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## MEDICAL SAVINGS ACCOUNTS: EFFICIENT AND EQUITABLE? IS IT TOO SOON TO TELL?

By Brian Dent

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### Introduction

The ability of Americans to make decisions regarding their families is a highly valued freedom. Among the most important liberties is the choice of health care.<sup>1</sup> As our society ages, our citizens' ability to control health care costs and options is reduced.<sup>2</sup> Even though the government has worked to provide security for older Americans, these programs have not kept pace with growing health care costs leading the elderly to be less financially secure.<sup>3</sup> These problems have been exacerbated because many Americans over the years have relied on low deductible health insurance that provides no incentive for the consumer to seek lower cost health care or to seek preventive care.<sup>4</sup> With that in mind, many in Congress sought a plan that would create an incentive for prudent health care purchases that would control health care costs.<sup>5</sup>

One such plan, introduced in the mid-1990s, is the medical savings account (MSA).<sup>6</sup> A medical savings account allows an individual to deposit funds into a tax-exempt trust or custodial account to pay for medical expenses<sup>7</sup> associated with a high deductible health insurance plan.<sup>8</sup> Additionally, the plan permits an individual deduction for the deposited amount.<sup>9</sup> When the account holder eventually uses the funds to pay for the medical expenses, the distribution is not included in the gross income of the individual.<sup>10</sup> At present, only employees of small employers and the self-employed are eligible to participate in medical savings accounts.<sup>11</sup>

Not available until 1997, medical savings accounts are relatively new. In their short life, have medical savings accounts proven an efficient and equitable tax advantaged means of paying unreimbursed qualified health care expenses of the account holders and their families? Will medical savings accounts encourage participants to control their health care costs by making prudent health care purchases? This article will review the medical savings accounts' legislative history, tax treatment, use by

corporations, value relative to another tax advantaged savings vehicle<sup>12</sup>, and acceptance by the tax paying public. Finally, suggested improvements to the plan will be presented.

### Legislative History

In the early 1990s, the Clinton administration challenged Congress to pass sweeping reforms in government-supported health care to provide universal health care to all Americans and to slow the growth of health care costs.<sup>13</sup> The health care debate raged for a number of years with a variety of plans offered by liberals and conservatives alike, but it was not until 1994 that Senator Chaffee's "Health Equity and Access Reform Today Act" brought medical savings accounts to the forefront.<sup>14</sup> The Chaffee bill's primary objective was to stem the growth of health care costs by reducing fraud, limiting frivolous malpractice suits, reducing regulation, revising antitrust laws to allow joint ventures by health care providers, and establishing medical savings accounts.<sup>15</sup> These accounts not only would allow the individual to make cost effective health care spending choices, but also would reward individuals who spent their health care dollars wisely by allowing them to carry over any leftover money in the account to the following year.<sup>16</sup> The proposed bill also provided that contributions to the medical savings accounts would be deductible within limits.<sup>17</sup>

While there was support for the medical savings accounts, partisan disputes between the liberal and conservative factions within Congress put the plan on hold until 1996.<sup>18</sup> In a speech on the floor of the Senate, Senator Faircloth (R-NC) summed up the conservative position saying:

This real issue behind medical savings accounts is a question of whether health care reform should move toward greater government control of our health care system, as President Clinton advocates,

or whether health care reform should place more decision making authority in the hands of individuals. Once individual Americans have the power to control how their own health care dollars are spent, they will never allow the government to take that power back.<sup>19</sup>

In opposition, Representative McDermott (D-WA) articulated the liberal viewpoint:

Republicans are obsessed with medical savings accounts. . . . Republicans in the House want us to believe that [medical savings accounts] are the way to expand patient choice and to control health care costs, when in my opinion nothing could be further from the truth. The only things that are known for sure about MSA's is that they will provide lavish tax breaks for the healthiest and wealthiest in our society and that this will cause the cost of health care insurance to increase, making it more difficult and less affordable for employers to offer adequate health insurance.<sup>20</sup>

