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Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care

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Abstract

The creation of tax-free health savings accounts presents a new opportunity to reduce the distortions created by federal tax preferences for health-related expenditures that ultimately could help eliminate those distortions. This paper proposes changes to current law that would allow most workers to receive the full amount that they and their employer spend on their health benefits as a tax-free cash contribution to the worker's health savings account. Restructuring the exclusion for employer-sponsored health benefits in this way would enable more individuals to obtain health insurance that matches their preferences, would increase efficiency in the health care sector, and could reduce inequities created by the exclusion. These changes also offer a means of limiting the currently unlimited tax exclusion for employer-sponsored health benefits that may be more politically feasible than past proposals.

KEYWORDS: health saving accounts, tax, costs, tax reform, nongroup

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I. Introduction

Various provisions of the federal tax code alter relative prices within the health sector, as well as the relative prices of health versus non-health expenditures. The most notable of these provisions, both in terms of its impact on the health care sector and the federal budget, is the exclusion of employer-sponsored health benefits from federal income and payroll taxes. While cash wages are generally subject to both types of tax, compensation in the form of employer contributions to employee health benefits is not. The projected revenue loss to the federal treasury from the exclusion of employer-paid health benefits in 2007 was \$147 billion. That was nearly twice the size of the projected loss from the second-largest revenue loser, the mortgage interest deduction (OMB, 2006).

Excluding employer-sponsored health benefits from the income and payroll tax bases lowers the effective price of employer-sponsored health coverage relative to coverage obtained outside an employment setting. (If we measure prices in terms of units of labor, the effective price of employer-sponsored coverage falls by a percentage equal to the worker's marginal tax rate.) The price of employer-provided health benefits falls relative to other uses of cash wages as well, including saving, out-of-pocket medical expenditure, and other forms of consumption. The exclusion therefore distorts prices in three principal ways:

1. It reduces the price of health expenditures relative to non-health expenditures;
2. It reduces the price of financing medical care through third-party health insurance relative to self-insurance (i.e., saving) and direct out-of-pocket expenditure; and
3. It reduces the price of employer-sponsored health insurance relative to insurance purchased from other sources.

These price distortions helped to create America's employment-based system of private health insurance (Helms, 2006). An estimated 60 percent of Americans are covered by such insurance (DeNavas-Walt et al., 2006).

Critics identify several problems created by this feature of the tax code. First, the exclusion leaves workers with less control over their health insurance decisions and their compensation. Because most workers have their health insurance chosen for them by an employer, workers are less likely to obtain coverage that matches their preferences. Second, economists argue that the exclusion reduces efficiency by encouraging excess health insurance coverage, encouraging consumption of low-value medical care, and distorting the labor

market. Third, economists and other commentators criticize the exclusion as inequitable, both in terms of horizontal and vertical equity.

For these and other reasons, some have advocated eliminating the exclusion (Friedman, 2001). Doing so would eliminate the tax-induced distortion of workers' health insurance decisions by requiring workers to pay income and payroll taxes on the value of their employer-sponsored health benefits just as they pay taxes on income devoted to other purposes. Others have proposed reducing such distortions by limiting the exclusion; for example, by imposing a cap on the value of health benefits that may be excluded from taxation. Such a cap would require workers to pay taxes on the amount of employer-sponsored health benefits that exceed the cap. Assuming a worker prefers health insurance with premiums that exceed the level of the cap, the cap would eliminate the distortion of that worker's health insurance decisions at the margin. A recent presidential commission on tax reform proposed capping the exclusion at the average value of employer-sponsored health benefits: \$5,000 for individual health coverage and \$11,500 for family coverage (Mack et al., 2005). Most recently, President George W. Bush proposed limiting the exclusion by replacing it with a standard deduction for health insurance that would be available to all taxpayers regardless of where they obtain coverage (Burman et al., 2007).

Efforts to eliminate, or even limit the exclusion typically meet significant political opposition. Either option would impose taxes on previously untaxed activity. Those who argue that the exclusion encourages greater cross-subsidies to less-healthy workers – i.e., greater “pooling” – argue that eliminating or limiting the exclusion would reduce such pooling by diminishing the incentive to purchase health insurance through employment-based groups. Opposition from various groups has defeated attempts to limit the exclusion for over 20 years.

The creation of tax-free health savings accounts (HSAs) presents a new opportunity to limit the exclusion and facilitate its elimination. This paper argues that altering the rules governing HSAs could better satisfy individual preferences than the current exclusion and improve the efficiency, and possibly the equity, of the federal tax code's treatment of health-related uses of income. The same changes could cap the exclusion as well, and do so in a way that may be more politically feasible than past proposals. Though these changes would raise a number of objections, including concerns regarding free-riders and revenue loss to the federal treasury, those problems could be addressed by adjusting different parameters.

II. Health Savings Accounts

HSAs offer a foundation for transitioning to a tax system that is neutral toward health expenditures. In 2003, the federal government created tax-free health

savings accounts (HSAs), allowing taxpayers who are under age 65 and covered by a qualified high-deductible health plan¹ to save a limited amount of income in an account (the HSA) for medical expenditures. Individuals with qualified coverage may contribute up to \$2,900 to their HSA in 2008. Families with qualified coverage may contribute up to \$5,800.²

HSAs represent a significant change in the tax treatment of different ways of financing medical care. Traditionally, federal tax law has bestowed the most preferential tax treatment on employer-sponsored, third-party health insurance. Deductions for out-of-pocket medical expenditures, for example, are narrowly tailored and less widely utilized.³ Prior to the creation of Archer medical savings accounts (a more restrictive precursor to HSAs) in 1997, no tax breaks existed for self-insurance – that is, saving for one's future medical expenses.⁴

The tax treatment of HSA contributions roughly mirrors the tax treatment of employer-sponsored health insurance (Cannon, 2006).⁵ HSAs are truly a

¹ In 2008, a qualified self-only health plan may have a deductible of no less than \$1,100 and no more than \$5,600. A qualified family policy may have a deductible of no less than \$2,200 and no more than \$11,200. HSA-qualified high-deductible health plans are generally prohibited from covering medical services below the plan's deductible. A statutory exception exists for preventive care, which qualified health plans may cover below the deductible. IRS regulations further permit below-the-deductible coverage for treatment "that is incidental or ancillary to a preventive care service" and delivered under circumstances "where it would be unreasonable or impracticable to perform another procedure to treat the condition" (IRS, 2004). Total out-of-pocket exposure is limited to \$5,600 for self-only coverage and \$11,200 for family coverage.

² HSA holders ages 55 to 64 may make additional "catch-up" contributions of \$900 in 2008 (Treasury, 2005). The minimum and maximum deductibles, maximum out-of-pocket exposure, and maximum HSA contribution limits are indexed annually to reflect changes in the cost of living. The maximum catch-up contribution amount rises by \$100 annually until 2009.

³ Medical expenses in excess of 7.5 percent of adjusted gross income, for example, are deductible for income tax purposes. Certain workers can purchase medical services tax-free through employer-sponsored flexible spending accounts (FSAs). In 2002, the IRS allowed employers to make tax-free contributions on behalf of an employee to a health reimbursement arrangement (HRA), from which the employee can purchase medical services tax-free.

