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Health Accounts/Arrangements: An Expanding Role Under the Affordable Care Act?, 47 J. Marshall L. Rev. 991 (2014)

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HEALTH ACCOUNTS/ARRANGEMENTS: AN EXPANDING ROLE UNDER THE AFFORDABLE CARE ACT?

EDWARD A. MORSE¹

This article outlines the foundations of health-related accounts and arrangements, including tax and economic considerations affecting their role in various designs for health insurance coverage. It explores the impact of the Affordable Care Act and related administrative guidance affecting their usage, arguing that emerging trends showing that insured patients are bearing increasingly significant levels of out-of-pocket costs suggest an expanding role for consumer-directed accounts and arrangements, albeit one clouded by looming excise taxes imposed on “excess benefit” coverage beginning in 2018. It also examines the potential to utilize health accounts/arrangements to resolve moral and ethical conflicts in healthcare policy. Building on a suggestion by Professor Zelinsky, this article argues that an expanded approach to using health accounts/arrangements could enhance freedom not only for religious employers, but also for nonreligious employers concerned about respecting the religious beliefs of their employees.

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I. INTRODUCTION

Health-related spending/saving accounts and arrangements, consisting of health savings accounts (HSAs), health flexible spending arrangements (health FSAs), and health reimbursement arrangements (HRAs), are widely used to help patients fund their healthcare costs. Recent data shows that approximately 21 percent of all civilian workers had access to an HSA and 40 percent had access to health FSAs through their employers.² Workers at larger firms generally have even higher access rates, as 29 percent of employees at firms with 500 or more workers had access to HSAs and 71 percent had access to health FSAs.³

Although widely available, these health accounts/arrangements fund only a small portion of annual personal healthcare costs, most of which are funded through government and private insurance. Data compiled by the federal government show total personal healthcare expenditures of \$2.186 trillion in 2010.⁴ Of this total, 77.9 percent (about \$1.7 trillion) was financed by health insurance, including private and government programs, while 13.7 percent (\$299.7 billion) was financed by out-of-pocket payments.⁵ Of these total out-of-pocket payments, it is likely that health accounts/arrangements fund less than one-seventh of this amount.⁶

2. See BUREAU OF LABOR STATISTICS, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES, MARCH 2013 tbl. 41 (2013) [hereinafter BLS], available at www.bls.gov/ncs/ebs/benefits/2013/ebb10052.pdf (showing “Healthcare reimbursement account” under “Section 125 cafeteria benefits,” which as discussed below, reflects health FSAs).

3. *Id.*

4. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH, UNITED STATES, 2012, at 325 tbl. 114 (2013), available at www.cdc.gov/nchs/data/hsu/2012/114.pdf (showing \$2.186 trillion in personal health care expenditures in 2010).

5. *Id.*

6. According to one recent study, the combined total balance of HRAs and HSAs for 2012 was approximately \$17.8 billion. Paul Fronstin, *Health Savings Accounts and Health Reimbursement Arrangements: Assets, Account Balances, and Rollovers, 2006-2012*, EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF, 382, at 4 (2013). This does not necessarily reflect the total annual payments from such accounts, but even if we assume this entire balance would be distributed in a single year it would comprise no more than 6 percent of out-of-pocket funding based on the 2010 spending level of \$299.7 billion. For health FSAs, annual contribution data is more difficult to come by, but annual contributions would necessarily approximate annual spending due to the “use-or-lose” requirement imposed on these accounts. See Janemarie Mulvey, *Health Care Flexible Spending Accounts*, CONG. RES. SERV. 7-5700, at 5 (2012) (stating that “[f]ew surveys ask about FSAs, and those that do obtain only limited information.”); *id.* at 7 (discussing “use it or lose it” requirement).

Health saving/spending accounts and arrangements nevertheless provide an important source of liquidity for patients to cover a sizable sum of these out-of-pocket costs. They may also provide other benefits, including a small measure of cost containment through conferring autonomy on the patient (albeit in varying degrees) to select and pay providers directly through funds they either own or control, instead of through an insurance intermediary.⁷

Health saving/spending accounts and arrangements predate the Affordable Care Act (ACA), and only a few provisions in the ACA target these accounts directly.⁸ However, it appears that the

Nevertheless, a rough estimate may be constructed as follows: 124,992,900 civilian workers (BLS, *supra* note 2) * .40 (availability rate per BLS, *supra* note 2) * .37 (participation rate in 2009 per Mercer study, Mulvey, *supra*) * \$1420 (2009 average contribution among participating employees per Mercer study, Mulvey, *supra*) = \$26.3 billion. Combining these two figures (\$17.8 billion + \$26.3 billion = \$44.1 billion) would produce approximately one-seventh of out-of-pocket costs based on 2010 spending levels. (i.e., \$44.1 billion / \$299.7 billion = 14.71%).

7. See, e.g., William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 U. MEMPHIS L. REV. 279, 369-70 (2009) (noting that “[t]he third-party payment system that consumers finance has produced a health care system with perverse incentives for them to overconsume with little concern for the value they receive for the price that they ultimately pay . . . [w]hen consumers understand that they provide the funds that others disburse to health care providers, they will demand more net value from all of the health care services for which they pay. Maximization of such net value will require some form of consumer-driven health care (“CDHC”) wherein consumers directly pay for the health care they receive and reap savings when they choose less expensive alternatives. CDHC will cause consumers to reward only those health care providers who successfully compete for their custom.”); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TULANE L. REV. 777, 792 (2006) (stating that “[t]he theory behind CDHPs [consumer-driven health plans] is that individuals should be incentivized to act as consumers when they purchase medical services. That is, individuals should be taught to approach medical care purchasing decisions like they approach the purchasing decision for any other consumer good. The consumer must perform a cost-benefit analysis and, taking into account her limited resources, decide which goods will maximize her utility.”) As will be discussed below, the savings dimensions permitted in HSAs and HRAs contribute to this incentive structure in a way that is not present with health FSA's. *Id.* However, all three accounts permit some consumer autonomy outside of a system controlled by insurance providers. It should also be noted that while consumer-driven plans often focus on change in the demand side of the healthcare equation (which, admittedly, is not always elastic), some supply side effects may also occur, including attention to more cost-effective care options. *Id.* at 803. Cost savings may also be possible through enhancing the speed of payment to providers who prefer the rapid access to payment through a direct electronic payment mechanisms utilized with consumer driven accounts, as compared with longer payment processes through insurance intermediaries. Based on experience of the author, some providers offer discounts for cash payments, including electronic payments from an HSA, for this reason.

8. See, e.g., Pub. L. No. 111-148, Title IX, § 9003, 124 Stat. 119, 854 (restricting

ACA is producing other transformative effects on financing healthcare, which suggest that an expanded role for consumer-driven accounts – and particularly for the HSA – may be coming. As implementation of the ACA unfolds, it appears that patients who are covered by health insurance will bear increasingly significant levels of out-of-pocket costs. Although the ACA sets an upper limit on such costs – for 2014, total out-of-pocket expenses are capped at \$6,350 (single) and \$12,700 (family)⁹ – other features of the ACA, including expanded minimum benefits, repeal of annual and lifetime benefit limits, and community rating limitations, have translated into an environment of rising premium costs for private health insurance. In order to find ways to keep premiums affordable, insurers have resorted to raising deductibles and co-payments to the extent permitted by law,¹⁰ continuing a recent trend toward expanding patient responsibility for healthcare payments.¹¹

When given the choice, it appears that many employers and consumers prefer to accept the tradeoff of greater personal responsibility for future health care costs in the form of deductibles and co-payments in order to reduce current outlays for insurance premiums.¹² Such preferences are rational and prudent

medical expense distributions for medicine and drugs other than a prescribed drug or insulin); *id.* § 9005, 124 Stat. 854-55 (restricting qualified benefits through a health FSA to an annual salary reduction of \$2,500).

9. Rev. Proc. 2013-25, 2013-21 I.R.B. 1110.

10. *See, e.g.,* Leslie Scism and Timothy W. Martin, *Higher Deductibles Fuel New Worries of Health-Law Sticker Shock*, WALL ST. J., Dec. 8, 2013, available at <http://online.wsj.com/news/articles/SB10001424052702303330204579246211560398876> (noting that the average individual deductible for a bronze plan on an exchange is \$5,081/year, 42% higher than the \$3,589 average in 2013 before the ACA went into effect).

11. *See* INSTAMED, TRENDS IN HEALTHCARE PAYMENT ANNUAL REPORT, at 4 (2012), available at www.instamed.com/wp-content/uploads/Trends-in-Healthcare-Payments-Annual-Report-2011.pdf (noting that, between 2010 and 2012, percentage of payments coming from private third party payers declined from 23% to 20%, attributing difference to increased patient responsibility).

12. The ACA recognizes this tendency by permitting those under 30 and others for whom insurance coverage might otherwise be unaffordable to purchase catastrophic coverage (albeit without premium subsidies) in order to avoid penalties for being uninsured. *See* Pub. L. No. 111-148, § 1302(e), 124 Stat 119, 168 (2010) and 26 CFR § 156.155 (describing “Enrollment in catastrophic plans”). *See also* Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 77 Fed. Reg. 70584, 70586 (Nov. 26, 2012) (noting that “[a]dditionally, young adults and people for whom coverage would otherwise be unaffordable will have access to a catastrophic plan that will have a lower premium, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing.”). Secretary Sebelius has also granted an administrative exemption expanding the scope of permitted catastrophic coverage to those facing cancellation of existing coverage under the act. Letter from Kathleen Sebelius to [Senator] Mark R. Warner, at 2 (Dec. 19, 2013), available at www.hhs.gov/healthcare/facts/factsheets/2013/12/letter-to-senator.pdf.

if the combined outlays for insurance and out-of-pocket costs remain affordable. However, for patients without access to these health accounts, these out-of-pocket costs must be paid from after-tax earnings, if they can be paid at all.¹³ After all, even insured patients may externalize costs to others if they lack the means to pay them. By imposing additional constraints on itemized deductions for medical expenses,¹⁴ the ACA has modestly enhanced the value of income tax incentives for establishing health accounts and arrangements that allow medical expenses to be paid from pretax earnings.¹⁵ The potential for Social Security/Medicare tax avoidance also incentivizes employers to provide health benefits, which continues in the post-ACA environment.¹⁶

While each of these accounts offer similar opportunities for tax savings, other changes in the post-ACA environment are making HSAs relatively more attractive than their counterparts. The ACA provides an additional nudge away from plans using health FSAs and toward those using HSAs by capping the annual employee contribution limits for FSAs at \$2,500 beginning in 2013, which is well below the permitted contribution levels for HSAs.¹⁷ ACA changes involving so-called “market reforms” have also affected the ability of employers to offer health FSA and HRAs that are not integrated with employer-provided healthcare plans.¹⁸ HSAs are not affected by these requirements.