In March of 1996, the House of Representatives passed H.R. 3103, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), containing a provision for medical savings accounts.<sup>21</sup> On the other hand, the following month the Senate passed S. 1028, the Kennedy-Kassebaum bill,<sup>22</sup> without a provision for medical savings accounts.<sup>23</sup> Senator Kennedy was adamantly opposed to the inclusion of medical savings accounts in the final version of the bill,<sup>24</sup> and Kennedy led a 94-day filibuster against the plan, thereby delaying any work of the House of Representative and Senate conferees.<sup>25</sup> It was not until July 31, 1996, that a House-Senate Conference Committee Report was issued.<sup>26</sup> Generally, the conferees' agreement mirrored the House Bill with several modifications regarding medical savings accounts.<sup>27</sup>

The House-Senate compromise on the accounts narrowed eligibility,<sup>28</sup> placed a limit on participants in a given tax year,<sup>29</sup> raised the surtax on non-qualified

distributions from ten to fifteen percent,<sup>30</sup> included a balance remaining in a decedent's account in his gross estate,<sup>31</sup> set a time limit of December 31, 2000 as the end of the demonstration period for this "pilot project,"<sup>32</sup> and finally directed the Department of the Treasury and the General Accounting Office to evaluate the plans.<sup>33</sup> The Senate<sup>34</sup> and the House<sup>35</sup> approved the conference report and President Clinton signed the bill into law August 21, 1996.<sup>36</sup> Subsequent amendments were negligible.<sup>37</sup>

Recent proposed legislation would dramatically expand medical savings accounts. As recently as June 2001, Republicans in the House of Representatives offered a proposal to increase eligibility, remove the limits on participation, reduce minimum deductibles, enable employers and employees to contribute to the accounts, and make the medical savings account permanent.<sup>38</sup>

### **Tax Treatment of Medical Savings Accounts**

In general, subject to limits and caps on participation, contributions to medical savings accounts are deductible when made by an eligible individual and can be excluded from wages for employment tax purposes if made by an employer for an individual.<sup>39</sup> Earnings in and qualified distributions from the accounts are not taxable; non-qualified distributions are taxable with some exceptions.<sup>40</sup>

### **Eligibility**

To be eligible to participate in a medical savings account, the individual must be employed by a small employer<sup>41</sup> and covered by his employer's high deductible health plan<sup>42</sup> or be self-employed and covered by a high deductible health plan.<sup>43</sup> In either case, the individual may not be covered by any additional insurance.<sup>44</sup> The individual or the employer may make employee contributions; however, a self-employed individual is not eligible to participate if his contractor either contributes or covers the individual under a health plan.<sup>45</sup>

### **Limits on Contributions and Caps on Participation**

Medical savings accounts have two limits on contributions. There are limits on both insurance

deductibles and total compensation allowable. An individual with a family may contribute up to 75% (65% for singles) of his annual deductible, and to contribute the full amount the person must have the high deductible insurance for a full year.<sup>46</sup> As for compensation limits, employees may not contribute more than their total compensation.<sup>47</sup> The self-employed are limited to their net self-employment income.<sup>48</sup> In addition to limits on contributions, the total number of participants in medical savings account plans is limited to 750,000.<sup>49</sup>

### **Distributions**

Distributions from a medical savings account that are used to pay for qualified medical expenses<sup>50</sup> not covered by a high deductible health care plan may be excluded from income.<sup>51</sup> These distributions are only excludable from income in those months that an individual is covered by the high deductible plan.<sup>52</sup> Distributions to pay for non-qualified medical expenses are fully taxable with an additional fifteen percent penalty added. Exceptions are made for distributions after the age of Medicare eligibility or due to death or disability.<sup>53</sup> Specifically, in the event of the death of the account holder, the disposition of any balance remaining in the medical savings account depends on the account holder's designation of beneficiary.<sup>54</sup> When a spouse is the designated beneficiary, the medical savings account is treated as an account of the spouse with the attendant restrictions on distributions.<sup>55</sup> If the selected beneficiary is not a spouse, the account ceases to be a medical savings account on the date of death and the fair market value of the account is taxable to the beneficiary.<sup>56</sup> If there is no designated beneficiary, the fair market value will be included in the decedent's final tax return.<sup>57</sup>