⁴ Though FSAs and HRAs use something resembling a savings account, both "accounts" are subject to a use-it-or-lose-it rule. Workers forfeit funds left in their FSA at the end of the year, while workers with an HRA forfeit leftover balances when they leave their employer. Thus workers cannot save the funds involved. Moreover, HRAs need not even be funded. Employers may set up HRAs as notional accounts, covering HRA liabilities only as they are incurred.

⁵ HSA contributions made by employers are excluded from income and payroll taxation. Workers with access to a Section 125 cafeteria plan may themselves make HSA contributions that are excluded from both income and payroll taxation. Workers without access to a cafeteria plan may only deduct HSA contributions for income tax purposes. HSA funds remain untaxed if they are left in the account (interest accrues tax-free) or withdrawn to pay qualified medical expenses (IRS, 2005a). HSA distributions for non-medical expenses are taxed as income and assessed a 10-percent penalty, though the penalty is waived if the distribution occurs after the account holder

savings vehicle, in that HSA funds remain the property of the account holder even when she changes jobs or insurance companies. Thus, HSAs reduce the tax code's disincentive against financing medical expenses by pooling one's own resources over the course of a lifetime (Herrick, 2005).

Because HSAs expand health-related tax deductions, they may distort consumers' allocation decisions even further. However, HSAs arguably do less to encourage greater health care spending than proposals to extend tax deductibility solely to out-of-pocket expenditures (Cogan et al., 2005), since HSAs offset (at least in part) the added incentive to increase medical consumption by presenting consumers with a tax-neutral tradeoff between additional consumption and saving. While some economists have argued for HSAs as a second-best alternative to eliminating health-related tax preferences (Friedman, 2001), others question (Pauly, 1994) and even reject (Furman, 2006) the wisdom of extending preferential tax treatment to even more out-of-pocket medical expenditures and self-insurance.

Other objections to HSAs include those based on perceived inequities and concerns about risk segmentation (Cannon, 2006). HSAs allow high-income earners to reduce their tax liability more than low-income earners. In addition, some argue that leveling the playing field between employer-sponsored third-party insurance and self-insurance will reduce cross-subsidies to less-healthy workers.

III. Large Health Savings Accounts

HSAs present a new opportunity for restructuring and limiting the tax exclusion of employer-sponsored health insurance that may appeal to its various critics. Changing three parameters of current HSA law could create a substitute for the exclusion and other health-related federal tax preferences that would improve efficiency within the health care sector while possibly reducing the inequities created by the exclusion. These changes also offer a way to limit health-related tax preferences that may be more politically feasible than past proposals. Finally, these changes could serve as a transitional step toward a tax system that is neutral toward health expenditures, and therefore increases allocative efficiency across economic sectors.

This paper proposes changes to current HSA law that would allow most workers to contribute the full amount both they and their employer spend on their health benefits to the worker's HSA. Three principal changes are proposed:

dies, suffers a disability, or reaches age 65. Upon death of the account holder, the HSA either reverts to the account holder's spouse; becomes part of the account holder's estate, where the value of the HSA is taxed as income; or is taxable to the beneficiary (IRS, 2005b).

1. Increase HSA contribution limits dramatically. For illustrative purposes, assume the maximum annual contribution limits would be roughly tripled, from \$2,850 to \$8,000 for individuals and from \$5,500 to \$16,000 for families.
2. Remove the requirement that HSA holders be covered by a qualified high-deductible health plan. HSAs would be open to those covered by any type of insurance, as well as the uninsured.
3. Allow HSA holders to purchase health insurance, of any type and from any source, tax-free with HSA funds.

These changes would allow all individuals to set up a “large” HSA. Subject to the new contribution limits, workers could contribute as much income as they choose. Those Large HSA funds would finance workers’ health insurance premiums and any other qualified medical expenses. These changes would eliminate the tax code’s influence over tradeoffs between self-insurance and third-party insurance, and between employer-sponsored insurance and other sources of insurance.

A hypothetical can illustrate how Large HSAs could work. Suppose a worker currently receives family coverage through her employer. The total premium is \$12,000 per year, of which the employer pays \$9,000 and the worker pays \$3,000.⁶ Rather than set aside \$9,000 for the worker’s health benefits, the employer would add that amount to the worker’s salary. As with an FSA, the worker could then direct the employer to deposit a portion of her salary, pre-tax, into her HSA. Those Large HSA contributions would be exempt from both income and payroll taxes, just as employer contributions to workers’ HSAs are today. The combined contributions from a worker and her spouse would be limited, for example, to \$16,000.

The worker could then use her Large HSA funds to establish levels of third-party insurance and self-insurance that satisfy her preferences. She could use her Large HSA funds to continue paying premiums under her employer’s health plan. Alternatively, she could use those funds to purchase less- or more-comprehensive coverage through her spouse’s employer, through another group, or the non-group market. The federal tax code would no longer reward or punish her for choosing a particular mix of self-insurance and third-party insurance, or for choosing third-party insurance from a particular source. Whatever Large HSA funds she does not spend in the present would be available to cover future out-of-pocket medical expenses or health insurance premiums. As with current-law HSAs, she could withdraw those funds for non-medical purposes, subject to

⁶ These figures are close to the nationwide averages for employer-sponsored family coverage in 2007 (Kaiser/HRET, 2007).

income taxes and a 10-percent penalty, which would be waived if the distribution occurs after she suffers a disability or reaches age 65.

Employers who currently do not offer health benefits might be willing to arrange Large HSA payroll deductions for their workers, since administering direct deposits is less burdensome than administering health benefits. Nevertheless, some workers would not be able to arrange Large HSA contributions via payroll deduction. If workers could not exempt Large HSA contributions from payroll taxes, that would preserve an inequity where the federal government effectively levies higher taxes on individuals whose employers do not offer health benefits. That problem could be addressed by creating an income tax credit to offset the payroll taxes paid on non-employer HSA contributions (CEA, 2006). Allowing such a credit for non-employer Large HSA contributions would provide tax neutrality to those who contribute to a Large HSA other than through a payroll deduction. The Bush administration's proposed standard deduction for health insurance provides another mechanism for achieving tax neutrality: after workers certified the amount they deposit into their Large HSA, employers could deduct that amount from the workers' payroll tax base (see Burman et al., 2007).

These changes to current HSA rules would improve efficiency, and potentially equity, within the health care sector. At the same time, they would facilitate a move toward tax neutrality for health-related expenditures. Large HSAs will also raise concerns regarding vertical equity and other issues, many of which can be addressed by adjusting parameters such as the maximum allowable contributions.

A. Individual Preferences

One consequence of the preferred tax treatment granted to employer-sponsored health insurance is that workers are often unable to obtain their preferred type of health coverage. Most workers' health insurance choices are limited to the options offered by their employer. (Workers who purchase coverage outside an employment setting lose the benefit of the exclusion and also must pay the higher administrative costs associated with non-group insurance.) In 2007, 51 percent of covered workers had only one health plan choice; only 17 percent of covered workers had more than two choices (Kaiser/HRET, 2007). Because it is rare that a firm can satisfy the diverse preferences of all its employees, an employment-based system of health insurance leaves many workers' preferences unsatisfied. The mismatch between the coverage that employees prefer and what they get creates a welfare loss estimated at 5-10 percent of health insurance expenditures (Pauly et al., 1999).