Finally, ACA provisions designed to impose a 40 percent excise tax on plans with “excess benefit” coverage beginning in 2018¹⁹ will also likely reinforce the trend toward patient

13. Uncompensated care, defined to include both the cost of bad debt and charity care, totaled more than \$41 billion in community hospitals in 2011 – or about 5.9% of their total expenses. See AMERICAN HOSPITAL ASSOCIATION, UNCOMPENSATED HOSPITAL CARE FACT SHEET, at 3 (2013), available at www.aha.org/content/13/1-2013-uncompensated-care-fs.pdf (providing these statistics). This total does not include uncompensated care outside of hospitals, such as through private doctors or clinics. Moreover, this total does not include the underpayment reflected in government reimbursements for Medicare and Medicaid patients, which according to the AHA, totaled \$56 billion in 2012. See AMERICAN HOSPITAL ASSOCIATION, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET, at 3 (2014), available at www.aha.org/content/14/2012-medicare-med-underpay.pdf (providing the amount of underpayments omitted). Thus, it appears that government underpayments are a larger financial problem than uncompensated care from private patients.

14. See Pub. L. No. 111-148, Title IX, § 9013, 124 Stat 119, 868 (increasing AGI limitation in I.R.C. § 213 from 7.5% to 10% for taxpayers other than seniors effective in 2013).

15. See *infra* part II.A.3 (discussing income tax).

16. See *infra* part II.A.4 (discussing employment tax).

17. I.R.C. § 125(i) (2004), as added by Pub. L. No. 111-148, Title IX, § 9005, 124 Stat 119, 855 (2010).

18. Notice 2013-53, I.R.B. 2013-36, discussed in part II.C., *infra*.

19. I.R.C. § 4980I (2010).

responsibility. Cost-conscious employers may find a high deductible health plan coupled with an HSA to be an attractive alternative for delivering health benefits to their employees in compliance with the ACA, while lowering outlays for health insurance.²⁰

This article will examine the current rules and incentives for using health-related spending/savings/reimbursement accounts and their role in the healthcare structure produced by the ACA. Part II provides an overview of salient features of each kind of account or arrangement, along with changes imposed by the ACA that may affect their utility. Part III explores the cost environment for choosing high deductible health plans (HDHP) compared to other common insurance products and the potential costs and benefits from HSA participation, along with some other trends that favor an expanded role for HDHP/HSA utilization. Part IV explores the potential for an HDHP/HSA approach toward resolving emerging conflicts over moral and ethical concerns over healthcare in a pluralistic society. Finally, Part V offers some concluding remarks.

II. HEALTH ACCOUNTS AND ARRANGEMENTS: A STRUCTURAL OVERVIEW

Despite similar roles in financing healthcare, HSAs, health FSAs, and their close cousins, HRAs differ in important respects. Independent legal requirements erect practical constraints on utility, which must be considered in the design of any health plan that includes them. Part A discusses HSAs, while Parts B and C discuss health FSAs and HRAs, respectively.

A. HSAs

HSAs were formally approved as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.²¹ Accordingly, they could not effectively be implemented before plan years for 2004. HSAs are an expanded and more flexible version of a similar concept, the Archer Medical Savings Account (MSA), which originated in 1996 as a pilot project available only to self-employed persons and to employees of a small employer covered by a high deductible health plan.²² Key features of HSA participation are explored below.

20. See *infra* part III.C (discussing tax benefits and incentives).

21. Pub. L. No. 108-173, Title XII, § 1201, 117 Stat. 2066, 2469 (Dec. 8, 2003), codified at I.R.C. § 223.

22. See generally H.R. REP. NO. 391, at 30419 (2003) (Conf. Rep.); Ann. 2007-44, 2007-19 I.R.B. 1238 (describing criteria for cut-off of Archer MSA pilot program prescribed by I.R.C. § 220(j)). Archer MSA provisions are retained in the Code for purposes of serving existing employer accounts, but new Archer MSAs cannot be created beginning in 2007. I.R.C. § 220(j)(2).

1. Eligibility: HDHP Coverage (and Only HDHP Coverage)

Coverage by an HDHP is an important prerequisite to participation in an HSA.²³ A HDHP must satisfy limits on annual deductibles and out-of-pocket costs as prescribed by the Code, which are subject to annual inflation adjustments.²⁴ For 2014, a HDHP requires an annual deductible that is not less than \$1,250 (self-only coverage) or \$2,500 (family coverage).²⁵ These deductible limits are more generous to the insured than those applicable to Archer MSA rules, which require a range of \$2,200-\$3,250 (single) and \$4,350-\$6,550 (family).²⁶ Like other insurance plans offered under the ACA, an HDHP is also subject to a limitation on annual out-of-pocket expenses (defined to include deductibles, co-payments, and other amounts, but not insurance premiums) that does not exceed \$6,350 (self-only coverage) or \$12,700 (family coverage).²⁷

Eligibility for HSA participation is also constrained by the scope of other insurance coverage available to the individual. With the exception of certain other kinds of permitted insurance, such as specified coverage for accidents, disability, dental, vision, or long-term care,²⁸ coverage under any other health plan that is not an HDHP terminates one's eligibility to make contributions to an HSA.²⁹ Medicare coverage also terminates eligibility for continuing HSA participation.³⁰

23. See I.R.C. § 223(c)(1)(A) (2004) (defining eligible individual by reference to insurance coverage, not by reference to employment status).

24. See I.R.C. §§ 223(c)(2) (2004) (defining deductible and coverage limits for HDHPs); 223(g) (prescribing cost of living adjustments to such amounts).

25. Rev. Proc. 2013-25, 2013-21 I.R.B. 1110.

26. See Rev. Proc. 2013-35, 2013-47 I.R.B. 537 (§ 3.25) (defining inflation-adjusted amounts for Archer MSAs in 2014).

27. Rev. Proc. 2013-25, 2013-21 I.R.B. 1110. A plan may have an even higher deductible for out-of-network services and still not violate the out-of-pocket limitation in section 223. I.R.C. § 223(c)(2)(D). It should be noted that an HDHP for an Archer MSA is subject to lower limitations on out-of-pocket costs, \$4,350 (self-only) and \$8,000 (family). Rev. Proc. 2013-35, 2013-47 I.R.B. 537 (§ 3.25).

28. I.R.C. § 223(c)(1)(B). For example, an employer could use an HRA to offer vision, dental, and preventive care without jeopardizing HDHP coverage. In fact, the employer could even use the HRA to allow the employee to purchase the HDHP coverage without jeopardizing the employee's HSA participation. Notice 2008-59, 2008-29 I.R.B. 123 (Q&A 1). Presumably, such a purchase after 2013 would need to involve an integrated plan, not from an individual market. See *infra* notes 136-44 and accompanying text.

29. I.R.C. § 223(c)(1)(A)(ii). See also Rev. Rul. 2004-38, 2004-15 I.R.B. 717 (requiring prescription drug coverage rider to include deductible tracking HDHP so as not to jeopardize HDHP coverage requirement).

30. See I.R.C. § 223(b)(7) (precluding any individual from HSA participation upon the first month that he or she is entitled to benefits under title XVIII of the Social Security Act, and for each month thereafter). Note that for this purpose, Medicare eligibility means receipt of benefits, not merely reaching the age for eligibility as the statute might otherwise suggest. See

ACA requirements applicable to non-grandfathered policies, including preventive health services that must be provided without a deductible or copayment, are presumptively applicable to all HDHPs offered in the current marketplace.³¹ Although this requirement might appear to create an intractable dilemma for an insurance regime founded on high deductibles borne by the patients, the Service has recently clarified that an otherwise valid HDHP will not be disqualified merely because it provides required preventive health services without imposing a deductible.³² This is consistent with the original legislative history enacting the HSA regime, which recognized the possibility of preventive care coverage in connection with a viable HDHP.³³

Although anyone covered by an HDHP is eligible to open an HSA, the cooperation of a third party is required, as the Code requires that an HSA be maintained in trust for the benefit of the beneficiary.³⁴ A qualified independent trustee is required,³⁵ and that trustee is prohibited from commingling trust assets with other property other than for investment purposes.³⁶ A trust or

Notice 2004-50, 2004-33 I.R.B. (Q&A 2) (stating, “[u]nder [section 223(b)(7)], mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA. Rather, the term ‘entitled to benefits under’ Medicare means both eligibility and enrollment in Medicare.”). Medicare beneficiaries can also participate in HSA-type accounts under so-called “Medicare Advantage” plans, in which accounts are used to pay health care costs. Medicare Medical Savings Account (MSA) Plans, www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-savings-accounts/medical-savings-account-plans.html (last visited 2/7/2014).

31. See discussion *infra* Part IV (discussing exemptions that include religious employers under current regulations and others subject to injunctive relief from the ACA obtained through litigation).

32. Notice 2013-57, 2013-40 I.R.B. 293. The notice is consistent with the spirit of I.R.C. § 223(c)(2)(C), which states: “A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).” However, this reference to section 1871 of the Social Security Act appears erroneous, as this provision governs regulatory authority rather than defining preventive care. 42 U.S.C. § 1395hh (2014).

33. See H.R. CONF. REP. NO. 108-391, at 839 (2003) (“A plan does not fail to qualify as a high deductible health plan merely because it does not have a deductible for preventive care as required under State law.”)

34. See I.R.C. § 223(d)(1) (defining the term “health savings account” as “a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary . . .” with additional requirements).

35. See I.R.C. § 223(d)(1)(B) (identifying that a qualified independent trustee shall be “a bank (as defined in section 408(n) [26 USCS § 408(n)]), an insurance company (as defined in section 816 [26 USCS § 816]), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section”).

36. I.R.C. § 223(d)(1)(D); Notice 2004-50, *supra* note 30, at Q&A 66.

custodial arrangement ensures that the account is funded and held for the benefit of the employee and kept independent from employer control. This ownership feature facilitates portability for employee-participants who leave their employment, and it also creates the potential for savings and investment to fund health care needs in future periods.

Trustees must conform to limitations on permissible investments for HSA funds,³⁷ and they are also required to respect maximum limits on the annual HSA contributions, other than rollovers from other eligible health accounts.³⁸ However, neither trustees nor employers are directly responsible for determining whether HSA distributions are used for qualifying medical expenses, which remain the responsibility of the owner of the account.³⁹ Notably, the HSA trust or custodial agreement may not restrict HSA distributions to pay only qualified medical expenses, thus leaving this matter to the beneficiary of the account, subject only to information reporting requirements imposed on the fiduciary.⁴⁰

2. Funding

HSA funding can come from a variety of sources: employers and employees can share responsibility for funding;⁴¹ even third parties can make gifts for that purpose.⁴² The total amount of such

37. Notice 2004-50, *supra* note 30, at Q&A 65.

38. *See id.* at Q&A 73 (stating, “[e]xcept in case of rollover contributions described in section 223(f)(5) or trustee-to-trustee transfers, the trustee or custodian may not accept annual contributions to any HSA that exceed the sum of: (1) the dollar amount in effect under section 223(b)(2)(B)(ii) (i.e., the maximum family coverage deductible) plus (2) the dollar amount in effect under section 223(b)(3)(B) (i.e., the catch-up contribution amount”).

39. Notice 2004-2, 2004 I.R.B. 269 (Q&A 29, 30). However, fiduciaries allowing electronic access by payment cards are required to take some precautions to ensure that payment cards are not used to purchase nonprescription drugs. Notice 2011-5, 2011-3 I.R.B. 314, modifying Notice 2010-57, 2010-39 I.R.B. 396.

40. Notice 2004-50, *supra* note 30, at Q&A 79. *See also* Notice 2008-59, *supra* note 28, at Q&A 27 (noting that payment card access may be restricted to health care providers, but there must be other means of access that are not restricted “such as through online transfers, withdrawals from automatic teller machines or check writing”).