### **Measuring Effects of the Medical Savings Accounts**

Originally, the medical savings account demonstration was to last from 1997 until 2000.<sup>58</sup> During that period, Congress required the Department of the Treasury to determine levels of participation and the revenue impact of the accounts.<sup>59</sup> When Congress created the medical savings accounts, the expected reduction in revenue was to be \$118 million in 1997, \$249 million in

1998, \$264 million in 1999, \$285 million in 2000, \$303 million in 2001, \$320 million in 2002, \$338 million in 2003, \$356 million in 2004, \$373 million in 2005, and \$391 million in 2006.<sup>60</sup>

### **Corporate Medical Savings Account**

Even before the passage of the Health Insurance Portability and Accountability Act of 1996 containing the provision for the medical savings account, corporations were using in-house medical savings accounts to reduce health care costs and increase health care choices for employees.<sup>61</sup> Though the Federal tax treatment of the corporate medical savings account was unfavorable, the employers found them to be effective in controlling health care costs, and as an added benefit, the employees strongly embraced the accounts.<sup>62</sup> A number of large employers utilized medical savings accounts, and the successes included Dominion Resources, Golden Rule Insurance Company, and the United Mine Workers Union.<sup>63</sup>

Dominion Resources, the parent corporation of Virginia Power, instituted its program in 1989 with 200 employees.<sup>64</sup> For their employees who chose the high deductible health plan option, there was a savings in premiums that the workers could keep in a medical savings account.<sup>65</sup> Additionally, if its employees' health care expenses stayed below the deductible, they shared in the company's health care savings. Rebates for healthy behavior were also available. Both the rebates and the shared portion of the company's saving could be put into the medical savings accounts.<sup>66</sup> Since the program's inception, the firm's health cost rose less than one percent annually, and by 1992, the company was under-spending its health budget; significantly, however, it was popular with the employees<sup>67</sup> who saw it as an opportunity to control their health plan while personally saving money.<sup>68</sup>

Another firm with a successful medical savings account program was the Golden Rule Insurance Company.<sup>69</sup> Initiated in 1993, 80% of the employees chose to be in the program that consisted of the choice between a traditional low deductible health plan and a high deductible health plan with a \$1000 credit to the employee's medical savings account.<sup>70</sup> After only eight months of operation, the plan saved the average worker about \$600. The company, as a whole, saved nearly a

half million dollars with the added benefit that the employees were using the money now on hand in their accounts for preventive care.<sup>71</sup>

The United Mineworkers' Union added medical savings accounts to its contracts with coal producers. Under past contracts, mine workers had no deductible, but that was replaced by a \$1000 deductible plan that paid each miner a bonus at the beginning of the year of \$1000.<sup>72</sup> The bonus was to be used for health care, but if the miners were careful with their spending of the bonus, any remaining funds could be used for anything they chose.<sup>73</sup>

### **Comparison to the FSA, Another Tax Advantaged Savings Plan**

Another tax advantaged savings program that exists today is the health FSA (flexible spending arrangement) offered under "cafeteria plans."<sup>74</sup> Under this arrangement, an employee does not include in gross income the contributions made by his employer to the account that will be used to pay for medical expenses outside his health plan.<sup>75</sup> Money contributed to the health FSA that is not spent used during a given calendar year is forfeited.<sup>76</sup>

While both medical savings account and the health FSA have comparable purposes, it is clear that the medical savings account is more valuable. Medical savings accounts offer continued tax-free growth and have the added benefit of continuing from year to year versus the "use it or lose it" aspect of the health FSA.<sup>77</sup> The "use it or lose it" feature promotes health care spending when it may not be necessary, which leads to inefficient use health care dollars resulting potentially in higher medical fees.<sup>78</sup>