As they exist today, HSAs do little to improve this situation. HSAs only slightly reduce the tax penalties imposed on those who obtain their preferred level of health coverage. For example, if a consumer obtains more (or less) coverage than may be combined with an HSA, she is penalized because she is ineligible to make tax-free HSA contributions. If she obtains coverage outside an employment setting, she is penalized even if her preferred coverage qualifies her to open an HSA: her HSA contributions are deductible only against her income taxes (not payroll taxes), and she must purchase her health plan with dollars subject to both income and payroll taxes. In effect, HSAs enable a consumer to avoid tax penalties only when (1) her coverage preference falls within the statutory parameters of an HSA-qualified health plan and (2) she obtains coverage in an employment setting.

Restructuring the exclusion with Large HSAs would allow a closer fit between each individual's preferences and her health insurance coverage. Once funds are contributed to a Large HSA, they may be put to any health-related use without penalty. A worker could use her Large HSA funds to purchase coverage from her employer, her spouse's employer, a non-employment group, or the non-group market. She could purchase HMO, PPO, POS, or fee-for-service coverage. Within those categories, she could select any combination of deductibles and coinsurance. She could also choose not to purchase any third-party insurance and instead accumulate savings in her Large HSA. Her coverage options would no longer be confined to those offered by her employer or those defined by Congress. A Large HSA would give her ownership of her health benefits, in particular the portion of her compensation that even existing HSAs do not enable her to control: the funds that purchase her health insurance.

B. Efficiency

Economists criticize the exclusion for reducing economic efficiency. This occurs in two principal ways. First, economists credit the exclusion with encouraging excess health insurance coverage (Feldstein, 1973; Feldstein and Friedman, 1976; Feldstein and Gruber, 1995; Gruber and Poterba, 1996). An individual reaches the optimal amount of insurance when the cost of an additional unit of coverage (including, in particular, the cost of additional moral hazard) is equal to the benefit of an additional unit of risk protection (Feldstein and Friedman, 1976). The exclusion traditionally upset that balance by artificially lowering the price of an additional unit of employer-sponsored coverage relative to the prices of other group insurance, non-group insurance, self-insurance, direct (out-of-pocket) medical expenditures, and non-health expenditures. Because health insurance itself alters the price of medical care to consumers, lowering the relative price of health insurance encourages even greater consumption of medical

care whose cost exceeds its value. By diverting resources from other activities to the health care sector, where those resources often purchase low-value, zero-value, and even harmful care (Newhouse et al., 1994), the tax exclusion creates a welfare loss most recently estimated at \$106 billion in 2002 (Conover, 2004). Excessive coverage may also be described as a suboptimal mix of self-insurance and third-party insurance.

Second, by tying health insurance to employment, the exclusion reduces efficiency by making labor less mobile than if health insurance were portable. Research suggests that workers make employment decisions in part based on their demand for health insurance (Glied, 1994). The unwillingness to change jobs for fear of losing one's health insurance is known as "job lock." Although "the economic costs of job lock may be modest" (Gruber and Madrian, 2004), workers might allocate their labor more efficiently in the absence of a tax penalty on fully portable health insurance.

HSAs make only modest improvements in efficiency. First, by reducing somewhat the tax preference for third-party insurance over self-insurance, HSAs could reduce the welfare loss associated with excess coverage. However, that depends on employers providing HSA coverage to workers who prefer high-deductible insurance – and only to such workers. To the extent that employers do not offer HSAs, the welfare loss from excess coverage will persist. Moreover, to the extent that employers impose HSAs on workers who do not want high-deductible coverage, HSAs may create new welfare losses. Second, the welfare losses associated with workers changing coverage (or losing coverage altogether) when they change jobs persist despite the availability of HSAs. Though the funds accumulated in a worker's HSA remain the worker's property through changes in employment, the same cannot be said of the high-deductible health plan. Workers with HSA coverage still face the loss of their health insurance when they change jobs, because the tax code continues to penalize insurance that is tied to the consumer.

Large HSAs would provide even greater tax benefits for self-insurance than do current-law HSAs. This is not necessarily advantageous (Pauly, 1994; Furman, 2006). On balance, however, Large HSAs could reduce economic distortions and improve efficiency, given the set of tax provisions they would replace.

First, Large HSAs would reduce distortions *within* the health sector. Large HSAs would improve efficiency within the health sector primarily by reducing excessive medical spending. By giving workers ownership of the money that purchases their health benefits and presenting them with undistorted tradeoffs between third-party insurance and self-insurance, Large HSAs would make consumers more cost-conscious when purchasing their health insurance. Thus, Large HSAs would encourage plan features aimed at reducing low-value services,

such as higher deductibles and coinsurance, care management, electronic medical records, and other health information technologies. Since Large HSAs would place no limit on out-of-pocket exposure, in many cases they would encourage greater cost-sharing than existing HSAs. Plan features such as care management and health information technologies can also improve efficiency by enhancing quality. In addition to creating financial incentives to choose such features, Large HSAs would give consumers the agility necessary to do so.

Second, Large HSAs could also lead to greater allocative efficiency *across* economic sectors. Allowing individuals to adjust their Large HSA contributions, much like workers can adjust contributions to an FSA, would enable workers to allocate their income between health-related and non-health-related uses more flexibly than at present. Workers who prefer less health insurance could more easily allocate income to non-health uses than under the current exclusion, where it is costly to purchase less coverage than one's employer offers. More importantly, Large HSAs would limit the price distortion between health- and non-health-related uses of income by limiting health-related tax preferences (discussed further below).

Creating tax parity between health insurance and health savings is an important part of reducing distortions both within the health sector and across economic sectors. Many health-tax reform proposals pursue parity between third-party and first-party *payment* for medical services; that is, between health insurance and out-of-pocket expenditures. Such parity, however, might preserve a tax bias that favors third-party over first-party *pooling*. Saving allows consumers to self-insure against future medical expenses by pooling their own income over the course of a lifetime. If a dollar of income is untaxed when used to purchase health insurance but taxed if saved for future medical expenses, then at the margin the tax system will encourage taxpayers to finance their medical consumption by pooling their income with others rather than by saving. Eliminating that distortion would promote efficiency within the health sector by enhancing consumers' cost-consciousness when purchasing third-party insurance (and when purchasing medical services out-of-pocket). Likewise, because such parity would encourage less insurance and more savings, it would increase the probability that income initially devoted to health-related uses will be re-allocated to non-health uses. Unlike income spent on insurance premiums, funds deposited in a Large HSA can be withdrawn, taxed, and spent on non-health items.

C. *Equity*

Critics fault the exclusion for violating both horizontal and vertical equity. Horizontal equity requires that similar individuals be treated the same. Most agree that the exclusion violates this principle with regard to both workers and

firms. Though two workers may have identical incomes, one may be able to purchase health insurance tax-free, while the other must do so with after-tax dollars solely because of where she works. Workers who are temporarily unemployed suffer under the same inequity. The exclusion may further create horizontal inequities if, by diverting consumers away from non-group insurance, it results in higher administrative costs in that market (Pauly et al., 1999). The exclusion also creates horizontal inequities between firms, as firms that do not offer health benefits may be at a disadvantage when competing for workers against firms that do offer health benefits. At the same time, firms that offer health insurance may suffer a competitive disadvantage if they hire disproportionate numbers of workers with expensive medical conditions, or with dependents who have expensive medical conditions.