41. Notice 2004-50, *supra* note 30, at Q&A 11. *See also* Notice 2004-50, *supra* note 30, at Q&A 81 (specifying that an employer who contributes to an employee’s HSA is not responsible for determining the maximum annual contribution limit for that employee, but that employer must determine whether the employee is covered under an HDHP (including whether FSAs or HRAs provided by that employer potentially jeopardize that coverage)).

42. The legislative history suggests that a contribution from someone other than an employer will be treated as a gift, but the contributed amount may be deducted by the donee. *See* H.R. CONF. REP. NO. 108-391, at 846 (2003) (stating, “[u]nder the conference agreement, contributions made by or on behalf of an eligible individual are deductible by the individual. Thus, for

funding is limited depending upon the type of HDHP coverage for the account owner. For 2014, annual contributions to an HSA are limited to \$3,300 (self-only) or \$6,550 (family).⁴³ Individuals age 55 and over are allowed to make an additional \$1,000 contribution.⁴⁴ “Family” coverage includes anyone other than the account owner,⁴⁵ and thus may include children (dependents and eligible adult children under age 27) and/or a spouse.⁴⁶ For married couples, the maximum allowed for family coverage applies even if both spouses are separately covered by a high deductible health plan.⁴⁷ Spouses may not maintain a joint HSA,⁴⁸ but instead must coordinate their contributions so as to comply with the limitation.

Employers who wish to contribute to an employee’s HSA can use a section 125 cafeteria plan to facilitate their contributions and contributions from their employees through salary reduction agreements.⁴⁹ Although cafeteria plans generally may not offer benefits that defer compensation, HSA accounts are specifically exempted from this restriction despite the fact that they can entail substantial future benefits for their owners.⁵⁰

Employers offering an HSA benefit through a cafeteria plan

example, contributions made by an eligible individual’s family members are deductible by the eligible individual to the extent the contributions would be deductible if made by the individual.”); *id.* at n. 30 (“Under present law, contributions made on behalf of another individual are generally treated as gifts. The present-law gift tax rules apply to contributions made on behalf of another individual.”); *see also* Notice 2004-2, *supra* note 39, at Q&A 18 (designating that contributions by a family member to an HSA are deductible by the donee, assuming that donee is eligible for an HSA).

43. Rev. Proc. 2013-25, 2013-21 I.R.B. 1110.

44. I.R.C. § 223(b)(3).

45. I.R.C. § 223(c)(4).

46. If one spouse is otherwise covered by insurance that does not constitute an HDHP, the other spouse may still maintain an HDHP covering himself and his dependents, thereby preserving eligibility for HSA participation at the family level. Notice 2004-50, *supra* note 30, at Q&A 31. However, if both spouses are covered by an HDHP, the family deductible contribution limit must be allocated between them. *Id.* at Q&A 32.

47. I.R.C. § 223(b)(5); *see also* Notice 2014-1, 2014-2 I.R.B., at Q&A 7, 8 (providing guidance as to the implementation of the joint-deduction limitation concerning same-sex spouses). Given that two individuals with their own dependents and their own HDHP insurance could contribute \$6,550 each for family coverage (defined as “any coverage other than self-only coverage”, I.R.C. § 223(c)(5)), marriage would potentially reduce the total eligible amount of HSA contributions. However, it might also permit savings by combining coverage for some families into one policy.

48. Notice 2004-50, *supra* note 30, at Q&A 63.

49. Prop. Treas. Reg. § 1.125-1(a)(3)(J), 72 Fed. Reg. 43938, 43959 (2007) (designating that HSA contributions are qualified benefits). Cafeteria plans allow employees to acquire eligible benefits that might otherwise constitute taxable income under the income tax doctrine of constructive receipt. *See id.* § 1.125-1(b).

50. I.R.C. § 125(d)(2)(D); Prop. Treas. Reg. § 1.125-1(o)(3)(iv), 72 Fed. Reg. 43938, 43959 (2007).

are required to describe those contribution benefits and allow employee participants to change their salary reduction elections.⁵¹ Generally speaking, but for section 125 of the Code, a salary reduction agreement would otherwise result in constructive receipt of salary income by the employee, followed by that employee's acquisition of a benefit for which a deduction might be allowable to that employee.⁵² However, a section 125 cafeteria plan changes the fundamental nature of this transaction. Not only does it allow the employer to contribute toward employee benefits without taxable income to the employee, but it also effectively converts the employee's salary reduction agreement into an employer contribution.⁵³

Employers and employees may also fund an employee's HSA account without using a section 125 cafeteria plan.⁵⁴ Contributions in this form ultimately achieve similar income tax treatment for both the employer and the employee, including deduction for the employer and exclusion from the employee's gross income.⁵⁵ However, as discussed below, employee contributions outside of a cafeteria plan are subject to federal employment taxes (FICA and FUTA), which presents a significant detriment for failing to follow the approach based on the cafeteria plan.⁵⁶

Section 125 cafeteria plans require employers to comply with nondiscrimination rules, which ensure that benefits are not stacked in favor of highly compensated employees.⁵⁷ However, such plans avoid more restrictive comparability rules in section 4980G of the Code, which are imposed on employer contributions that occur outside of a cafeteria plan.⁵⁸

51. Prop. Treas. Reg. § 1.125-2(c)(1), 72 Fed. Reg. 43938, 43959 (2007).

52. See Prop. Reg. § 1.125-1(b), 72 Fed. Reg. 43938, 43959 (2007) (explaining role of cafeteria plan as exclusive means to avoid constructive receipt).

53. Prop. Reg. § 1.125-1(r), 72 Fed. Reg. 43938, 43959 (2007). As those regulations explain, "An employee's salary reduction election is an election to receive a contribution by the employer in lieu of salary or other compensation that is not currently available to the employee as of the effective date of the election and that does not subsequently become currently available to the employee." Prop. Reg. 1.125-1(r)(2), 72 Fed. Reg. 43938, 43959 (2007). A discussion of the income tax issues is located in Part II.A.3.

54. See, e.g., I.R.C. § 223(a) (permitting contributions "by or on behalf of" an eligible individual).

55. See I.R.C. §§ 162(a) (deduction for reasonable compensation); 106(d)(1) (employee exclusion for accident and health plan benefits).

56. See *infra* Part II.A.4 (discussing the tax ramifications of a cafeteria plan benefit).

57. I.R.C. § 125(c).

58. See Prop. Reg. 1.125-7(n), 72 Fed. Reg. 43938, 43959 (2007) (stating that, "[i]f an employer contributes to employees' Health Savings Accounts (HSAs) through a cafeteria plan (as defined in § 54.4980G-5 of this chapter) those contributions are subject to the nondiscrimination rules in section 125 and this section and are not subject to the comparability rules in section 4980G. See §§ 54.4980G-0 through 54.4980G-5 of this chapter"). It should be

Although a full comparison between nondiscrimination and comparability rules is beyond the scope of this analysis, a cafeteria plan may offer greater flexibility to employers to achieve their own policy goals. For example, an employer may wish to match employee HSA contributions in order to further incentivize employee saving. If a match is done outside of a cafeteria plan, the comparability rules would not be satisfied, as this would potentially produce a dissimilar contribution among all eligible individuals.⁵⁹ In contrast, a matching approach could potentially pass the nondiscrimination rules applicable in a cafeteria plan.⁶⁰ Likewise, an employer plan to differentiate contributions based on age (as correlated to likely healthcare expenditures) would not satisfy the comparability rules, whereas a similar program could potentially satisfy the nondiscrimination rules.⁶¹

Comparability rules applicable to contributions outside of section 125 cafeteria plans nevertheless permit some forms of differential treatment. For example, an employer may choose to pass on some of the cost savings from its employees who select self-only coverage by making a contribution to the HSA of each employee in that category, while making no contribution (or a reduced contribution) to those with family coverage.⁶² Such a practice – or even the opposite policy decision to reward family coverage – likely satisfies the comparability requirements.⁶³

An employer's current-year contributions to an HSA are taken into account as though such amounts provide first-dollar coverage for purposes of assessing minimum value and affordability requirements imposed by the ACA.⁶⁴ For a large employer, this is important because of the possibility that a lower-paid employee eligible for employer-provided coverage might otherwise be eligible for coverage through a state Exchange on affordability grounds, thereby triggering an employer penalty.⁶⁵

noted that the ACA made a simplified cafeteria plan design available for small employers, generally defined to include those with fewer than 100 employees during the past two years. I.R.C. § 125(j).

59. I.R.S. Notice 2004-50, 2004-33 I.R.B. 196 (Q&A 46). Differential contributions for employees having comparable coverage present the threat of a 35 percent excise tax on the employer's entire HSA contribution. I.R.C. § 4980G; Treas. Reg. § 54.4890G-1.

60. I.R.S. Notice 2004-50, *supra* note 59, at Q&A 47.

61. *See id.* at Q&A 49, 50.

62. *See* Whitney R. Johnson, *HSA Programs for Groups: Employer Versus Employee Responsibilities*, 28 BENEFITS Q. 43, 46-47 (Third Quarter, 2012) (discussing the options of employers in relation to various types of employee coverage).

63. *Id.* As this author notes, however, rewarding self-only coverage is a common practice of employers. *Id.*

64. 78 Fed. Reg. 25909-01 (May 3, 2013). Presumably this does not contemplate a salary reduction arrangement, which might also be considered an employer contribution.

65. *See generally* Edward A. Morse, *Lifting the Fog: Navigating the*

Some commentators have suggested that a small employer may have a different incentive in providing insurance coverage that fails affordability or minimum value requirements, which would still allow lower-paid workers access to coverage through a state Exchange with the benefit of premium subsidies.⁶⁶ This would presumably require the employee to reject employer coverage altogether, as section 125(f)(3) of the Code restricts the use of cafeteria plans to provide insurance through an Exchange, unless the employer is otherwise eligible to acquire group coverage through an Exchange.⁶⁷

3. *Income Taxes*

An HSA offers three principal income tax advantages over other forms of private savings or earnings that might otherwise be used to meet healthcare needs. First, individual contributions to the account are currently deductible as an “above-the-line” deduction.⁶⁸ This accelerates the timing of the deduction, as compared to the deduction for medical expenses otherwise allowed only when “paid during the taxable year.”⁶⁹ Moreover, even if a medical expense deduction would otherwise be allowed for a direct payment by the taxpayer, it is still an itemized deduction subject to a limitation of ten percent of adjusted gross income.⁷⁰ Thus, the current income tax treatment of HSA contributions essentially allows the individual participant to prepay eligible medical costs

Penalties in the Affordable Care Act, 46 CREIGHTON L. REV. 207, 220-24 (2013) (discussing employer penalties under I.R.C. § 4980H).

66. See Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1958-63 (2013) (discussing employer motivations in providing employees with different levels of coverage).

67. See I.R.S. Notice 2013-54, 2013-40 IRB 287 (Q&A 12) (discussing an employer’s ability to provide Exchange coverage through a Code § 125 plan, in situations where the employer’s plan operates on a plan year other than the calendar year). I.R.C. § 125(f)(3) was added by section 1515 of the ACA. I.R.C. § 125(f)(3). As the Notice also points out, this restriction does not apply if the employer is a “qualified employer (as defined in ACA § 1312(f)(2)) offering the employee the opportunity to enroll through an Exchange in a qualified health plan in a group market.” I.R.S. Notice 2013-54, 2013-40 IRB 287 n.11. Section 1312(f)(2)(A) of the ACA provides in part: “[t]he term ‘qualified employer’ means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.” 42 U.S.C. § 18032(f)(2)(A). Beginning in 2017, large employers may also be eligible to offer group plans through an Exchange. 42 U.S.C. § 18032(f)(2)(B).