### **Acceptance of Medical Savings Accounts by Taxpayers**

When Congress passed the provision for medical savings accounts in the Health Insurance Portability and Accountability Act of 1996, it charged the Department of the Treasury as well as the General Accounting Office with monitoring the effects of the medical savings accounts.<sup>79</sup> The Department of the Treasury reported that the number of returns with the medical savings account deduction were 16,912 in 1997, 42,235 in 1998, and 43,419 in 1999.<sup>80</sup> The amount of these deductions (in thousands of dollars)

was 16,912 in 1997, 62,071 in 1998, and 77,162 in 1999.<sup>81</sup>

The General Accounting Office Report was delivered in December 1998.<sup>82</sup> The report noted that demand for medical savings accounts was lower than many in the insurance industry expected and remained well below the caps imposed by the demonstration program.<sup>83</sup> Providers of medical savings accounts responded to the demonstration program rapidly with more than fifty companies nationwide offering the product, but after one year, the number declined. The decline was attributed to a lack of consumer demand and the design of the demonstration program.<sup>84</sup> Of those insurers offering the plans, only a few were aggressively marketing them to the public, while the remainder was taking a "wait-and-see" approach to the product.<sup>85</sup> The latter group, for the most part, had entered the program as a way of protecting the market share for their other product lines, and when the expectation of low sales of the product gave way to reality, their appetite for marketing medical savings accounts waned even more.<sup>86</sup>

The report noted that the low sales figures could be attributed to the way medical savings accounts had been marketed.<sup>87</sup> Primarily, the major insurance companies sold their product through small local insurance brokers and agents. These insurance companies overestimated the popularity of this new product with its sales force. Sales of the product were disappointing.<sup>88</sup> Three areas were cited as problems for local agents and brokers. First, agents needed more training to address the complex tax effects that accompanied a sale of a medical savings account. Second, when selling the high deductible plans required by the program, commissions to the agents were lower. Third, the time needed to explain the product to the consumer was longer<sup>89</sup> than for other insurance products.<sup>90</sup> With perceived difficulty in selling the product, some information showed that marketing plans shifted away from the tax advantages to the cost savings of the high deductible plans.<sup>91</sup> Finally, the report indicated the future of the medical savings account program was not bright, and it would only improve if the overall medical savings account design were overhauled.<sup>92</sup>

### **Conclusion**

Whether medical savings accounts provide an efficient and equitable tax advantaged means of paying unreimbursed qualified health care expenses for account holders and their families remains to be seen. The number of participants in the program is too small to give a definitive answer. From reading Section 220 of the Internal Revenue Service Code, one may conclude that because of the restrictive eligibility requirements that medical savings accounts will not be equitable. On the other hand, after reading the results of the General Accounting Office Report and realizing that more than one in three of the first year's accounts were opened by an individual who was previously uninsured,<sup>93</sup> a conclusion may be drawn that medical savings accounts, because of their affordability, are equitable.

With few medical savings accounts opened and because of the complex tax effects of the accounts, one could infer that lower income individuals were not aware of the program. Again, looking at the General Accounting Office Report, one can see that it was, among other things, the lack of profitability to the insurance sales force that caused the product not to be in the forefront of any insurance purchasers consciousness.<sup>94</sup>

The lack of consciousness of the program and the subsequent lack of participation make it difficult to determine if the medical savings account would help individuals control their health care costs by making prudent health care purchases. Looking at the positive medical savings account experiences of Dominion Resources, Golden Rule Insurance Company, and the United Mine Workers' Union, the medical savings account could do well if offered to workers in the broader context of the entire country.

To be successful, medical savings accounts would need to be promoted and expanded throughout the country, but this expansion will not occur if changes are not made to the program. Specifically, broader eligibility requirements would allow more taxpayers to participate in the program. Accordingly, along with permanence, the cap of 750,000 accounts must be removed to allow all taxpayers to participate. With a larger group participating in the medical savings account program, more data can be gathered to determine the equity and efficiency of the plans, and determine what portion of the plans need further improvement. Essentially, medical savings accounts

must move from being a demonstration to a permanent option for health care, because as it stands now uncertainty is holding back participation.<sup>95</sup>

#### Endnotes

<sup>1</sup> *Id.*

<sup>2</sup> Regina T. Jefferson, Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise, 48 Cath. L. R. 685, 685 (Spring 1999)(citing Jennifer Cheeseman Day, U. S. Dep't. of Commerce, P25-1092, Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1992-2050, at xiv tbl. G. (1992)).