There is less agreement about vertical equity. Generally, vertical equity is the principle that policies should help those who most need assistance; that benefits should flow to those with lower incomes and burdens should disproportionately fall on those with higher incomes. Unlike horizontal equity, observers disagree about what constitutes vertical equity and whether redistribution is even desirable (Hall and Rabushka, 1995; Slemrod, 2000).

Some consider the exclusion to be regressive (Furman, 2006) because the *benefits* of the exclusion – reduced tax liabilities – are clearly tilted toward those with higher incomes. Equivalently, one can say the exclusion reduces effective marginal tax rates for many high-income individuals. However, others argue that higher marginal tax rates reduce efficiency (Pauly and Goodman, 1995; Hall and Rabushka, 1995), which may mean that high marginal tax rates themselves are inequitable if they reduce the standard of living of future generations – and particularly of low-income individuals – below what it otherwise would be. Some argue that the effects of high marginal tax rates on efficiency and liberty make them undesirable even for current generations (Hall and Rabushka, 1995).

At the same time, some argue the exclusion promotes vertical equity based on need by making coverage more affordable to workers with costly medical conditions. The exclusion encourages employment-based insurance, which many believe enables greater pooling of health risks (i.e., subsidies across risk categories) than non-group health insurance would allow (Furman, 2006; Fronstin, 2006; Custer, 1999). The result is that more high-cost individuals are able to obtain health coverage. However, others question whether employment-based insurance pools risk more broadly than non-group insurance. Some note that employers and workers engage in numerous strategies to reduce pooling in employer-sponsored health plans (Glied, 1994; Pauly et al., 1999; Bhattacharya and Bundorf, 2005; Strunk et al., 2005). Moreover, Pauly and others find significant pooling in non-group markets (Marquis et al., 2006), and question

whether much additional pooling takes place in employment-based pools (Pauly and Herring, 1999; Pauly et al., 1999).

A final example of vertical inequity is that the exclusion deprives lower-income individuals of benefits a less-distorted market might provide. Linking health insurance to employment may narrow the coverage choices of unskilled workers relative to skilled workers. First, any firm that offers comprehensive health benefits risks adverse selection; that is, it runs the risk of attracting less-healthy workers who desire comprehensive health benefits. Because workers can generally obtain jobs beneath, but not above, their skill level, firms that hire predominantly unskilled labor are more vulnerable to adverse selection than firms that hire skilled workers. When firms such as Wal-Mart protect themselves against adverse selection by offering less comprehensive health benefits (Hall, 2005) or no health benefits at all, that restricts the coverage choices of unskilled workers relative to those of skilled workers. The result is that unskilled workers are more likely not to be offered health benefits than skilled workers, are more likely to have fewer insurance choices than if insurance were not linked to employment, and are more likely to be offered less coverage than they would prefer. Second, unskilled workers are therefore more likely to have no option for coverage but what is available in the non-group market, where the exclusion contributes to high administrative costs.

HSAs offer only marginal improvements in horizontal equity. The income tax deductibility of non-employer HSA contributions brings the tax treatment of those without access to employer-sponsored coverage somewhat closer to that of workers with such access. HSAs also improve horizontal equity by reducing tax penalties on those who prefer more self-insurance and less third-party insurance. Insofar as HSAs make it easier for employers to offer coverage, HSAs reduce horizontal inequities between firms. Insofar as HSAs spur growth in the non-group market, they may help make such coverage more affordable by reducing administrative costs. However, each of these improvements is slight, and large horizontal inequities remain.

Judgments about HSAs' impact on vertical equity are mixed. Some criticize HSAs for expanding a tax exclusion whose benefits were already heavily tilted toward the wealthy (CBPP, 2006). Others note that many low-income workers would benefit from HSA-like coverage (Nichols et al., 1996). Again, insofar as HSAs expand non-group coverage or make it easier for firms to begin offering coverage, low-income workers will benefit.

By comparison, Large HSAs could generate dramatic improvements in both horizontal and vertical equity. All workers at a given income level could deposit the same amount into their Large HSA and face the same tax consequences – regardless of their place of employment or insurance preferences. Workers would no longer be penalized for purchasing coverage from someone

other than an employer. Moreover, those who purchase non-group insurance could expect to see reduced loading costs in a thicker non-group market (Pauly et al., 1999). Large HSAs would also reduce horizontal inequities between firms. Those that do not offer health benefits could arrange to make pre-tax deposits into workers' Large HSAs, which would better enable those firms to compete for workers.

Large HSAs would have ambiguous effects on vertical equity, however they could be designed to satisfy the concerns of those who value vertical equity. Some will see greater vertical inequity in contribution limits of \$8,000 and \$16,000. Indeed, many high-income earners would be able to shelter more income from taxation with a Large HSA than they do now. However, Large HSAs for the first time would limit the amount of health benefits that workers can exclude from taxation. Contribution limits of \$8,000 for individuals and \$16,000 for families would have required about 3 percent of covered workers in 2006 to pay taxes on a portion of their health benefits (Sheils, 2005). Workers with health benefits whose value exceeds those caps are likely to be higher-income workers. If the contribution limits were not indexed, then over time an increasingly large share of disproportionately high-income workers would pay taxes on a growing portion of their health benefits. Finally, that share could be increased by setting lower contribution limits, for example \$5,000 for individuals and \$10,000 for families.

At the same time, Large HSAs would offer significant benefits to low-income earners, many of whom receive no health-related tax breaks. Large HSAs would grant low-income workers universal access to the exclusion. Whether through employer contributions or another mechanism, all workers could use pre-tax income either to purchase health insurance or to save for future medical expenses. Individuals could take advantage of the tax exclusion to the extent they need and are able to do so, rather than to the extent their employer will allow. Again, low-income workers would benefit insofar as Large HSAs expand their coverage choices or help reduce the administrative costs of non-group insurance.

Another vertical equity issue involves the effect of Large HSAs on pooling. Insofar as Large HSAs reduce pooling, that would benefit low-risk insureds at the expense of sicker individuals. Some suggest that greater reliance on non-group insurance may not reduce pooling much, if at all (Pauly et al., 1999). However, even if Large HSAs were to reduce subsidies across risk categories, they would still provide expanded tax benefits to many high-risk individuals, particularly those currently without access to employer-sponsored insurance. Importantly, unlike proposals that offer tax benefits only for health insurance itself (tax credits, a standard health insurance deduction, etc.) or that condition other tax benefits on the purchase of insurance (current-law HSAs),

Large HSAs would benefit even the uninsurable, who could set thousands of dollars aside, completely tax-free, for their medical expenses.

Finally, Large HSAs raise issues of intergenerational equity. If Large HSAs expand the revenue loss due to the exclusion, and with it the federal deficit, that inequitably shifts the burden of current government outlays from current to future generations. On the other hand, encouraging current generations to save for future medical expenses could reduce the burden of entitlements on future generations. If Large HSAs increase the efficiency of the health care sector in the present, that too benefits future generations.