68. I.R.C. §§ 62(a)(19), 223(a).

69. I.R.C. § 213(a).

70. See I.R.C. § 213(a) (allowing deduction for medical care “to the extent that such expenses exceed 10 percent of adjusted gross income”); I.R.C. § 63(d) (defining “itemized deductions” in part as those allowable other than “deductions allowable in arriving at adjusted gross income”); see also § 62(a) (listing deductions allowable in computing adjusted gross income; medical expenses not included in such listing).

with pretax dollars, thus effectively monetizing the tax benefit immediately as compared with a system that depends on allowing deductions when the expense is paid.⁷¹

Second, optional employer contributions can also be made on a tax-favored basis. If an employer contributes funds to an employee's HSA, these funds become the employee's property.⁷² Unlike similar cash payments to an employee, which would otherwise generally be considered gross income to the employee, employer contributions to an HSA are excluded from the employee's gross income in the same manner as employer-provided insurance coverage, whether or not provided through a cafeteria plan.⁷³

When HSA funds are distributed for qualified medical expenses, such distributions are likewise excluded from the employee's gross income.⁷⁴ In order to avoid any duplication of this tax benefit, distributions from an HSA used to pay for medical expenses are not eligible for any medical expense deduction.⁷⁵ This tax exemption on employer contributions thus becomes a permanent benefit when those funds are used for qualified medical expenses. However, the exemption becomes merely a deferral if HSA funds are distributed for any reason other than qualifying medical expenses, as such distributions trigger regular income taxes and may also trigger a penalty tax.⁷⁶

Third, HSA funds not currently needed for medical expense distributions can be invested, and those investment earnings are exempt from tax.⁷⁷ This feature of the HSA allows savings for future medical needs beyond the current tax year, which is made possible by vesting property rights in the individual owner. Unfortunately, these property rights also mean that HSA balances

71. See *infra* part II (presenting illustrations of this benefit).

72. See I.R.C. § 223(d)(1)(E) (stating that "the interest of an individual in the balance in his account is nonforfeitable.")

73. I.R.C. § 106(d)(1); see also I.R.C. § 3401(a)(22) (stating that HSA contributions under section 106(d) are excluded from wage base for employer withholding tax purposes). Such treatment is consistent with other employer-provided health insurance benefits. See Rev. Rul. 56-632, 1956-2 C.B. 101 (discussing the exclusion from withholding requirements for employer-provided health insurance benefits for employee, spouse and dependents); I.R.S. Notice 2010-38, 2010-20 IRB 682 (extending exclusion to employer-provided health benefits for children under age 27 under A.C.A. provisions).

74. I.R.C. § 223(f)(1).

75. I.R.C. § 223(f)(6).

76. I.R.C. § 223(f)(2). Penalties are discussed in section 223(f)(4). See I.R.C. § 223(f)(4) (imposing a 20% penalty on taxable distributions, other than those for disability, death, or upon Medicare eligibility). It should be noted that this penalty is greater than the 10% penalty imposed on premature distributions from a retirement account, such as an IRA. See I.R.C. § 72(t). However, to the extent the penalty tax can be avoided upon reaching Medicare eligibility, the treatment for HSA distributions resembles a retirement account (i.e., taxable as gross income, without penalty).

77. I.R.C. § 223(e)(1).

are subject to claims by the IRS in collection actions,⁷⁸ as well as claims by a former spouse in the context of divorce, who is eligible to retain the character of the HSA after receiving an award in a property settlement.⁷⁹

After reaching eligibility for Medicare or upon becoming disabled, distributions not used for qualified medical expenses are no longer subject to the 20 percent penalty tax, but are merely treated in the same manner as other taxable income.⁸⁰ Upon the death of the account holder, a surviving spouse named as a beneficiary in the HSA can also retain HSA status for the account.⁸¹ Others who inherit an HSA must include the fair market value in gross income,⁸² albeit without any penalty taxes for distributions other than for qualified medical expenses.⁸³

4. *Employment Taxes*

Employment tax benefits from HSA participation may also be realized, but a FICA tax exemption is not always commensurate with the income tax benefits outlined above. Employer contributions to an employee's HSA are exempt from the FICA wage base, whether made through a cafeteria plan or directly to the employee's HSA. Section 3121(a)(5) defines cafeteria plan benefits excludable from the FICA wage base as follows:

(5) any payment made to, or on behalf of, an employee or his beneficiary . . .

(G) under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125

78. See I.R.S. CCA 200927019 (July 2, 2009) (stating IRS Chief Counsel interpretation that HSA is "property [or] rights to property" under I.R.C. § 6331, and thus eligible for levy). Since the levied funds would not be used for qualified medical expenses, the levy would thus involuntarily trigger the additional 20% penalty tax, assuming the holder is not otherwise exempt due to age or disability. See I.R.C. § 223(f)(4) (2012). Although distributions from qualified retirement plans that occur on account of levy under section 6331 are exempt from the 10% penalty applicable to early distributions, see I.R.C. § 72(t)(2)(A)(vii) (2012), no similar exemption exists for the HSA.

79. See I.R.C. § 223(f)(7).

80. See I.R.C. § 223(f)(4)(B), (C). Section 9004 of ACA increased the penalty from 10% to 20% effective in 2011.

81. See I.R.C. § 223(f)(8)(A); I.R.S. Notice 2004-2, 2004-2 IRB 269 (Q&A 31) (stating, "[i]f the account beneficiary's surviving spouse is the named beneficiary of the HSA, the HSA becomes the HSA of the surviving spouse.")

82. See I.R.C. § 223(e)(8)(B); Notice 2004-2, *supra* note 81, at Q&A 31 ("If ... the HSA passes to a person other than the account beneficiary's surviving spouse, the HSA ceases to be an HSA as of the date of the account beneficiary's death, and the person is required to include in gross income the fair market value of the HSA assets as of the date of death.")

83. See I.R.C. § 223(f)(4).

would not treat any wages as constructively received[.]⁸⁴

Thus, any employer contribution (whether or not made on account of an employee's salary reduction agreement, which is nevertheless treated as made by the employer)⁸⁵ is exempt from the FICA wage base if made through a cafeteria plan.

If the employer does not offer a cafeteria plan benefit, the employer's contribution may nevertheless be excluded from the FICA wage base under a different provision. Section 3121(a)(2)(B) of the Internal Revenue Code also excludes from the FICA definition of wages

the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of . . .

(B) medical or hospitalization expenses in connection with sickness or accident disability.⁸⁶

Administrative guidance from the IRS confirms that employer contributions to an HSA receive parallel treatment, regardless of whether the employer utilizes a cafeteria plan. Notice 2004-2 states in part:

Q-19. What is the tax treatment of employer contributions to an employee's HSA?

A-19. In the case of an employee who is an eligible individual, employer contributions (provided they are within the limits described in A-12) to the employee's HSA are treated as employer-provided coverage for medical expenses under an accident or health plan and are excludable from the employee's gross income. The employer contributions are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act. Contributions to an employee's HSA through a cafeteria plan are treated as employer contributions. The employee cannot deduct employer contributions on his or her federal income tax return as HSA contributions or as medical expense deductions under section 213.⁸⁷

84. I.R.C. § 3121(a)(5).

85. See Prop. Treas. Reg. § 1.125-1(r), 72 Fed. Reg. 43938, 43959 (2007).

86. I.R.C. § 3121(a)(2); see I.R.C. § 3306(b)(2)(B)(showing that the wage base for federal unemployment taxes (FUTA) contains a similar exemption).

87. See Notice 2004-2, *supra* note 81. This is also consistent with the legislative history. See *Medicare Prescription Drug, Improvement, and*

Notice 2004-2 also illustrates that using a cafeteria plan matters in a significant way for employees making contributions to their HSAs. The transformation created by the cafeteria plan for income tax purposes – i.e., a salary reduction arrangement converts the employee’s contribution of his wages into a contribution by the employer – also affects the FICA wage base.⁸⁸ The exemption granted in this context is more generous toward the employee than a contribution through a salary reduction agreement to a qualified cash or deferred retirement arrangement, which does not receive an exemption from employment taxes.⁸⁹

Employee contributions to an HSA outside of an employer-provided cafeteria plan are deductible for federal income tax purposes,⁹⁰ but they remain within the FICA wage base, as the exemptions provided above are for employer contributions only. Thus, an employee who establishes his/her own HSA and funds it independently fares worse than one whose employer provides a cafeteria plan benefit, in that he or she will be able to reduce income taxes (i.e., through the deduction allowed in section 223(a)), but not employment taxes on contributed amounts. The employer also likely fares worse to the extent that the employer could have also reaped FICA tax savings from an employee’s salary reduction agreement in a cafeteria-plan based approach.⁹¹

Self-employed persons fare worse than employees with cafeteria plans when taxes under the Self Employment Contributions Act (SECA) – the counterpart to FICA taxes for the self-employed – are computed.⁹² SECA taxes are imposed on the

Modernization Act of 2003, H.R. REP. NO. 108-391, at 842 (2003) (Conf. Rep.) (stating that “employer contributions to a health account (including salary reduction contributions made through a cafeteria plan) are excludable from gross income and wages for employment tax purposes to the extent the contribution would be deductible if made by the employee . . .”)

88. See Notice 2004-2, *supra* note 81, at Q&A 19 (stating, “[c]ontributions to an employee’s HSA through a cafeteria plan are treated as employer contributions. The employee cannot deduct employer contributions on his or her federal income tax return as HSA contributions or as medical expense deductions under section 213.”); see also I.R.S. CCA 200117038 (April 27, 2001) (“Employer contributions to the cafeteria plan are usually made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits. Salary reduction contributions are not actually or constructively received by the participant. Therefore, those contributions are not considered wages for federal income tax purposes. In addition, those sums generally are not subject to FICA and FUTA. See Sections 3121(a)(5)(G) and 3306(b)(5)(G) of the Code.”)

89. See I.R.C. § 3121(v)(1)(A).

90. See I.R.C. § 223(a).

91. This assumes that the FICA tax savings (after any income tax benefits) on HSA contributions are greater than the administrative costs associated with establishing a cafeteria plan.

92. See generally IRS, Self-Employment Tax (Social Security and Medicare Taxes), available at www.irs.gov/Businesses/Small-Businesses-&Self-

net earnings from self-employment, as defined in section 1402(a) of the Code.⁹³ The deduction allowed for HSA contribution is an adjustment to gross income under section 62(a)(19) of the Code, rather than a deduction attributable to a trade or business that would reduce the net earnings from self-employment.⁹⁴ Accordingly, a self-employed person must pay SECA taxes on her HSA contribution, although she is allowed a deduction for federal income tax purposes for half of this payment.⁹⁵ In this sense, the self-employed person is treated similarly to an employee without an employer-provided cafeteria plan benefit that includes an HSA.