<sup>3</sup> Senator J. Robert Kerrey, Welfare Reform: Economic Security for the Next Century, 9 Stan. L. & Pol'y Rev. 13, 14 (1998).

<sup>4</sup> Joint Committee on Taxation General Explanation of Tax Legislation Enacted in the 104<sup>th</sup> Congress (JCS-12-96) 321, 321 (December 18, 1996)(hereinafter-Joint Committee on Taxation).

<sup>5</sup> *Id.*

<sup>6</sup> 26 U. S. C. § 220 (2001).

<sup>7</sup> Qualified Medical Expenses are further defined in 26 U. S. C. § 213(d)(2001). As provided in 26 U. S. C. § 220(d)(2)(2001), it should be noted that health insurance premiums are not qualified medical expenses with the exception of premiums for continuation coverage, qualified long-term care, and coverage during a period of unemployment.

<sup>8</sup> 26 U. S. C. § 220 (c)(2)(2001) defines high deductible health plans for individual coverage as plans with deductibles in the range of \$1500 to \$2250. For family coverage, the range is \$3000 to \$4500. Out-of-pocket expenses must not exceed \$3000 for individuals and \$5500 for families. These plans are much like major medical or catastrophic health plans. To compare, comprehensive health plans have a lower deductible and a higher cost in premiums and allow liberal numbers of physician visits with only a small amount of co-payment. The increased use of physicians/health care services raises demand for medical services and the costs of such services rise.

<sup>9</sup> 1996-51 I. R. B. 5, Notice 96-53 (December 16, 1996).

<sup>10</sup> 26 U. S. C. § 220(f)(2001). Distributions used to pay for non-qualified medical expenses are subject to inclusion in the individual's gross income for that year as well as to a fifteen percent surtax.

<sup>11</sup> 26 U. S. C. § 220(c)(4)(A)(2001). A small employer is defined as one who employs fifty or fewer employees on average during either of the last two calendar years. There are special rules for new employers and growing employers.

<sup>12</sup> The health FSA (flexible spending arrangement) as provided for in 26 U. S. C. § 125 (2001)(see Treas. Reg. § 1,125-4(i)(6)).

<sup>13</sup> *Hearing on Health Consumer Choice Health Security*

*Act*, House Ways and Means Comm., 103<sup>rd</sup> Cong. 1 (1994)(testimony of William Thomas, Member of Congress from the 21<sup>st</sup> District of California).

<sup>14</sup> *Hearing on the Tax Treatment of Health Insurance and Medical Expenses*, U. S. Senate Comm. on Finance, 103<sup>rd</sup> Cong. 1 (1994)(testimony concerning S. 1770 by Alan J. Auerbach, Professor of Economics and Law-University of Pennsylvania and Research Associate-National Bureau of Economic Research).

<sup>15</sup> *Hearing on Health Consumer Choice Health Security Act*, House Ways and Means Comm., 103<sup>rd</sup> Cong. 3-4 (1994)(testimony of William Thomas, Member of Congress from the 21<sup>st</sup> District of California). Because of fraud, many millions of dollars are lost within the health care industry. The bill gave additional authority to the federal government to detect and investigate fraudulent insurance schemes. Excessive regulations prevent an efficient delivery of health care services. Under this proposed law, forms would be standardized, state laws preventing the electronic transmission of claims data would be preempted, and consumers of health care services would have access to comparative pricing data to make more informed decisions. The then current laws also prevented health care providers from becoming more efficient through partnering arrangements that would run afoul of the antitrust laws. Finally, costly malpractice litigation needed to be curbed. The bill capped damage awards, limited legal fees and required alternative dispute resolution in order to contain costs.

<sup>16</sup> *Id.* at 4. (Congressman Thomas argues that consumer involvement in health care decisions is the key to controlling health care costs. This is contrary to past notions that large health insurance companies can efficiently allocate health care dollars. By removing these insurance companies from the equation, a more disciplined approach to health care spending can be attained.

