distribution for any purpose.[231]

Withdrawals for eligible medical expenses incurred by the employee and/or his or her dependents after the HSA has been established are nontaxable unless employees are reimbursed from any other source or the withdrawals are deducted by the employee, as provided in Code Section 223(f)(2)[232] and IRS Notice 2004-2, Q&As 25-26.[233] This means an employee could be reimbursed for eligible medical expense that occurred many years in the past. Since the employee must report the treatment of withdrawals on IRS Form 1040, the employee must justify the treatment if audited by the IRS. Employees should be advised to keep evidence of any medical expenses incurred in the past.

Lack of Control - As indicated above, an employee is in complete control of his own HSA; the employer has no control over how funds in the HSA are spent.[234] Most HSA trustees or custodians give employees full access to their HSAs by providing employees and their dependents checking accounts and/or debit cards. As a result, no one can stop an employee from using his or her HSA to buy chips and beer while picking up a prescription at the local drug store.

Under IRS Notice 2004-50, Q&A-80, an HSA trustee or custodian may place reasonable restrictions on both the frequency and the minimum amount withdrawn from an HSA.[235] An HSA trustee or custodian may prohibit distributions for amounts of less than $50 or only allow a certain number of distributions per month.[236]

230. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 272, Q&A-24 (2004).
231. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-79 (2004).
232. I.R.C. § 223(f)(2).
233. I.R.S. Notice 2004-2, 2004-1 C.B. 269, Q&A-25-26 (2004).
234. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-79 (2004).
235. I.R.S. Notice 2004-50, 2004-2 C.B. 196, Q&A-80 (2004).
236. *Id.*

If an employer is contributing all or a part of the HSA contribution for the employee, the employer must understand that it cannot control how the contributions are spent or invested in the HSA. The employer must trust that its employees will use and invest their HSAs wisely.

Employee's inability to contribute - Some employers must realize that there will be a segment of their employee population that can never afford to contribute to an HSA on their own. Unless the employer makes contributions to employees' HSAs, some employees will not have any balances in their HSAs. If an employer cannot contribute to employees' HSAs and adopts a HDHP, there may come a day when an employee cannot pay his or her portion of incurred medical expenses under the employer's health plan, has not contributed to an HSA, and may lose a house or car due to unpaid medical bills.

In adopting an HDHP, the employer has to educate and communicate to its employees their greater responsibility to fund and pay for medical expenses. Unlike Health FSAs, employers are not responsible for fronting any funds for employees in their HSAs. Once the employee's HSA funds are gone, it becomes the employee's responsibility to pay for the expense. As employers cut-back medical benefits further by raising deductibles and increasing the employee's share of coinsurance amounts, employees will face a real financial burden if they suffer a major medical expense and have not contributed to an HSA.

Portability - Under IRS Notice 2004-50, Q&A-79, an HSA trust or custodial agreement cannot restrict the employee's ability to rollover or transfer assets from that HSA.[237] If an employer requires an employee to establish an HSA at a particular financial institution so as to either receive an employer contribution and/or contribute through payroll deduction, then the employee has the ability to transfer funds to another HSA, sponsored by another financial institution at any time. The first institution may make it difficult for an employee to make this transfer by imposing fees, but cannot altogether prohibit transfers or rollovers.

Use of Health Reimbursement Arrangements ("HRA") or Health Flexible Spending Accounts ("Health FSA") with HSAs - In Revenue Ruling 2004-45, the IRS mandates that an employee cannot participate in both a Health FSA, HRA, and HSA in the same calendar month, unless the employee's situation is one of the following:

- under a Health FSA and/or HRA, the employee's reimbursed expenses are limited to dental, vision and/or preventive care

237. *Id.*

benefits ("Limited Purpose Health FSA or HRA");

- if an employee suspends participation in an HRA for the year ("Suspended HRA");
- if the health FSA or HRA pays expenses above the deductible of the HDHP ("Post-Deductible Health FSA or HRA"), and if the deductible limits for the HDHP and the HRA are different, contributions to the HSA are limited to the lower of the deductibles; or
- if the HRA pays or reimburses the employee's expenses incurred after the employee retires ("Retirement HRA").[238]

In adopting an HSA program, an employer must limit or eliminate the use of devises (such as Health FSAs) that their employees have used for many years. There could be situations in which some employees could contribute less under an HSA than under a Health FSA, depending on the limits that the employer imposed under the Health FSA.