Self-employed partners are subject to a similar disadvantage, as payments from the partnership to their own HSA are treated as guaranteed payments, rather than an employer contribution on behalf of an employee.⁹⁶ As a result, those payments are part of the income from self-employment for SECA purposes. Like other self-employed persons, the partner may deduct the HSA contribution for income tax purposes, but the self-employment tax liability remains applicable.

Within an S corporation, 2-percent shareholder-employees are generally treated similarly to partners for income tax purposes regarding healthcare.⁹⁷ However, they may fare better than the partner in terms of employment taxation. The 2-percent shareholder-employee is treated as an employee for FICA purposes, and thus is generally taxable on FICA wages.⁹⁸ However, to the extent the employer has a benefit plan for employees (and not just ad hoc payments for the owners), the 2-percent shareholder-employee may be eligible to exclude such amounts from the FICA wage base under the rules of section 3121(a)(2)(B).⁹⁹

B. Health FSAs

Health FSAs are employer-provided benefits designed to reimburse qualified medical expenses¹⁰⁰ incurred by an employee

Employed/Self-Employment-Tax-Social-Security-and-Medicare-Taxes (“Self-employment tax is a tax consisting of Social Security and Medicare taxes primarily for individuals who work for themselves. It is similar to the Social Security and Medicare taxes withheld from the pay of most wage earners.”).

93. See I.R.C. § 1402(a).

94. See I.R.S. Notice 2004-50, 2004-2 C.B. 196 (Q&A 84).

95. 26 U.S.C. § 164(f).

96. See Notice 2005-8, 2005-1 C.B. 368 (Q&A 1, 2) (explaining the disadvantage to self-employed partners).

97. See *generally* I.R.S. Notice 2008-1, 2008-2 I.R.B. 251 (discussing healthcare tax issues in S corporations for 2-percent shareholder-employees).

98. Notice 2005-8, *supra* note 96, at Q&A 3.

99. *Id.*; see also I.R.S. Announcement 92-16, 1992-5 IRB 53 (discussing FICA Taxation of Health Insurance Premiums for 2% Shareholder- Employees of S Corporations).

100. I.R.C. § 213(d). After 2010, these expenses do not include

or former employee, including her spouse, dependents, and children under age 27 permitted to be covered under their parents' insurance.¹⁰¹ These arrangements can be funded jointly by employers and employees. When offered to employees under a cafeteria plan, the employer contribution is excluded from the employee's gross income.¹⁰² Employees may also fund these arrangements through electing annual salary reductions of up to \$2,500, which are likewise excluded from gross income.¹⁰³ Distributions from a Health FSA for eligible medical expenses are likewise excluded from the gross income of the employee in the same manner as employer-provided payments of other health benefits.¹⁰⁴

As noted above, cafeteria plans may not be used to provide for deferred compensation.¹⁰⁵ This statutory restriction has

nonprescription medications. See I.R.C. § 213(b). Other exceptions also apply, including a restriction on using a health FSA to reimburse for premiums on other healthcare insurance coverage. Prop. Treas. Reg. § 1.125-5(k)(4), 72 Fed. Reg. 43938, 43959 (2007). Additional restrictions on coverage may also apply when a health FSA is available for an employee that has an HSA to ensure that there is no other coverage that could jeopardize HDHP coverage for the employee. See, e.g., Rev. Rul. 2004-45, 2004-1 C.B. 971 (describing limited purpose health FSA or post-deductible health FSA).

101. See I.R.C. § 106(c) (defining flexible spending arrangement for the limited purpose of that section); see also I.R.C. § 105(b) (excluding employer-provided reimbursements for medical care). As amended by the Affordable Care Act, children who have not attained age 27 as of the end of the taxable year are also eligible for this exclusion, including flexible spending arrangement benefits provided under cafeteria plans. I.R.S. Notice 2010-38, *supra* note 73.

102. I.R.C. § 125(a). Employer contributions are not limited by the \$2,500 cap in section 125(i). I.R.S. Notice 2013-54, *supra* note 67. However, as a practical matter, employers may prefer to benefit employees through other means, including making higher contributions for their insurance coverage.

103. I.R.C. § 125(i)(1). This amount is indexed for inflation. I.R.C. § 125(i)(2). The \$2,500 limitation was added by PPACA effective for plan years beginning after December 31, 2012. See Notice 2012-40, 2012-26 I.R.B. 1046. According to Notice 2012-40, prior to the enactment of section 125(i), there was no statutory limit imposed on elective salary reductions, although plan sponsors often imposed such limits. *Id.* Section 125(i)(1) does not restrict an employer contribution, but if the employer wishes to maintain the exemption for a health HSA from various requirements imposed on group health plans, the employer must restrict such contributions to an amount that does not exceed twice the employee's salary reduction election (or, if greater, \$500 plus the salary reduction election), assuming the employer wants to avoid other restrictions on group health plans. I.R.S. Notice 2013-54, *supra* note 67.

104. I.R.C. §§ 125(a), 106(a), 105(b).

105. See I.R.C. § 125(d)(2)(A) (stating that the term "cafeteria plan" does not include deferred compensation plans). Although certain exceptions are provided, including one for health savings accounts. See I.R.C. § 125(d)(2)(D) (stating that the general rule, that cafeteria plans do not include any plans providing for deferred compensation, does not apply to amounts that "a covered employee may elect to have the employer pay as contributions to a health savings account"), no similar exception is carved out for flexible

traditionally meant that benefits acquired through a cafeteria plan could not be carried over to a future taxable year, and a “use-or-lose” requirement has emerged to protect the tax benefits accorded through the cafeteria plan.¹⁰⁶ This “use-or-lose” rule was liberalized in 2005 when the Service formally adopted a grace period rule, which permitted an employee to use amounts from the previous year to pay expenses incurred during the period of up to two months and fifteen days following the end of the plan year.¹⁰⁷ This grace period rule was based on other tax law, which exempted payments made within the fifteenth day of the third month after the taxable year in which the services were performed from the scope of deferred compensation.¹⁰⁸

In 2013, the Service administratively created a new exception to the “use-or-lose” rule by permitting an employer the option to amend its plan to allow up to \$500 of unused funds to be carried over to the following plan year.¹⁰⁹ This carry-over amount does not count against the annual indexed maximum salary reduction amount under section 125(i) (i.e., \$2,500 in 2013).¹¹⁰ Moreover, if an employer elects to permit a carry-over, the grace period of two months and fifteen days may not be used by the employee to increase the amount of permitted expenditures.¹¹¹

The legal authority for this new exception is dubious given the traditional rationale for the “use-or-lose” rule noted above, which is also reflected in proposed regulations governing FSAs.¹¹² While the grace period offered in 2005 had a plausible foundation in regulations interpreting the scope of deferred compensation, the new administrative approach arguably violates the statutory rule against deferred compensation without the benefit of any statutory authority. Congress in 2003 considered a provision to allow up to \$500 of unused health benefits in an FSA to the next taxable year, but this provision was not enacted.¹¹³ The ACA’s enactment of a

spending arrangements.

106. See I.R.S. Notice 2013-71, 2013-47 I.R.B. 532 (allowing an employee to use remaining amounts “from the previous year . . . to pay expenses incurred for certain qualified benefits during the period of up to two months and 15 days immediately following the end of the plan year”).

107. *Id.* (citing I.R.S. Notice 2005-42, 2005-1 C.B. 1204).

108. *Id.* (citing Treas. Reg. § 1.404(b)-1T, Q&A-2).

109. *Id.*

110. *Id.*

111. See *id.* (stating, “adopting this carryover provision is not permitted to also provide a grace period”). This does not affect the practice of using a “run-out” period to reimburse expenditures incurred but not processed until the following tax year. *Id.*

112. See, e.g., Prop. Treas. Reg. § 1.125-5(k)(3), 72 Fed. Reg. 43938, 43959 (2007) (explaining that reimbursement of advanced payments for orthodontia work does not violate the deferred compensation restriction).

113. See Conference Report, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 2003-3 C.B. 189, H.R. REP. NO. 108-391, 2003 WL 25545955 (Nov. 21, 2003) (noting “House bill allows up to \$500 of unused

\$2,500 indexed limitation in section 125(i) limits the scope of any potential deferral through a health FSA, but otherwise has no logical connection to the proscription against deferred compensation in section 125(d). Thus, it does not provide authority for such a change.¹¹⁴

The \$2,500 indexed limit now imposed by the ACA is applied on an employee-by-employee basis, and does not vary based on whether self-only or family coverage applies through another employer-provided healthcare plan. Thus, it provides the maximum salary reduction permitted for each employee during the plan year, regardless of the number of individuals for which medical expense reimbursement is proper.¹¹⁵ Accordingly, each spouse who is offered an FSA benefit by his or her employer is permitted to participate in his/her own FSA and elect to defer \$2,500 in his/her account.¹¹⁶ Couples in which both spouses have access to an FSA are thus able to make contributions of up to \$5,000 (indexed), rather than only \$2,500 in families in which only one spouse has access to an employer-provided FSA.

The combination of the limited time period for benefits under the “use-or-lose” approach, coupled with the statutory limits on salary deferral benefits that can be obtained through a cafeteria-style FSA, significantly constrains the utility of a health FSA to fund healthcare expenditures. The permitted cap of \$2,500 in elective salary deferral is only a fraction of the deferral permitted in an HSA, and it is not tailored to the potential needs of multiple persons within the same family coverage who may need to draw upon this resource.

Moreover, the “use-or-lose” feature is not conducive to saving for the future, which leaves families subject to out-of-pocket costs that could reach up to \$12,700 at current indexed levels. The option for saving beyond the current year is part of the incentive structure that is behind the theory that consumer directed health

health benefits in an employee’s health FSA to be carried forward,” but such provision was not enacted).

114. See I.R.S. Notice 2012-40, *supra* note 103. The notice states,

The \$2,500 limit, while not addressing the ‘use-or-lose’ rule, limits the potential for using health FSAs to defer compensation and the extent to which salary reduction amounts may accumulate over time. Given the \$2,500 limit, the Treasury Department and the IRS are considering whether the use-or-lose rule for health FSAs should be modified to provide a different form of administrative relief (instead of, or in addition to, the current 2½ month grace period rule).

Id.

115. See *id.* (noting that “\$2,500 is the maximum salary reduction contribution each employee may make for a plan year, regardless of the number of individuals (for example, a spouse, dependents, or adult children) . . . whose medical expenses are reimbursable under the employee’s health FSA”).

116. *Id.*

plans can contribute to cost savings through consumer choices.¹¹⁷ Although the health FSA provides for some measure of consumer autonomy by permitting consumers to make direct payments to providers using payment card systems, the limited ability to retain or save unused amounts may actually stimulate spending levels above those deemed optimal by the individual, who would rationally chose to spend rather than lose the balance of unused salary reductions. The capacity for saving within HSAs (or, as discussed below, HRAs) thus provides a considerable advantage over FSAs in this respect.

Of course, it is possible to combine a health FSA with an HSA, but the scope of FSA benefits must be constrained in order to maintain the employee's eligibility for HSA participation.¹¹⁸ HSA participation requires not only HDHP coverage, but also no other coverage that is not permitted coverage.¹¹⁹ For example, a "limited-purpose health FSA" may provide reimbursement only for vision, dental, or preventive care, which is considered permitted coverage under section 223(c)(2)(C) of the Code.¹²⁰ Alternatively, a "post-deductible health FSA" can reimburse an even broader range of expenses, but those must be incurred after the minimum annual deductible for the HDHP under section 223(c)(2)(A)(i) of the Code has been satisfied.¹²¹ But given the "use-or-lose" requirement imposed on any health FSA, employee contributions through a salary deferral agreement present some risk of loss, which significantly detracts from their utility apart from pairing limited or post-deductible FSAs with an HSA in order to increase the potential for savings in such arrangements.