<sup>17</sup> *Hearing on the Tax Treatment of Health Insurance and Medical Expenses*, U. S. Senate Comm. on Finance, 103<sup>rd</sup> Cong. 5 (1994)(testimony by Alan J. Auerbach, Professor of Economics and Law-University of Pennsylvania and Research Associate-National Bureau of Economic Research)(Also see, 1993 S. 1770, § 2002 for limitations on deductibility).

<sup>18</sup> 142 Cong. Rec. S10564-05 (daily ed. September 13, 1996)(from remarks by Senator Frist).

<sup>19</sup> 142 Cong. Rec. S9501-01 (daily ed. September 13, 1996)(statement of Senator Faircloth)(conservatives believed that the medical savings accounts would prevent the United States from moving further down the path toward a socialized form of medical care similar to what is found in many European countries).

<sup>20</sup> 142 Cong. Rec. H6684-05 (daily ed. June 20, 1996)(statement of Representative McDermott)(liberals feared that the number of people participating in more standardized health care coverage would decline because of medical savings accounts, and that in turn would cause the cost of insurance to rise because the risk would not be spread over a broad segment of the population).

<sup>21</sup> H. R. Rep. 104-496, Pt. 1, 104<sup>th</sup> Cong., 2d Sess. (March 19, 1996)(House Ways and Means Committee Report outlined provisions of medical savings accounts. Notably, eligibility was

broad, distributions for non-qualified medical expenses had a ten percent surtax, no estate tax applied to balances at the death of an account holder, and the plans were effective for all taxable years following December 31, 1996).

<sup>22</sup> Senator Edward Kennedy, D-MS, and Senator Nancy Landon Kassebaum, R-KS, were the primary sponsors of the Senate version of the Health Insurance Portability and Accountability Act of 1996.

<sup>23</sup> S. 1028, 104<sup>th</sup> Cong., 2d Sess. (April 23, 1996)(passed in Senate 100-0).

<sup>24</sup> Senator Kennedy opposed the medical savings accounts not only because of the reasons stated by Rep. McDermott, but also, because of his perception that the insurance industry would benefit from the medical savings accounts. He pointed to the high volume of campaign contributions to proponents of the accounts by major insurance companies as proof.

<sup>25</sup> 142 Cong. Rec. S10564-05 (daily ed. September 13, 1996)(statement of Senator Frist).

<sup>26</sup> H.R. Rep. No. 104-736, 104<sup>th</sup> Cong., 2d Sess. (July 31, 1996)(to accompany H.R. 3103).

<sup>27</sup> *Id.* at 283.

<sup>28</sup> *Id.* (employees of small employer's and the self-employed were the only ones eligible to participate) See also 26 U. S. C. § 220 (c)(4)(A)(2001), *supra* note 12.

<sup>29</sup> *Id.* at 287 (a limit of 750,000 taxpayers was determined to be the "threshold level" for participation during the life of the medical savings account provision in the law that was to end on December 31, 2000).

<sup>30</sup> *Id.* at 286.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 292.

<sup>33</sup> *Id.*

<sup>34</sup> 142 Cong. Rec. S9526 (daily ed. August 2, 1996)(Senate agreed to the report by a vote of 98-0).

<sup>35</sup> 142 Cong. Rec. H9796 (daily ed. August 1, 1996)(House agreed to the report 421 to 2).

<sup>36</sup> 142 Cong. Rec. D879 (daily ed. September 3, 1996).

<sup>37</sup> 26 U. S. C. A. § 220 (2001)(there has been one extension of the demonstration period to December 31, 2001 and medical savings accounts are now referred to as Archer MSA's. Former Rep. Archer was chairman of the House Ways and Means Committee at the time the original bill passed and a strong proponent of medical savings accounts).

<sup>38</sup> *Health Care: House Republicans and One Democrat Offer Proposal To Expand Tax-Favored MSAs*, Daily Tax Report(BNA), 123 DTR G-4(2000)(All individuals with high deductible health insurance plans would be eligible, and the deductible level would be lowered to \$1000 for individuals and \$2000 for families.)