Under IRS Notice 2005-86, if an employer amends its cafeteria plan to provide a "grace period," (a period not exceeding two and one-half months after the end of the plan year) all participants under the cafeteria plan are not eligible to contribute to an HSA during the grace period, even if a participant spent his or her entire Health FSA balance by the end of the plan year and did not take advantage of the grace period for tax years beginning before 2007.

For taxable years beginning after December 31, 2006, Section 302 of the Act amends Code Section 223(c)(1)(B) by providing that if an employer has amended its cafeteria plan to provide a "grace period," such provisions will be disregarded for determining a participant's eligibility to contribute to an HSA if: (i) the balance in the participant's Health FSA account at the end of the plan year is zero, or (ii) in accordance with rules prescribed by the IRS, the entire remaining balance in the participant's Health FSA account at the end of the plan year is contributed to an HSA as provided above.

Lack of Significant Savings in Coverage - In 2005, a national broker of individual market health insurance reported that its nationwide average for single-coverage monthly premiums on HSA-eligible plans, with deductibles between $2,000 and $2,999, was $166, compared to $213 for non-HSA plans with deductibles under $500.[239]

238. I.R.S. Rev. Rul. 2004-45, 2004-22 I.R.B. 971 (2004).
239. GAO Study, *supra* note 84, at 27.

Increased Health Care Spending - Since HSAs do not require any prior approval on the amount spent, HSAs could encourage some enrollees to obtain additional health care services tax free. In the past, some elective procedures may have not been covered by the employer's health plan and the employee can use his or her HSA to reimburse those expenses.[240]

The switch to providing health coverage through a HDHP and a HSA is a major change in providing coverage to employees. The employee will have to take more responsibility in funding and spending his or her health care dollars. Since employees will be spending more of their own funds, the question is: "Will they hesitate in obtaining care?" HSAs and HDHPs may become part of a greater movement to reduce costs for active employees, retired employees, and retirees, through the use of "consumer driven health care" plans.

VIII. FINAL THOUGHTS

Controlling health care costs must be our number one domestic priority. If health care costs continue to increase at a faster rate than inflation, such increases will destroy any future for Medicare and employer-sponsored health care, limiting the ability of American businesses to compete in the world wide economy. Finding solutions to this problem will take years and will be very complex. Here are some of the key questions we must ask ourselves to address this problem:

- Is consumer-driven health care "the" solution to save our health care system? *No.*
- Is it (at best) a temporary solution to help reduce costs? *Maybe.*
- It is still too early to tell whether consumer-driven health care can sustain reduction in health care costs over a number of years. Many CDHP programs contain a number of elements that can reduce costs, such as wellness programs, disease management and consumer awareness, but, both employers and participants must understand that adoption of CDHPs brings many risks and poses further possible issues. These issues include:

240. For example, a tax deduction is available for out-of-pocket medical costs in excess of 7.5% of adjusted gross income ("AGI"). In addition, if offered by a firm, an employee can contribute pre-tax dollars to a Flexible Spending Account to pay for out-of-pocket medical costs incurred during the year.

- Will the adoption of high deductible plans bring more problems for employers in the long run because participants may be forced to ration health care to save costs?
- Will employers spend the time and money to educate participants on how to use both consumer education and Health Savings Accounts effectively?
- Will health care cost information be available and reliable to help participants determine the cost of health care services?
- Will providing health care cost information to participants have any effect in the future on the costs of services and procedures?
- Can employers provide health care programs to those employees and dependents with chronic conditions at a reasonable cost?
- Can consumer-driven health care plans reduce costs significantly over a number of years to enable more employers to sponsor health care programs for their employees, thus reducing the number of uninsured individuals in the United States?
- Will health insurance providers and consultants be honest with employers in selling consumer-driven health care plans to fully disclose both the positives and the negatives of their programs?
- With baby boomers utilizing the health care system more and more over the next 10 to 15 years, will the health care system be ready to meet the demand? Will cost be less important than availability of services?