117. See Kratzke, *supra* note 7, at 370 (explaining that in order for consumers to maximize net value of the health care services that they pay for, there needs to be a form of "consumer-driven health care wherein consumers directly pay for the health care they receive and reap savings when they choose less expensive alternatives," thus resulting in cost savings).

118. See, e.g., Rev. Rul. 2004-45, 2004-22 I.R.B. 971, 2004-1 C.B. 971 (describing a "limited-purpose health FSA" or a "limited-purpose HRA" that can be combined with an HSA and not violate the HDHP coverage limitation).

119. See I.R.C. § 223(c)(1)(A) (explaining that an "eligible individual" is one who is covered under an HDHP plan and is not covered under any health plan that is not an HDHP or provides coverage for a benefit that is already covered under an HDHP).

120. See Prop. Treas. Reg. § 1.125-5(m)(3), 72 Fed. Reg. 43938, 43959 (2007) (defining a limited purpose health FSA as a health FSA which "only pays or reimburses permitted coverage benefits" as defined in section 223(c)(2)(C)).

121. See Prop. Treas. Reg. § 1.125-5(m)(4), 72 Fed. Reg. 43938, 43959 (2007) (explaining that a post-deductible health FSA is one that pays or reimburses for such medical expenses as preventive care or medical expenses incurred after the minimum annual HDHP deduction). These proposed regulations indicate that a health FSA can also reflect a combination of these benefits without jeopardizing HSA participation. Prop. Treas. Reg. § 1.126-5(m)(5).

C. HRAs

HRAs can be viewed as close relatives of HSAs and FSAs because they all assist employees with financing healthcare costs in a tax-favored manner. Like the FSA and HSA, an employer's payment of medical benefits through an HRA is excludable from the employee's gross income, thus achieving a tax-favored approach to covering medical costs.¹²²

HRAs enjoy some distinctive features that also need to be considered. Notably, an HRA must be funded solely by an employer; salary reductions from the employee that are permitted in an FSA or HSA offered through a cafeteria plan may not be used to fund HRA benefits.¹²³ Unlike the HSA, which requires a separate trustee or custodian to receive cash contributions funding a trust account, an HRA may be maintained by the employer as a purely notional account.¹²⁴ Unlike the "use-or-lose" requirement for an FSA, unused HRA benefits may generally be carried forward to future periods,¹²⁵ but this does not result in the same robust property rights as in an HSA. For example, an employee who retires or who terminates his employment relationship may not receive the unused balance of an HRA in cash, lest such a payment disqualify the entire HRA plan from tax-favored treatment.¹²⁶ In many cases, the unused balance simply reverts to

122. See I.R.S. Notice 2002-45, 2002-28 I.R.B. 93 (noting exclusion from employee gross income under sections 106 and 105 of the Code).

123. See *id.* at § I (stating that an HRA "is an arrangement that is . . . not provided pursuant to salary reduction election or otherwise under a § 125 cafeteria plan"). Self-employed individuals are not eligible for an HRA. *Id.* (clarifying that an HRA is an "arrangement . . . paid for solely by the employer").

124. See *Kaiser/HRET 2013 Annual Survey of Employer Health Benefits*, THE HENRY J. KAISER FAMILY FOUND., at 133 (2013) (hereinafter "Kaiser/HRET Survey"), available at <http://kff.org/private-insurance/report/2013-employer-health-benefits/> (noting that "HRAs are accounting devices, and employers are not required to expend funds until an employee incurs expenses that would be covered by the HRA").

125. See I.R.S. Notice 2013-54, *supra* note 67, at § II(A) (stating, "amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years.") For this reason, an HRA may not be part of a section 125 cafeteria plan, which only exempts an HSA (but not an HRA) from this proscription against deferred compensation. I.R.C. § 125(d)(2)(A); see also I.R.S. Notice 2002-45, *supra* note 122, at § IV (holding that "employer contributions to an HRA may not be attributable to salary reduction or otherwise provided under a § 125 cafeteria plan").

126. *Id.* at § II. The mere right to receive cash other than for reimbursement for medical care expenses disallows the tax-favored treatment of the entire arrangement; this result does not depend on the participant actually exercising the right. See *id.* (stating that "an HRA does not qualify for exclusion under § 105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement other than the reimbursement of medical care expenses"). Limited property rights in the form of permitting a rollover contribution from an HRA or an FSA to an HSA have

the employer,¹²⁷ although the employer may allow a former employee to use funds for healthcare expenses.¹²⁸

The tax rules which provide the foundation for health reimbursement arrangements have a long pedigree, despite the fact that the IRS did not provide specific guidance involving HRAs until a Notice issued in 2002.¹²⁹ Some roots for their tax-favored treatment can be seen in the IRS recognition of the tax similarity of reimbursing an employee for health insurance costs instead of making a payment directly to an insurer, as in the case of an employer-provided health plan. In 1961, the Service ruled that no substantial difference existed among varying direct and indirect approaches to making such payments for the purpose of applying the exclusion from income under section 106 for employer-provided accident and health plans.¹³⁰ That ruling was premised on employee accountability to substantiate that costs had indeed been incurred, so that the putative reimbursement did not merely constitute another form of cash payment for services.¹³¹ Section 105 of the Code provides a similar income tax exclusion benefit for employees when an employer reimburses amounts incurred for medical care.¹³²

In Notice 2002-45, the Service set out formal guidance to outline the tax treatment of HRAs and limitations upon the benefits that they provide.¹³³ This guidance originally

been permitted for certain taxpayers transitioning to HDHP/HSA coverage. See I.R.S. Notice 2007-22, 2007-10 I.R.B. 670, 2007-1 C.B. 670 (discussing the new rules, which allow for health FSA or HRA amounts to be rolled over into an HSA in limited circumstances). However, these limited rights are not comparable to the ownership autonomy conferred in connection with an HSA, as discussed above.

127. See generally Joanne Sammer & Stephen Miller, *Consumer-Driven Decision: Weighing HSAs vs. HRAs*, SOCIETY FOR HUMAN RESOURCE MANAGEMENT (May 3, 2013), available at www.shrm.org/hrdisciplines/benefits/articles/pages/hsasvshras.aspx (stating that upon termination of employment, an HRA's accumulated funds will "generally revert back to the employer").

128. See Kaiser/HRET 2013 Survey, *supra* note 124, at 133 (noting that "unspent funds in the HRA usually can be carried over to the next year (sometimes with a limit). Employees cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to former employees to pay for health care.").

129. See I.R.S. Notice 2002-45, *supra* note 122 (providing information on the tax treatment an HRA plan).

130. Rev. Rul. 61-146, 1961-2 C.B. 25.

131. See *id.* (distinguishing Rev. Rul. 57-33, 1957-1 C.B. 303, where accountability was not required).

132. See I.R.C. § 105(b) (excluding certain reimbursements of amounts expended for medical care from gross income). See also Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 793-94 (2006) (noting that prior to Notice 2002-45, employers relied upon law firm opinion letters in providing HRA-type benefits).

133. See I.R.S. Notice 2002-45, *supra* note 122 (discussing income tax exclusions and benefits).

contemplated that an HRA could be used not only to reimburse expenses for medical care, but also to pay for premiums for accident or health coverage.¹³⁴ Thus, under this pre-ACA guidance, an HRA could be used to reimburse the cost of insurance acquired by the employee, provided the employee substantiated the premium amounts. Alternatively, an HRA could be used to reimburse other health care costs not covered by insurance in connection with an employer-provided plan, much like a FSA. As discussed below, however, new restrictions are being imposed to curtail the use of an HRA to acquire insurance, other than insurance from an employer's own group health plan.¹³⁵

HRAs are creatures of administrative development, rather than being created through a specific statutory provision. There is no indication that Congress specifically focused upon HRAs in the ACA, but it appears that the agencies responsible to administering the ACA now contemplate a more limited role for HRAs in providing insurance coverage in the post-ACA environment. The IRS has recently issued Notice 2013-54, which expands upon prior guidance issued in connection with the role of so-called "market reforms" in the ACA: the requirement to offer certain preventive services without cost sharing and a proscription against annual dollar limits on essential benefits, both of which are effective for group health plans in 2014.¹³⁶ As a result of this guidance, prior practices involving the use of HRAs to reimburse an employee for individual health coverage or the similar practice of an employer paying individual premiums directly are effectively terminated, thus further constraining the use of HRAs as a vehicle for employers to deliver healthcare benefits.

As explained in the preamble to regulations issued in 2010,

When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711 [i.e., the annual limit proscription], the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements.¹³⁷

134. *See id.* at § II (explaining that "[r]eimbursements for insurance covering medical care expenses as defined in § 213(d)(1)(D) are allowable reimbursements under an HRA, including amounts paid for premiums for accident or health coverage for current employees, retirees, and COBRA qualified beneficiaries.")

135. *See infra* text accompanying note 141 (explaining that non-integrated HRAs are only available to employees covered by employer provided health plans that meet certain requirements).

136. *See* I.R.S. Notice 2013-54, *supra* note 67 (providing guidance on applying the ACA to employer healthcare plans).

137. *See* Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37190 (June 28, 2010) (discussing HRA integrated coverage).

Stand-alone HRAs (i.e., those that are not integrated with group health plan coverage) that are providing benefits solely to retirees are otherwise exempted from ACA provisions,¹³⁸ but the fate of other stand-alone HRAs in light of the annual limit proscription was identified as a matter for further guidance.¹³⁹

On January 24, 2013, the Department of Labor issued Q&A guidance that an HRA used to purchase coverage on the individual market, as opposed to the employer's group market, would not be considered integrated and in compliance with the proscription against annual limitations.¹⁴⁰ Notice 2013-54 summarizes this guidance as follows:

In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition. Further, the HRA FAQs indicate that the Departments intend to issue guidance providing that:

(a) for purposes of the annual dollar limit prohibition, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies provided under an employer payment plan, and, therefore, an HRA used to purchase coverage on the individual market under these arrangements will fail to comply with the annual dollar limit prohibition; and

(b) an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in the coverage, and any HRA that credits additional amounts to an individual, when the individual is not enrolled in primary coverage meeting the annual dollar limit prohibition provided by the employer, will fail to comply with the annual dollar limit prohibition.¹⁴¹

This DOL guidance signaled that individual market coverage would not be treated in the same manner as group coverage provided by the employer for purposes of avoiding the annual dollar limit prohibition. The Notice essentially reaffirms that guidance, but it also permits integration to occur in connection with an employee's group coverage through a spouse's employer.¹⁴²

138. *See id.* at 37,191 (referring to stand-alone HRAs).

139. *See id.* (inviting comments concerning the application of PHS application to other stand-alone HRAs).

140. *See* FAQs about the Affordable Care Act Implementation Part IX, Q2 (Jan. 24, 2013), available at www.dol.gov/ebsa/faqs/faq-aca11.html (explaining that "an employer-sponsored HRA cannot be integrated with individual market coverage" because it would violate section 2711 of PHS Act).