D. A Step toward Neutrality

Large HSAs present an opportunity to limit the tax exclusion and other health-related deductions that may be more politically feasible than past proposals. If so, this reform may also facilitate a transition to tax neutrality for health expenditures.

The Large HSA approach could help overcome the two main obstacles to eliminating or limiting the exclusion. First, eliminating the exclusion would tax currently untaxed economic activity by subjecting all employer-sponsored health benefits to both income and payroll taxes. Capping the exclusion would do the same insofar as the value of one's health benefits exceeds the specified cap. Those whose tax liability would rise naturally resist such proposals, while anti-tax activists resist on principle. The second obstacle is more technical. Capping or removing the exclusion would require employers to determine the value of each worker's health benefits for the purpose of calculating the taxes due. Determining the value of each worker's health benefits could be a difficult task for many employers.

Large HSAs could help overcome both obstacles. First, Large HSAs could reduce political opposition to a cap. The higher the contribution limits, the smaller the number of workers who would see any of their current health benefits subject to taxation. As noted earlier, contribution limits of \$8,000 for individuals and \$16,000 for families would have required only about 3 percent of covered workers in 2006 to pay taxes on a portion of their health benefits. Indeed, workers whose health benefits are less expensive than the contribution limits would be able to exclude more income than they do now.

More important, however, is that workers would gain greater control over their earnings. If a worker who currently excludes \$9,000 worth of health benefits is suddenly subject to an \$8,000 Large HSA contribution limit, she would have to pay taxes on \$1,000 of her premiums. However, she would have far more control over the first \$8,000. Her employer's influence over those earnings would disappear. The exclusion causes workers to lose a significant amount of control

over their earnings and health care decisions, which itself is akin to a tax. Large HSAs would eliminate that tax, and therefore arguably could reduce taxes even for those whose benefits exceed the contribution limits.

Second, Large HSAs could reduce the difficulties involved in calculating the value of health benefits for individual workers. Though many firms attribute a premium cost to each worker's health benefits, not all do. Self-insured plans pay claims as they occur, therefore there may be no premium already assigned to each worker (Fronstin, 2006).

Assigning premiums in such cases would be a delicate task. Whatever premium the firm assigns to a worker would become part of that worker's income. Younger workers would prefer that employers assign premiums (and "cash them out") as though premiums had been community-rated; that is, uniform across workers. Older workers would prefer that employers cash them out as though premiums had been risk-adjusted; doing so would assign higher premiums, and therefore a greater increase in cash wages, to older workers. Older workers would have a strong argument to make, given that wages appear to vary across firms according to easily observable risk factors such as age (Pauly et al., 1999). That suggests that, in effect, premiums for employer-sponsored coverage are not community-rated within firms, and that high-cost workers currently pay more than low-cost workers for the same coverage, because high-cost workers also pay in the form of lower wages.

Employers might choose whatever method of assigning premiums they believe would be least disruptive to their workforce. Though the least disruptive strategy would vary across firms, most employers likely would choose some form of risk-adjustment, given that health benefits are a particularly important part of the employment contract for high-cost workers. Employers could assign premiums based on the cost of the worker's current plan, the number of family members covered by the plan, the worker's age, seniority, past claims, or some combination of these factors. Firms are unlikely to assign premiums that are 100-percent actuarially fair, as doing so could alienate young and healthy workers. However, even if employers favor high-cost workers in that process, labor markets would eventually dissipate any supra-competitive wages.

Simply eliminating or capping the exclusion would force firms and workers to confront these difficulties at the same time they confront a significant tax increase. In contrast, Large HSAs could minimize the likelihood that any worker would face a tax increase. Moreover, Large HSAs could make that process more transparent, by creating a moment (such as the beginning of a calendar year) when employers would be expected to convert their contribution to each workers' health benefits into a wage increase. By forcing that process to occur in the open, Large HSAs could generate more information and

predictability about those conversions, thereby enabling employers and workers to plan for and adjust to those changes.

Like other proposals to achieve parity between group and non-group coverage, Large HSAs would raise additional concerns. In converting the employer's premium contribution to cash wages, would firms shortchange particular groups of workers? Would they shortchange workers as a whole? Would employers continue to offer health insurance? What other coverage options would be available?

Large HSAs would allow workers and firms to sort through these issues gradually. On the first day the tax code substitutes Large HSAs for the current exclusion, workers and firms could continue operating as if nothing had changed. Most workers would receive the full value of their health benefits as a cash contribution into their Large HSA. Healthy workers would see no jarring increase in their tax liability that might encourage them to pare back on coverage by leaving the firm's health plan. Over time, labor markets would push employers to pay workers according to their market value, thereby reducing the likelihood that workers would suffer as a result of an employer's arbitrary valuation of the workers' health benefits. Finally, as health insurance markets matured, workers would grow more familiar and comfortable with other coverage options.

Large HSAs would thus develop the health insurance and labor market conditions necessary to move to a tax system neutral toward health-related uses of income. Allowing those changes to occur before making a transition to full neutrality would make that final transition less opaque or jarring. A revenue-neutral transition would essentially require eliminating tax breaks for Large HSA contributions and lowering tax rates concomitantly. Large HSAs would make the size of each worker's tax break more transparent, thus workers could readily calculate how they would be affected by (1) increasing their base of taxable income and (2) taxing that income at a lower rate. There will be winners and losers in any attempt at fundamental tax reform, yet Large HSAs could reduce the opacity of, and therefore much opposition to, such a transition. Likewise, after the transition, workers would be better equipped to navigate the level playing field between employer-provided and other types of insurance, because the playing field already would have been level for some time.

IV. Additional Effects

Large HSAs would have additional economic effects of interest to citizens and policymakers. Large HSAs could influence the cost of different insurance choices (including the choice not to purchase insurance), aggregate demand for medical care, economic output, and federal revenues.

A. Insurance Premiums & the Number of Uninsured

By altering the relative prices of various ways of financing medical expenses, Large HSAs could affect the availability and affordability of different insurance options. Large HSAs would reduce the cost of non-group coverage relative to group coverage, benefiting many individuals with non-group coverage, as well as many uninsured.

At the same time, that change could increase the cost of insurance for sicker-than-average households. Establishing tax parity between group and non-group coverage could make it easier for healthier households to find less costly coverage in the non-group market. To the extent that healthier households abandon employment-based groups, the risk profile of those groups will deteriorate, which could cause premiums to rise to the point that some sicker-than-average households might no longer be able to afford coverage.

Though some risk segmentation is likely, Large HSAs are unlikely to cause many employment-based groups to unravel or many currently insured individuals to lose coverage. Marquis and colleagues estimate that reducing the price of non-group coverage by 20 percent would motivate less than 0.05 percent of workers to leave their employment-based health plan, and that substantial shares of households with health problems not only obtain coverage in the non-group market but pay standard premiums as well (Marquis et al., 2006).