Consumer driven health care does not directly address the issue of increased demand and the uninsured. Everyone (including state and local governments, the federal government, employers, the insurance industry, and the health care industry) must come up with ways to provide health care to greater numbers of individuals at a reasonable cost. Consumer-driven health care may be one solution, but to make health care more available, it may will take a number of solutions.

Those solutions may include the expansion of Medicaid and or Medicare and the adoption of a universal health care program. Because of the current political climate in the United States, the adoption of a national single payer universal health care system is not likely. Over the last several

years, a number of states have considered universal health care initiatives, including:

California: SB 840, The "California Health Insurance Reliability Act" (CHIRA), a single payer bill, passed in the State assembly. It would have established the California Health Insurance System under which all state residents would be eligible for the single payer system.[241]

Illinois: The "Health Care Justice Act of 2004" created a commission that would make recommendations for implanting universal health care in Illinois.[242]

Maine: In recent months, there has been a heated fight to protect the finances of "Dirigo," Maine's health insurance plan for self-employed working and retired people, and for small business.[243]

Maryland: The Maryland Health Care for All Coalition is putting forth a new resolution to raise the state tobacco tax by $1 per pack in order to fund an expansion of "HealthChoice," Maryland's managed care program. [244]

Massachusetts: The "Health Care Access and Affordability Act" passed, which provides a multi-prong approach toward universal coverage. It requires all individuals who can afford to do so to maintain health insurance through their employer, a state-run program, or in the individual market. Private insurance companies would be encouraged to provide lower-cost plans by July 1, 2007.[245]

New Mexico: The "New Mexico Health Security Act" would establish a single-payer system.[246]

New York: New York City's City Council passed the "New York City Health Care Security Act of 2005." It would require medium and large grocers to provide certain levels of health care to employees.[247]

241. HealthCareForAll, *A Background History of SB 840, available at* http://www.healthcareforall.org/background_history.html (last visited Apr. 6, 2006) (laying out a timeline of the bill's history).

242. Health Care Justice Act, H.B. 2268, 93d Gen. Assem., Reg. Sess. (Ill. 2004).

243. *See* Susan J. Stabile, 19 ST. THOMAS L. REV. 87, 96 (2006).

244. H.B. 441, 2006 Leg., 421st Sess. (Md. 2006).

245. *See generally* Act Providing Access to Affordable, Quality, Accountable Health Care, ch. 58, 2006 Mass. Acts, *available at* http://www.mass.gov/legis/laws/seslaw06/sl060058.htm (last visited Oct. 9, 2006).

246. Health Security Act, H.B. 746, 47th Leg. Reg., First Sess. (N.M. 2005).

247. N.Y., N.Y., Council Int. No. 468-A Local Law 89 (2005).

Pennsylvania: The "Pennsylvania Balanced and Comprehensive Health Reform Act of 2005" was introduced. It creates a single payer bill that also contains medical malpractice reform.[248]

Vermont: The "Health Care Affordability Act" was passed, creating Catamount Health which will provide affordable, comprehensive coverage for uninsured Vermonters.[249]

Wisconsin: The Wisconsin AFL-CIO proposed a plan, the "Wisconsin Health Care Plan," to insure health care access that will be financed primarily by a per-worker assessment on employers.[250]

Before considering a single payer universal health care program nationally, numerous models should be tested and studied in the states. But states have to be careful when designing these programs to not run afoul of ERISA preemption issues under ERISA Section 514(a).[251] Federal legislation may be needed to grant states exceptions from this rule.

Only through this testing can the best provisions and procedures be discovered and implemented. Time is growing short, and as the number of uninsured Americans grows, there will be pressure to adopt a single-payer universal health program to cure all the ills in the current health care system. Before such a system is adopted, it has to be asked whether it would serve the needs of a large and complex society. Will the adoption of such a system cure the problem of escalating health care costs or just hide it from public view?

248. H.R. 1085, 2006 Gen. Assem., Reg. Sess. (Pa. 2006).

249. H. 861 Gen. Assem., Reg. Sess. (Vt. 2006).

250. Wisconsin State AFL-CIO, *The Wisconsin Health Care Plan*, June 16, 2005, http://www.wisaflcio. org/features/Wis%20Health%20Care%20Proposal.htm.

251. Employee Retirement Income Security Act of 1974 § 514(a), 29 U.S.C. § 1144(a) (2006).