141. I.R.S. Notice 2013-54, *supra* note 67, at § II.D.2.

142. *See id.* at § III.A.1., Q&A 4 (explaining that integration is allowed when an employee is covered by a spouse's employer).

Thus, as long as an HRA is integrated with an otherwise compliant group health insurance plan, the employer may continue to offer an HRA to its employees without violating either the annual limit or the preventive services requirements. In other words, the fact that the HRA does not itself ensure that certain preventive services are offered without cost sharing or that the employer's annual contribution to the HRA is a limited dollar value does not cause the employer to violate these market reform provisions of the ACA.¹⁴³ However, an employer that offers an HRA to provide benefits to an employee who is not covered by an integrated group plan, but instead is either not insured or insured through a policy from the individual market (including an exchange), would not be in compliance with the market reform provisions. As explained in the Notice,

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the preventive services requirements because (1) an employer payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.¹⁴⁴

Treasury regulations issued before Notice 2013-54 had specifically exempted Health FSAs from the annual dollar limitation otherwise imposed by the ACA.¹⁴⁵ However, the Notice clarifies that only an FSA offered through a cafeteria plan (which is subject to separate funding limits through section 125(i)) avoids the annual dollar limitation.¹⁴⁶ Moreover, the Notice also makes it clear that a health FSA would fail to satisfy the ACA's preventive

143. *See id.* at Q&A 6 (explaining that, in fact, this exemption for the HSA seems to apply even if the integrated coverage is not fully in compliance with all of the new ACA requirements because it is a grandfathered plan).

144. *See id.* at Q&A 3 (discussing requirements for compliance with preventive service requirements).

145. *See id.* at n. 9 (citing 26 C.F.R. § 54.9815-2711T(a)(2)(ii)) (explaining that HSAs, as well as the Archer MSAs, are outside the scope of these market reforms because they are not considered group health plans). *See* Patient Protection and Affordable Care Act: Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, 37190 (stating that “[b]oth MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and non-medical expenses. [Footnote omitted.] Moreover, annual contributions to MSAs and HSAs are subject to specific statutory provisions that require that the contributions be limited.” As discussed in part III.B., *infra*, this flexibility may further contribute toward a shift toward HDHP/HSA plans).

146. *See* I.R.S. Notice 2013-54, *supra* note 67, at Q&A 8 (explaining that exemption does not apply to health FSAs not offered through cafeteria plans).

services requirements if it is not integrated with an otherwise compliant group health plan.¹⁴⁷ This also constrains an employer's ability to provide a health FSA through a cafeteria plan without also offering group coverage.¹⁴⁸ The prospect of a penalty tax on nonconforming group health benefits by an employer looms large in this equation.¹⁴⁹

With an integrated approach, the type of HRA that remains available for use more closely resembles a FSA in terms of the covered medical costs, which include such items as co-payments, deductibles, as well as other medical care that does not constitute essential health benefits.¹⁵⁰ However, HRA coverage still differs from an FSA in that it may also be used to cover premiums in the employer's own group health plan, which is not part of the typical health FSA benefit coverage but presumably would be offered through a cafeteria plan.¹⁵¹ In addition, while the health FSA can be funded by employer contributions, those contributions are limited if the health FSA is going to be offered through a cafeteria plan.¹⁵² For the time being, there are no similar constraints on HRA funding. However, the excise tax on so-called "Cadillac plans" is looming, which will ultimately affect a broad range of employer funding practices.¹⁵³

III. PROSPECTS FOR HSAS IN THE POST-ACA WORLD

As shown in part I, above, the HSA, health FSA, and HRA each continue to provide utility in the post-ACA environment. But it appears that the stars are aligning in a manner that favors an HDHP/HSA regime, albeit perhaps with health FSAs and HRAs continuing in a supporting role. A combination of greater restrictions on health FSAs and HRAs will cause some employers to reassess their plans. Marketplace effects on the costs of procuring healthcare coverage appear to be providing an even stronger nudge toward cost containment, with higher premium

147. *See id.* at Q&A 7 (discussing how market reforms would apply to a health FSA that does not qualify as an excepted benefit).

148. *See id.* (explaining that the Notice does not expressly state whether group coverage through a spouse would be considered integrated for purposes of the health FSA, but such treatment would be consistent with the HRA treatment discussed above "with respect to each individual to whom such failure [in compliance] relates").

149. *See* I.R.C. § 4980D (explaining that a \$100 tax will be imposed for each day during the noncompliance period).

150. *See* I.R.S. Notice 2013-54, *supra* note 67, at Q&A 4.

151. *Id.*; *see also* Q&A 7 (explaining that health FSAs are not constrained by the annual dollar limitation or preventive services requirements to the extent they are paired with an employer-provided group health plan).

152. *See supra* notes 114-16 (referring to the \$2,500 limit).

153. *See infra* Part III.D (discussing the effect "Cadillac plans" may have on HDHP coverage).

costs likely translating into higher levels of consumer responsibility for a growing portion of their healthcare expenditures.

Part A rehearses a brief summary of ACA effects on HSAs, health FSAs, and HRAs, most of which have been explained in part II, above. Those familiar with these effects can skip to part B, which surveys recent data on the comparative costs of HDHP vs. PPO-based plans, showing the potential cost and benefit parameters for choosing an HDHP/HSA regime. Part C illustrates the impact of tax-based incentives on choosing the HDHP/HSA regime and briefly examines potential welfare-enhancing benefits from consumer autonomy outside of insurance coverage. Finally, part D covers the looming impact of the excise tax on so-called “Cadillac plans” effective in 2018 and its likely encouragement of HSA participation.

A. Summary of Significant ACA Impacts

As discussed in part II, above, new restrictions imposed by the ACA have primarily restricted the utility of the health FSA and the HRA, but not the HSA. These restrictions include the \$2,500 indexed limitation for employee contributions to a health FSA, which constrains their utility for patients seeking to cover healthcare expenses not otherwise covered by insurance.¹⁵⁴ Integration requirements also generally constrain employers from offering an FSA or HRA apart from also offering an employer-sponsored group health plan that otherwise conforms to ACA requirements.¹⁵⁵ Draconian penalties for nonconforming use of these accounts present a powerful incentive for employers to comply with the integration rules.¹⁵⁶

In contrast, the HSA remains comparatively unscathed. Although eligibility for HSA participation is linked to HDHP coverage that must otherwise conform to ACA dictates in the same manner as other insurance products, the HSA continues to provide eligible participants access to tax-favored health benefits for their out-of-pocket costs on similar terms. The HSA is not affected by integration requirements announced in Notice 2013-54,¹⁵⁷ and HSA participation rules allow an account to be maintained and funded regardless of whether HDHP coverage comes from an employer or some other source, including a policy acquired in the

154. See I.R.C. § 125(i) (explaining that cafeteria plan benefits will not be treated as qualified benefits unless the plan prevents the employee from electing a salary reduction contribution exceeding the \$2,500 limit).

155. See I.R.S. Notice 2013-54, *supra* note 67 (discussing constraints on the use of HRAs to deliver healthcare benefits).

156. See *generally* I.R.C. § 4980D (2014) (imposing a tax of “\$100 for each day in the noncompliance period with respect to each individual to whom such failure relates”).

157. *Supra* notes 136-152 and accompanying text.

individual marketplace.¹⁵⁸

The market reform provisions which push employers to integrate health FSA and HRA offerings with employer-provided insurance do not apply to HSAs, in part because the HSAs are subject to their own integration rules found in the eligibility requirement of section 223(a).¹⁵⁹ This feature may provide an additional nudge toward HDHP coverage and HSA participation, particularly among small employers who are tempted to drop insurance coverage for their employees and yet still wish to provide tax-favored assistance to their employees.¹⁶⁰

Employers offering group HDHP coverage through a cafeteria plan also retain the ability to combine an HRA and/or health FSA with an employee's HSA benefit. For example, an employer might offer a HDHP through a cafeteria plan along with an HSA and a limited purpose FSA funded by salary reductions in order to expand the total health saving benefits available to an employee.¹⁶¹ The employee enjoys a tax-free benefit from the employer's contribution for the HDHP and any contribution to his/her HSA, which can be expanded if the employee also participates in a limited purpose FSA offered by his employer.¹⁶² Assuming family coverage and one employed spouse, the total salary reduction contributions to the HSA could sum to \$6,550 (\$7,550 if age 55 or over), with an additional \$2,500 to a limited purpose FSA, bringing the total to \$9,050 (\$10,050 if age 55 or over).¹⁶³

The employer may expand the benefits available to the covered employee beyond its share of the premium payments for the HDHP and any contribution to the employee's HSA. For example, the employer could choose to make a contribution to a limited purpose FSA, which is not subject to the \$2,500 indexed annual limitation for employee contributions in section 125(i), though it may be otherwise limited through regulations.¹⁶⁴

158. *Supra* Part II.A.2 and accompanying text (discussing HSA funding).

159. *See* Patient Protection and Affordable Care Act, *supra* note 137, at 37190-91 (detailing the new rules and regulations governing HSAs and FSAs under the Affordable Care Act for patient protection).

160. *But see* I.R.C. § 4980H (2014) (imposing an additional economic barrier on employers subject to the shared responsibility payment for failing to offer affordable minimum coverage).

161. *See supra* Part II.A (discussing the rules and requirements for HSAs).

162. *See id.* (discussing the alternatives offered by HSAs and FSAs).

163. If both spouses are over 55 and maintain separate HSAs, the total could reach \$11,050 if both spouses divide the maximum HSA contribution plus make their respective individual \$1,000 contributions on account of age.

164. Special rules relating to group health plans, Treas. Reg. § 54.9831-1(v) (2010). More specifically, this regulation states:

Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements--

(A) Other group health plan coverage, not limited to excepted benefits, is

Through this device, the employee could cover non-essential benefits such as vision, dental, and similar benefits without tapping into the HSA, thereby preserving those funds for other deductibles, co-payments, and out-of-pocket costs associated with primary health coverage. The employer might offer a similar benefit from a HRA, which would effectively add to the amount of coverage provided in the limited purpose FSA.¹⁶⁵ As long as those reimbursements are designed to avoid any jeopardy to the HDHP coverage limitation, the employer retains flexibility to share responsibility for the employee's medical costs and the employee can cover remaining expenses on a tax-favored basis, perhaps while still saving a considerable balance in the HSA.

Instead of an HSA, some employers who offer HDHP coverage will continue to pair insurance offerings with an integrated HRA to which the employer contributes a fixed amount to assist the employee with deductible costs. An HRA offering may allow savings to the employer in comparison with an HSA contribution, in that the actual cost of the HRA is limited to the healthcare costs actually incurred, rather than the full cash contribution to the HSA.¹⁶⁶ With this method of cost sharing, the HRA can cover deductible amounts up to the level of the employer contribution, but the employee must cover additional deductible amounts from his own funds.¹⁶⁷ It remains to be seen whether the more employee-friendly HSA regime, which permits employee saving and retention of benefits, will prove more desirable than this approach.

Given that the prescribed lower limits of deductibles for the HDHP are relatively modest (\$1,250 single or \$2,500 family),

made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

Id.; see *supra* notes 136-42 and accompanying text (discussing the rules for group health plans).

165. But note that ordering rules care must also be followed where multiple reimbursement accounts are used. See Notice 2002-45, *supra* note 122, at § V (providing ordering rules for HRAs and Health FSAs).