That is consistent with Congressional Budget Office projections of the effects of a similar proposal, the Bush administration's standard health insurance deduction. The CBO projects that proposal would cause 6.3 million people to move from group to non-group coverage. Migration from employer-sponsored insurance to non-group insurance would be limited, the CBO writes, because "the former has significantly lower administrative costs and advantages in forming insurance pools with more predictable costs." An estimated 1.5 million people with group coverage would go uninsured, yet that number would be swamped by 7 million previously uninsured people who would obtain non-group coverage and a further 1.3 million who would obtain job-based coverage. On balance, the CBO projects that a standard deduction would reduce the number of uninsured residents by a net 6.8 million, though these estimates are "highly uncertain" (CBO, 2007). Given the similarities between the two proposals, Large HSAs are likely to have similar effects.

Large HSAs would affect the cost of going uninsured, however, in ways that a standard deduction would not. Large HSAs would not require that the account holder carry insurance. That would reduce the cost of that option for many uninsurable households – including any households that may lose coverage due to risk segmentation induced by Large HSAs – because it would dramatically expand the tax benefits available for the uninsurable. A standard deduction, like

many other proposed health-tax reforms, would provide no tax benefits to this group.

At the same time, the lack of any insurance requirement could encourage people to forgo coverage, build up savings, and rely on uncompensated care if they ever exhausted those funds. Though this concern is valid, Large HSAs would not so much attract free-riders as savers. Most Americans already have the option of forgoing health insurance and relying on uncompensated care.⁷ The only inducement added by Large HSAs would be the ability to save tax-free for one's medical expenses. If the lack of an insurance requirement would increase the number of uninsured, that necessarily means there are currently covered workers who do not drop that coverage *solely because* they do not have the opportunity to accumulate tax-free health savings without purchasing insurance.

Large HSAs nevertheless provide a considerable incentive for such individuals to purchase health insurance. Over time, these savers could accumulate substantial balances, which they would want to protect from being wiped out by a serious illness or injury (Phelps, 2003). The most obvious way to protect those assets is with health insurance. Even if the savers did not purchase insurance, they would have (at a minimum) their Large HSA balances to help pay for any needed medical expenses.

Finally, insofar as Large HSAs make consumers more price-sensitive, they can be expected to generate greater price transparency and competition, reducing costs for both the insured and the uninsured.

B. Demand for Medical Care

Large HSAs could increase or decrease overall demand for medical care. Their effect on each consumer's demand for medical care would depend on the consumer's Large HSA contribution limit, current income, insurance status, insurance premiums, risk-aversion, marginal tax rate, and any resulting changes in her overall compensation. Given that Large HSAs' greatest effect would arguably be to reduce the cost of self-insurance and out-of-pocket expenditures relative to third-party insurance, it seems reasonable to predict that Large HSAs would reduce overall demand for medical care.

To isolate some of the complicated effects that Large HSAs would have on the demand for medical care, assume that: (A) Large HSAs with contribution limits of \$8,000 per individual and \$16,000 per family would replace all existing federal tax preferences for health-related uses of income; (B) those Large HSA contribution limits would remain constant in nominal terms; and (C) each worker's overall compensation would remain constant – i.e., employers would

⁷ That option is still legal in at least 48 states.

“cash-out” each worker on an actuarially fair basis. Given those conditions, Large HSAs would:

1. Increase the inframarginal cost of third-party insurance relative to self-insurance for 160 million U.S. residents with employer-sponsored coverage. This would tend to reduce the demand for medical care.
2. Reduce the cost of self-insurance and out-of-pocket medical expenditures relative to other uses of income for 160 million residents with employer-sponsored insurance. This would tend to increase the demand for medical care.⁸
3. Encourage greater savings, as a result of (1) and (2). The resulting wealth effect would tend to increase demand for (health insurance and therefore medical care) over time, though this effect is likely to be small.⁹
4. Reduce the marginal cost of third-party insurance relative to non-health uses of income – but also relative to self-insurance and out-of-pocket medical expenditures – for most of the 160 million with employer-sponsored insurance. In 2006, approximately 97 percent of covered workers excluded from taxation less than they would have been able to under the proposed Large HSA contribution limits. Insofar as such workers prefer more coverage than their employer currently offers, this would tend to increase the demand for medical care.¹⁰

⁸ Reducing the cost of out-of-pocket medical spending relative to non-medical uses of income would tend to increase the demand for medical care. However, that effect would be mitigated to some extent by a concomitant reduction in the cost of saving for future medical consumption (and in the cost of saving for non-medical consumption after the worker turns 65) relative to other uses of income. (After age 65, the 10-percent penalty for non-medical withdrawals disappears and such withdrawals are taxed as regular income, much like 401(k)s and some IRAs.)

⁹ “In most studies using individual data, estimated income elasticities [for health insurance] are generally positive, but less than 1 for almost any measure of insurance chosen” (Phelps, 2003).

¹⁰ The cost of obtaining more coverage than one’s employer currently offers is higher than the additional premium and the worker’s marginal tax rate would suggest. Purchasing additional coverage generally involves either declining the plan offered by one’s employer or switching jobs. Therefore, the cost of obtaining additional coverage includes forgoing the tax break available under the employer’s plan, or alternatively, the costs involved in obtaining a different job that offers the desired level of coverage. Large HSAs would enable workers to purchase more coverage than their employer offers without sacrificing that tax break or changing jobs. Thus, although Large HSAs would reduce the cost of self-insurance and out-of-pocket spending relative to third-party insurance in most cases, Large HSAs could likewise dramatically reduce the

5. Increase the marginal cost of third-party insurance relative to other uses of income for those who exempt premiums in excess of the Large HSA contribution limits. In 2006, approximately 3 percent of covered workers would have fallen into this group. This would tend to reduce the demand for medical care.
6. Reduce the cost of third-party insurance, self-insurance, and out-of-pocket medical spending, relative to other uses of income, for an estimated 16 million residents with non-group coverage and 47 million uninsured residents. This would tend to increase the demand for medical care. However, that effect would be dampened to the extent that such households already deduct from their taxable income contributions to current-law HSAs or medical expenses in excess of 7.5 percent of their adjusted gross income (AGI). Moreover, medical expenses in excess of both 7.5 percent of AGI and applicable Large HSA contribution limits would be newly subject to income taxes, which would tend to reduce the demand for medical care. (See Appendix.)
7. Reduce the cost of leaving an employer's health plan by removing the attendant tax penalty. Insofar as they encourage healthier-than-average households to leave employment-based plans, Large HSAs would increase the cost of health insurance for sicker-than-average households. This would tend to reduce the demand for medical care.¹¹

Altering the initial Large HSA contribution limits or their rate of growth would influence these effects. Lower initial contribution limits would do more to reduce the demand for medical care than higher contribution limits. If contribution limits grow at a slower rate than health insurance premiums, that would tend to reduce the demand for medical care by reducing the demand for health insurance. If contribution limits grow at a rate slower than medical inflation, that likewise would tend to reduce the demand for medical care. Higher initial contribution limits and growth rates would put less downward pressure on demand for medical care, and at some point would increase overall demand.

If employers "cash out" all covered workers within a firm the same dollar amount, then sicker-than-average households would effectively suffer a loss in total compensation. This would tend to reduce the demand for medical care. Increasing cash wages in proportion to the expected benefit that each worker

marginal cost of third-party insurance for workers who prefer more coverage than their employer offers.