<sup>39</sup> Joint Committee on Taxation, *supra* note 5, at 322.

<sup>40</sup> *Id.*

<sup>41</sup> See 26 U. S. C. § 220 (c)(4)(A)(2001), *supra* note 12.

<sup>42</sup> See 26 U. S. C. § 220(c)(2)(2001), *supra* note 9.

<sup>43</sup> Joint Committee on Taxation, *supra* note 5, at 322.

<sup>44</sup> *Id.* The purpose of medical savings accounts is to reduce

demand on the supply of health care services. Thus, costs decline. To permit other insurance, i.e., a comprehensive health plan to be purchased would defeat the purpose of the medical savings accounts.

<sup>45</sup> *Id.* (self-employment by definition does not permit any income to be derived from an employer-employee relationship).

<sup>46</sup> 26 U. S. C. § 220(b)(2001)(for all months that an individual did not have the insurance, the amount of contribution is reduced by 1/12).

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* (this number is derived from income minus expenses, including the one-half of the self-employment tax deduction).

<sup>49</sup> 26 U. S. C. § 220(j)(2)(ii)(2001)(health insurance companies must report sales of these accounts to the Treasury/IRS on a first come first serve basis of eligible individuals).

<sup>50</sup> See 26 U. S. C. § 213(d)(2001).

<sup>51</sup> Joint Committee on Taxation, *supra* note 5, at 326.(spouse and dependent (see 26 U. S. C. § 152) expenses paid for by the distribution are also excluded.)(See 26 U. S. C. § 220(f)(1)(2001).

<sup>52</sup> *Id.*(this rule was implemented to make certain that medical savings accounts are used in combination with a high deductible plan and not by those covered comprehensive plans, because in so doing, the purpose of the plans is defeated – the reduction of health care costs by lowering demand for health care services.

<sup>53</sup> 26 U. S. C. § 220(e)(4)(2001)(For a description of Medicare eligibility see Section 1811 of the Social Security Act and for disability see 26 U. S. C. § 72(m)(7)(2001). Specifically, Medicare coverage is not considered a high deductible plan, and as for the disabled, a high deductible plan would not make sense, as their medical needs are greater.

<sup>54</sup> 26 U. S. C. § 220(e)(8)(2001).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.* at 9.

<sup>58</sup> Joint Committee on Taxation, *supra* note 5, at 333.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 333-334. 26 U. S. C. § 220(b)(2001) provides for limits on the deductibility of funds deposited in medical savings accounts based on a percentage of the deductible of the insurance plan. These limits in combination with the numerical limits placed on the number of accounts allowable in a given year during the demonstration period (see 26 U. S. C. § 220(j)(2001)) can roughly estimate the potential revenue losses due to deductibility but not for tax-free growth in the accounts.

<sup>61</sup> 142 Cong. Rec. S9501-01 (daily ed. August 2, 1996)(remarks of Senator Helms that further cites a study by the Rand Corporation that estimates that medical savings accounts could help low income workers reduce health care spending by up to 13 percent).

<sup>62</sup> *Hearing on Health Care Revision*, U. S. House of Representatives Comm. on Commerce, 104<sup>th</sup> Cong. 3 (1996)(testimony of Peter J. Ferrara, General Council and Chief Economist, Americans for Tax Reform.).

<sup>63</sup> These are examples of firms using medical savings accounts at

the time of the passage of the law in 1996. Other companies utilizing the accounts at that time were Quaker Oats, Forbes, and Dupont. Additionally, at that time, a number of states (Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi, and Missouri) had medical savings accounts for their employees, and other states were considering the account for their employees.

<sup>64</sup> *Hearing on Health Care Revision*, U. S. House of Representatives Comm. on Commerce, 104<sup>th</sup> Cong. 3 (1996)(testimony of Peter J. Ferrara, General Council and Chief Economist, Americans for Tax Reform).

<sup>65</sup> *Id.* (Families saved nearly \$1100 and individuals saved nearly \$500).