¹¹ The impact on demand among healthier-than-average households is captured by (1) and (4).

derives under the employer's health plan, on the other hand, would have a more neutral effect on overall demand. Nevertheless, the labor market would eventually dissipate any supra-competitive wages, which could ultimately reduce sicker households' incomes and reduce their demand for medical care.

How Large HSAs would affect the demand for medical care is ultimately an empirical question. Given that Large HSAs would dramatically reduce the cost of self-insurance relative to third-party insurance for the bulk of the population and cap federal tax preferences for medical care, it is reasonable to predict that on balance Large HSAs would reduce overall demand for medical care.

C. Economic Output & Consumer Welfare

Large HSAs would affect overall economic output and consumer welfare. By limiting federal tax breaks for health-related uses of income, Large HSAs could increase marginal tax rates for some workers, which implies a reduction in the quantity of labor supplied and lower economic output. At the same time, Large HSAs would reduce marginal tax rates for many workers, which implies the opposite. By expanding existing tax incentives to save for future medical expenses, Large HSAs would encourage greater national saving and higher future economic output. By reducing the existing tax-based distortions of workers' health spending and saving decisions, Large HSAs could increase overall consumer welfare in ways that standard measures of economic output would not capture.

Large HSAs could increase (or reduce) a worker's federal marginal tax rate by increasing (or reducing) a worker's taxable income, thereby moving the worker into a different tax bracket. To the extent that workers respond to Large HSAs by excluding additional income from taxation, that would reduce workers' taxable incomes, and thereby move many into lower tax brackets. Conversely, Large HSAs could move some workers into higher tax brackets by forcing some workers to reduce the amount of income they exclude from taxation for health-related purposes.

Assuming no change in a worker's tax bracket, Large HSAs would increase federal marginal tax rates to the extent that workers demand coverage more costly than the applicable Large HSA contribution limit. Likewise, to the extent that the last dollar of income a worker devotes to health-related uses falls below the applicable contribution limit, Large HSAs would reduce the worker's federal marginal tax rate.

Again, the effects that a standard deduction would have on the broader economy can illuminate the potential effects of Large HSAs. The CBO projects that a standard deduction would increase effective federal marginal tax rates by

1.2 percentage points in 2009 and 1.8 percentage points in 2017, and would somewhat increase national saving. On net, the CBO projects the proposal would reduce gross national product by less than 0.5 percent per year (CBO, 2007).

Two differences make it plausible to predict that Large HSAs would reduce future economic output less than a standard deduction. First, Large HSAs would increase marginal tax rates for fewer workers. While a standard deduction would create a large incentive to purchase a basic insurance policy, any marginal tax preference disappears after that initial margin. Large HSAs would preserve a tax preference for health-related uses of income up to the contribution limits, which suggests fewer workers would experience higher marginal tax rates. Second, even if Large HSAs were calibrated to have the same impact on federal revenues (and thus national saving) as a standard deduction, Large HSAs would still create an additional tax incentive for households to increase their savings. That could increase national saving and future economic output beyond what a standard deduction would achieve.

Finally, as with a standard deduction, Large HSAs would reduce the tax code's distortions of how workers allocate their earnings. Thus even if economic output were to remain constant, overall consumer welfare would rise because consumers would allocate their earnings to more highly valued uses.

D. Federal Revenues

Large HSAs would also affect federal revenues. If contribution limits are set sufficiently high, Large HSAs would reduce federal revenues for a number of years by exempting a greater share of workers' earnings from income and payroll taxes. Those contribution limits, however, would act as a cap on tax preference for health-related uses of income and would subject an ever-increasing share of earnings to taxation. Like the proposed standard deduction for health insurance (CBO, 2007), over the long term Large HSAs would increase federal tax revenues compared to current law.

V. Implementation Options

As suggested above, Large HSAs offer a number of implementation options. One is the level of the contribution limits, which can be calibrated to strike a politically viable balance between, for example, efficiency and equity. Higher contribution limits would hold more taxpayers harmless; reduce political resistance by workers, employers, and anti-tax activists; allow sicker people to set aside more money tax-free; and enable more workers to save for their future health needs. Higher contribution limits would also result in a larger revenue loss for the federal government; provide larger tax breaks for high-income earners;

and expand distortions between health-related and non-health-related expenditures. Low contribution limits would reduce economic distortions; increase the tax burden for more workers; reduce federal revenue losses; and encounter greater political opposition from anti-tax activists.

An important part of setting contribution limits would be the question of whether and how those limits would change over time. Different approaches would offer advantages and disadvantages, both political and economic. Contribution limits could be fixed in nominal terms or indexed to overall inflation, which tends to grow less rapidly than medical inflation. Such an approach effectively phases in lower contribution limits over time, with all the attendant advantages and disadvantages. In contrast, contribution limits indexed for medical inflation could reduce political opposition to Large HSAs by requiring fewer workers to pay taxes on a portion of their health benefits. However, that political benefit would come at the cost of preserving economic distortions that would be eliminated by contribution limits that rose more slowly.

These parameters could be adjusted to enable legislative approval. If a political equilibrium requires that Large HSAs redistribute more of the tax benefits from rich to poor, or result in a smaller revenue loss, or do more to limit the distortion of consumers' allocation decisions; then contribution limits may be adjusted downward, whether initially, over time, or both. If equilibrium requires that Large HSAs subject fewer currently untaxed expenditures to taxation, or encourage greater saving for future health needs, or provide unhealthy individuals greater ability to purchase medical care tax-free; then contribution limits may be adjusted upward. If policymakers wish to dampen demand for medical care, they may reduce or eliminate the 10-percent penalty for non-medical withdrawals from a Large HSA.

VI. Conclusion

The tax exclusion for employer-sponsored health benefits engenders considerable inefficiencies and inequities, and has earned critics of all political stripes. At the same time, the exclusion is the foundation of America's employment-based health care system, and therefore has defenders who are averse to unsettling the status quo. HSAs, as enacted in 2003, represent a rather modest step toward reducing price distortions within the health care sector, but do so at the expense of magnifying price distortions between the health care sector and other sectors.

HSAs create an opportunity, however, to restructure the exclusion in a way that would enable more individuals to obtain health insurance that matches their preferences, increase efficiency, eliminate the horizontal inequities created by the exclusion, and could even create improvements in vertical equity. Additionally, Large HSAs could serve as a step toward a tax system that offers no

preferred treatment to health expenditures, and thereby forces the health care sector to accomplish more with the resources devoted to it.

Appendix

To illustrate the complicated and countervailing effects that substituting Large HSAs for the current set of health-related federal tax breaks would have on the demand for medical care, consider households for whom 7.5 percent of adjusted gross income (AGI) is either greater than or less than the relevant Large HSA contribution limit:

Table I.			
<i>If 7.5% of a Household's AGI Is Less than the Household's Large HSA Contribution Limit, then Qualified Medical Expenses that Fall...</i>			
	<i>Between \$0 & 7.5 percent of AGI</i>	<i>Between 7.5 percent of AGI & the Large HSA Contribution Limit</i>	<i>Above the Large HSA Contribution Limit</i>
<i>Are Currently Subject to</i>	Income & payroll taxes	Payroll tax	Payroll tax
<i>And under Large HSAs Would Be</i>	Newly exempt from both income & payroll taxes	Newly exempt from payroll tax	Newly subject to income tax
<i>Which Would Tend to</i>	Increase the demand for medical care	Increase the demand for medical care	Reduce the demand for medical care
<i>...within that margin.</i>			

Table II.

<i>If 7.5% of Household's AGI Exceeds Household's Large HSA Contribution Limit, then Qualified Medical Expenses that Fall...</i>			
	<i>Between \$0 & the Large HSA Contribution Limit</i>	<i>Between the Large HSA Contribution Limit & 7.5 percent of AGI</i>	<i>Above 7.5 percent of AGI</i>
<i>Are Currently Subject to</i>	Income & payroll taxes	Income & payroll taxes	Payroll tax
<i>And under Large HSAs Would Be</i>	Newly exempt from both income & payroll taxes	Unchanged	Newly subject to income tax
<i>Which Would Tend to</i>	Increase the demand for medical care	Have no effect on the demand for medical care	Reduce the demand for medical care
<i>...within that margin.</i>			

References

- Bhattacharya, Jayanta and M. Kate Bundorf, "The Incidence of the Healthcare Costs of Obesity," 2005, National Bureau of Economic Research, Working Paper No. W11303.
- Burman, Leonard, et al., "The President's Proposed Standard Deduction for Health Insurance: An Evaluation," 2007, Urban Institute and Brookings Institution Tax Policy Center.
- Cannon, Michael F., "Cato Institute Policy Analysis no. 569: Health Savings Accounts: Do the Critics Have a Point?" 2006, Cato Institute.

- Center on Budget and Policy Priorities (CBPP), “A Brief Overview of the Major Flaws with Health Savings Accounts,” 2006.
- Cogan, John F., et al., *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System*, 2005, AEI Press/Hoover Institution, Washington, DC.
- Conover, Christopher, “Cato Institute Policy Analysis no. 527: Health Care Regulation: A \$169 Billion Hidden Tax,” 2004, Cato Institute.
- Custer, William F., et al., “Why We Should Keep the Employment-Based Health Insurance System,” *Health Affairs*, Vol. 18, No. 6.
- DeNavas-Walt, Carmen, et al., “U.S. Census Bureau Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States: 2005,” 2006, U.S. Census Bureau.
- Feldstein, Martin, “The Welfare Loss of Excess Health Insurance,” *Journal of Political Economy*, 1973, Vol. 81, No. 2, Part 1.
- Feldstein, Martin and Bernard Friedman, “Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis,” *Journal of Public Economics*, 1977, Vol. 7, No. 2.
- Feldstein, Martin, and Jonathan Gruber, James Poterba, ed., “A Major Risk Approach to Health Insurance Reform,” *Tax Policy and the Economy*, Volume 9, 1995, MIT Press, Cambridge, MA.
- Friedman, Milton, “How to Cure Health Care,” *Public Interest*, 2001, No. 3.
- Fronstin, Paul, “The Tax Treatment of Health Insurance and Employment-Based Health Benefits,” Employee Benefit Research Institute Issue Brief, No. 294, 2006, Employee Benefit Research Institute.
- Furman, Jason, “Our Unhealthy Tax Code,” *Democracy*, 2006, Issue #1.
- Furman, Jason, “Two Wrongs Do Not Make a Right,” *National Tax Journal*, 2006, Vol. 59.
- Glied, Sherry, *Revisiting the Tax Treatment of Employer-Provided Health Insurance*, AEI Press, 1994, Washington, DC.
- Gruber, Jonathan, and James Poterba, Martin Feldstein and James Poterba, eds., “Tax Subsidies to Employer-Provided Health Insurance,” *Empirical*

Foundations of Household Taxation, University of Chicago Press, 1996, Chicago, IL.

Hall, Cheryl, "A Novel Idea: Health Insurance You Take with You," *Dallas Morning News*, March 27, 2005.

Hall, Robert E., and Alvin Rabushka, *The Flat Tax*, Hoover Institution Press, 1995, Stanford, CA, 2nd edition.

Helms, Robert, "Mission Impossible: No One Is Going to Blow up Health Insurance," *Tax Notes*, 2006.

Herrick, Devon M., "Health Insurance: Why Rent When You Can Own?" *Health Care News*, May 1, 2005, <http://www.heartland.org/Article.cfm?artId=16866>.

Kaiser Family Foundation and the Health Research and Educational Trust (HRET), *Employer Health Benefits: 2007 Annual Survey*, 2007.

Mack, Connie, et al., "Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System," Report of the President's Advisory Panel on Federal Tax Reform, 2005, http://www.taxreformpanel.gov/final-report/TaxReform_Intro.pdf.

Marquis, M. Susan, et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 2006, Vol. 25, No. 3.

Newhouse, Joseph P., et al., *Free for All? Lessons from the RAND Health Insurance Experiment*, 1996, Harvard University Press, Cambridge, MA.

Nichols, Len M., et al., "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," 1996, Urban Institute.

Pauly, Mark V., "An Analysis of Medical Savings Accounts: Do Two Wrongs Make a Right?" 1994, AEI Press, Washington, DC.

Pauly, Mark V., and Bradley Herring, *Pooling Health Insurance Risks*, 1999, The AEI Press, Washington, DC.

Pauly, Mark V., and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," 1995, *Health Affairs*, Vol. 14, No. 1.

- Pauly, Mark et al., “Individual versus Job-Based Health Insurance: Weighing the Pros and Cons,” 1999, *Health Affairs*, Vol. 18, No. 6.
- Phelps, Charles E., *Health Economics*, 2003, Addison Wesley, Boston, MA, 3rd edition.
- Sheils, John F., “Percent Distribution of Covered Workers by Premium Amount Per Month for Those with Single and Family Coverage,” personal correspondence to Michael F. Cannon, January 7, 2005, author’s files.
- Slemrod, Joel B., ed., *Does Atlas Shrug? The Economic Consequences of Taxing the Rich*, 2000, Russell Sage Foundation/Harvard University Press, Cambridge, MA.
- Strunk, Bradley C., et al., “Tracking Health Care Costs: Declining Growth Trend Pauses in 2004,” 2005, *Health Affairs* Web Exclusive.
- U.S. Congressional Budget Office, “Appendix C – The President’s Proposal for a Standard Tax Deduction for Health Insurance,” in *An Analysis of the President’s Budgetary Proposals for Fiscal Year 2008*, 2007.
- U.S. Council of Economic Advisers (CEA), *Economic Report of The President, Together With The Annual Report of The Council Of Economic Advisers*, U.S. Government Printing Office, 2006.
- U.S. Department of the Treasury, “Indexed Amounts for Health Savings Accounts,” October 28, 2005, press release.
- U.S. Internal Revenue Service (IRS), “Notice 2004-50 - Part III - Administrative, Procedural, and Miscellaneous,” July 23, 2004 (corrected version posted August 10, 2004).
- U.S. Internal Revenue Service (IRS), “Publication 502: Medical and Dental Expenses (Including the Coverage Tax Credit) for Use in Preparing 2005 Returns,” 2005a.
- U.S. Internal Revenue Service (IRS), “Publication 969 (2005), Health Savings Accounts and Other Tax-Favored Health Plans,” 2005b.
- U.S. Office of Management and Budget (OMB), *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007*, U.S. Government Printing Office, 2006.