<sup>66</sup> *Id.* (in 1992, the firm paid out \$800 in savings rebates and \$600 in wellness rebates. Nearly eighty percent of the employees were enrolled in the program.)

<sup>67</sup> Testimony given at this hearing was provided by Ferrara and a number of other tax or health care specialists. No employees testified before the committee.

<sup>68</sup> *Id.* (health care costs for Virginia companies for the same period were rising at a twenty percent rate annually. Dominion Resources health care budget was down by nearly one-third).

<sup>69</sup> Roth, *supra* note 1, at 156.

<sup>70</sup> *Id.* (the traditional policy had a \$500 deductible with a 20% co-payment up to \$1000 while the high deductible plan had a \$2000 deductible associated with it).

<sup>71</sup> *Hearing on Health Care Revision*, U. S. House of Representatives Comm. on Commerce, 104<sup>th</sup> Cong. 3 (1996)(testimony of Peter J. Ferrara, General Council and Chief Economist, Americans for Tax Reform.)(the traditional policy may not have covered some of the services. Under this plan, employees can choose any service. Also, total out-of-pocket expenses under the medical savings account program were \$1000 annually versus \$1500 under the traditional plan).

<sup>72</sup> The miners must pay taxes on the full \$1000 whether it was used for health expenses or not.

<sup>73</sup> *Id.* (in arguing for medical savings accounts in his testimony, Ferrara says that since the accounts have been accepted by a labor union then the accounts will have a strong appeal with workers).

<sup>74</sup> 26 U. S. C. § 125 (2001)(see Treas. Reg. § 1.125-4(i)(6)).

<sup>75</sup> 26 U. S. C. § 106 (2001)(see Treas. Reg. § 1.106-1).

<sup>76</sup> 26 U. S. C. § 125 (2001).

<sup>77</sup> A comparison of medical savings accounts to the FSA in terms of revenue loss would depend on a variety of factors. Not the least of which is the eligibility requirement for medical savings accounts. The requirement reduces the number of accounts, but with positive tax-free investment growth, the lack of accounts could be offset. The FSA, while widespread, is limited in amounts allowable and does not grow. Since spending is required within a calendar year only on medical needs, there is a chance that additional revenues would be realized as the money is put back into the economy.

<sup>78</sup> See 48 Cath. L. Rev. 685 at 700.

<sup>79</sup> Joint Committee on Taxation, *supra* note 5, at 333. (the Department of the Treasury was to monitor reduction in federal revenues and participation in the plans and the General Accounting Office was to hire a group to study the effect of medical savings accounts on the health care industry and make a report by January 1, 1999).

<sup>80</sup> Internal Revenue Service, *Statistic of Income Bulletin*, vol. 20 no.4 (Spring 2001).

<sup>81</sup> *Id.* (the amount of the deductions will not reflect the total negative revenue effect of the medical savings account, because the total loss in revenues would reflect the losses from the tax-exempt status of the accounts. However, the expected loss in revenue for 1997, 1998, 1999 was to be \$118 million, \$249 million, and \$264 million, respectively, appear to be out of reach given the deductions taken).

<sup>82</sup> General Accounting Office, *Medical Savings Accounts: Results from Survey of Insurers* (1998).

<sup>83</sup> *Id.* at 5. (complexity both in development of a qualified medical savings account product as well as in marketing the product to the consumer was cited as reasons for limited demand).

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> *Id.* at 11.

<sup>87</sup> *Id.* at 15.

<sup>88</sup> *Id.* (during the first year of the program an estimated 41,668 medical savings accounts were opened compared to the legislated cap of 600,000 allowable during that period).

<sup>89</sup> The explanation of the tax advantages and savings features of the medical savings accounts made sale of the product more complex for both the sales people and the consumer when compared to traditional products.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 15-16 (the shift to affordability, may explain why, as reported by the Internal Revenue Service, more than one third of the first year's sales were to previously uninsured individuals when the original target market was thought to be professionals, partnerships, and the self-employed).

<sup>92</sup> *Id.* at 17.

<sup>93</sup> *Id.* at 16.

<sup>94</sup> Generally, higher deductible health plans have a lower commission structure than low deductible plans.

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