166. *Supra* notes 124-28, and accompanying text.

167. See Kaiser/HRET Survey, *supra* note 124, at 141 ("HRAs often are offered along with a high-deductible health plan (HDHP). In such cases, the employee pays for health care first from his or her HRA and then out-of-pocket until the health plan deductible is met. Sometimes certain preventive services or other services such as prescription drugs are paid for by the plan before the employee meets the deductible.").

combining the HDHP/HSA approach with an employer contribution to the HSA could potentially soften the impact of rising deductible costs on employees. However, as discussed in part B, below, recent data shows that employers – likely for affordability reasons – have generally been adopting HDHP coverage with even higher deductible limits than the statute requires, and they are also having employees bear responsibility for a greater share of their own healthcare costs.

B. Comparative Data on Costs and Benefits of HDHP Coverage

As shown in Figure 1, below, the average deductible for employer-provided coverage in 2013 is considerably higher than the deductible limits permitted by statute – \$1,250 (single) or \$2,500 (family). Even so, as compared with an employer-provided PPO plan that is not considered a HDHP, this data indicates that employees with a HDHP are paying only slightly higher deductibles than their counterparts covered by a PPO:

Figure 1: Average Deductibles (HDHP vs. PPO)¹⁶⁸

Coverage	Single	Family
HDHP	\$2,003	\$4,079
PPO	<u>\$799</u>	<u>\$1,854</u>
Difference	<u>\$1,204</u>	<u>\$2,225</u>

Of course, deductibles are not the only out-of-pocket expenses that must be incurred. Co-payments among plans are generally similar, meaning that costs that must be shared by the insured after reaching the deductible amount are not expected to be significantly different between the two policy approaches.¹⁶⁹ However, the cost of insurance coverage is also lower for the HDHP than for otherwise comparable PPO coverage, as shown below in figure 2:

168. Kaiser/HRET Survey, *supra* note 124, Exhibit 7.7 (single) and 7.14 (family). It should be noted that some plans may have separate deductibles for each covered person, which could also affect affordability. This is not reflected in the above figures.

169. *See id.* at Exhibit 7.27 (illustrating the expected similarities in copayments among the different plan options).

Figure 2: Average Employee/Employer Costs for HDHP vs. PPO (2013)¹⁷⁰

	Employee Portion:		Employer Portion:		Total Cost:	
	Single	Family	Single	Family	Single	Family
PPO						
Average	\$1,024	\$4,587	\$5,008	\$12,084	\$6,032	\$16,671
HDHP						
Average	<u>\$887</u>	<u>\$3,649</u>	<u>\$4,419</u>	<u>\$11,578</u>	<u>\$5,306</u>	<u>\$15,227</u>
Savings	<u>\$137</u>	<u>\$938</u>	<u>\$589</u>	<u>\$506</u>	<u>\$726</u>	<u>\$1,444</u>
% Savings	13.38%	20.45%	11.76%	4.19%	12.04%	8.66%
Employer Average Premium Share:			Ratio of Family/Single Average Premium Cost:			
PPO:	83.02%	72.49%	PPO: 2.76			
HDHP:	83.28%	76.04%	HDHP: 2.87			

Looking only to the employee's portion, the average family premium savings of \$938 would potentially leave the employee with responsibility for an additional \$1,287 in healthcare costs if covered by an HDHP instead of a PPO.¹⁷¹ For singles, the HDHP potentially imposes an additional \$1,067 in potential costs over the PPO option.¹⁷²

Some of this difference between the PPO and the HDHP may be ameliorated through other employer-provided benefits funded by the employer's savings from adopting a HDHP. From the data in figure 2, above, it appears that employers are paying relatively more of the premium cost for single coverage. However, employers are paying a significantly higher dollar value toward family coverage – which explains why some employers are economizing by restricting family coverage when a spouse is eligible through another employer.¹⁷³

An additional benefit for the HSA/HDHP approach lies in the potential for savings practices that depend on the conferral of property rights upon the HSA owner. The negative cost differential for the HSA/HDHP shown above exists only if the employee incurs healthcare costs in excess of the alternative PPO deductible amount. As illustrated in figure 3, below, if the

170. See *id.* at Exhibit 6.5 (portraying the lower cost of insurance for an HDHP plan compared to a PPO).

171. The family HDHP deductible (\$2,225 more than the PPO) less the lower premium outlay (\$938 less than the PPO) equals \$1,287.

172. The single HDHP deductible (\$1,204 more than the PPO) less the lower premium outlay (\$137 less than the PPO) equals \$1,067.

173. See, e.g., Steven Greenhouse, *U.P.S. to End Health Benefits for Spouses of Some Workers*, N.Y. TIMES (Aug. 21, 2013), available at www.nytimes.com/2013/08/22/business/ups-to-end-health-benefits-for-spouses-of-some-workers.html (showing how some companies, for example UPS, are cancelling spousal health benefits if the spouse is covered on a separate plan).

employee remains healthy during the year, the HSA/HDHP approach allows the employee to retain his/her share of premium cost savings. Until the employee spends up to the alternative deductible under the PPO plan, the employee retains the full share of the premium costs saved under the HDHP – \$938 in this example. The savings are reduced to zero as the plan reaches the point where insurance benefits (estimated at 80% of costs for both the PPO and HDHP plans) reach the amount of the premium differential. After medical expenses reach the deductible amount under the HDHP, the differential cost reaches a maximum of \$842 in this example, reflecting the maximum total disadvantage from adopting the HDHP plan if predicted medical spending exceeds premium savings.

Figure 3: Potential Annual Savings (Loss) from HDHP (Family Coverage)

	Healthy:		Less Healthy:		Unhealthy:	
	PPO	HDHP	PPO	HDHP	PPO	HDHP
Premium (Employee Share)	\$4,587	\$3,649	\$4,587	\$3,649	\$4,587	\$3,649
Medical Expense	\$1,854	\$1,854	\$3,026	\$3,026	\$4,079	\$4,079
Less: Insurance Benefit	\$0	\$0	\$938	\$0	\$1,780	\$0
Total Medical Cost	\$6,441	\$5,503	\$6,675	\$6,675	\$6,886	\$7,728
Out-of-Pocket Cost	\$1,854	\$1,854	\$2,088	\$3,026	\$2,299	\$4,079
Savings (Loss) in HDHP		\$938		\$0		-\$842

The amounts reflected in figure 3 above do not reflect the impact of any tax savings achieved from a deductible premium paid in each case. However, assuming that the employee invests the premium savings in a HSA, thereby generating a tax deduction for that difference, such an assumption would neutralize any tax difference in this example.

As shown in figure 3, even the employee who chooses the PPO will have to incur out-of-pocket costs. As the total amount of healthcare expenditures for that employee grows, those amounts can become significant. Although the ACA imposes a cap on the total out-of-pocket costs, the cap of \$12,700 for family coverage is a sizable sum. Finding the resources to pay these out-of-pocket costs presents one of the problems that the HSA is designed to address. For an employee with PPO coverage, the combination of limited annual contributions coupled with the “use-or-lose” character of

the health FSA does not permit this account to provide sufficient funds to address serious health incidents. For an employee with HDHP coverage, the HSA offers an avenue for accumulating those benefits during healthy years and, if the need arises, using them when significant health costs arise.

A. Tax Benefits and Incentives

Tax benefits sweeten the deal for the HSA participant, but that sweetness intensifies as the taxable income level (and marginal tax rate) for the employee increases. First, employees benefit from the exemption from FICA taxes conferred upon salary reductions used to fund an HSA through a cafeteria plan.¹⁷⁴ Second, employees with a positive marginal federal income tax rate receive a tax benefit from the income tax exemption conferred on the salary deferral, as well as that received on any unused, invested balance in the HSA. The current annual value of tax incentives from HSA contributions at various levels are illustrated in figure 4, below.

Figure 4: Employee Tax Incentives for HSA Contributions (Cafeteria Plan)

Contribution Level	\$938	\$3,300	\$4,300	\$6,550	\$7,550
FICA Tax (7.65%)	\$71.76	\$252.45	\$328.95	\$501.08	\$577.58
Income Tax (10%)	\$93.80	\$330.00	\$430.00	\$655.00	\$755.00
Income Tax (15%)	\$140.70	\$495.00	\$645.00	\$982.50	\$1,132.50
Income Tax (25%)	\$234.50	\$825.00	\$1,075.00	\$1,637.50	\$1,887.50
Income Tax (35%)	\$328.30	\$1,155.00	\$1,505.00	\$2,292.50	\$2,642.50
Income Tax (39.6%)	\$371.45	\$1,306.80	\$1,702.80	\$2,593.80	\$2,989.80
Min	\$71.76	\$252.45	\$328.95	\$501.08	\$577.58
Max	\$443.21	\$1,559.25	\$2,031.75	\$3,094.88	\$3,567.38

174. The FICA wage base is capped at 117,000 in 2014, up from \$113,700 in 2013. See SOCIAL SECURITY ADMINISTRATION, *Social Security Announces 1.5 Percent Benefit Increase for 2014* (Oct. 30, 2013), available at www.ssa.gov/pressoffice/pr/2014cola-pr.html (announcing the increase in benefits for 2014 and an increase in the cap from 2013). Thereafter, the tax rate is reduced only to the Medicare tax (i.e., 1.45% on both employer and employee). Thus, lower-earning participants below the FICA wage base limit receive a larger tax benefit than their higher-earning counterparts when it comes to the avoidance of the FICA tax.

The contribution levels in figure 4 start at \$938 (the average employee share of premium savings, shown in figure 3 above), then increase to \$3,300 (maximum HSA contribution for single coverage), \$4,300 (maximum HSA contribution for single coverage if over age 55), \$6,550 (maximum HSA contribution for family coverage), and \$7,550 (maximum HSA contribution for family coverage if over age 55). The income tax rates reflect common federal statutory rates at various levels. As shown, the minimum savings reflects only FICA taxes avoided, while the maximum reflects a combination of FICA plus the income tax savings at the maximum statutory rate, a total that potentially overstates the FICA tax savings.¹⁷⁵ State and local income taxes are not reflected, but if applicable they would add to the tax savings achieved.

It should be noted that FICA tax savings are available to both employers and employees for properly structured contributions to an HSA, but the self-employed person does not enjoy a comparable exemption from SECA taxes.¹⁷⁶ Similarly, self-employed persons are disadvantaged when compared to employees because they must pay SECA taxes on their health insurance premiums, which are deductible for federal income tax purposes but do not reduce the computation of the SECA tax base – net income from self-employment.¹⁷⁷

This differential tax treatment between employees and the self-employed lacks a solid policy justification. The employment tax exemption incentivizes the employer and the employee by lowering the net employment tax cost for providing (choosing) a qualified health benefit instead of additional cash compensation. Under the ACA, shared responsibility payments imposed on large employers and the individual mandate penalty provide negative incentives that further reflect the value judgment favoring health insurance coverage. Self-employed persons could be subject to both sets of penalties (if they are employers), but lack the same set of positive incentives in the form of the analogous SECA tax exemption. This should be rectified.

Given the correlation between marginal income tax rates and tax savings, it is not surprising that more higher-earning participants respond to this tax incentive by contributing to an

175. It is likely that the full FICA tax savings would not be achieved by salary reduction in many cases if the salary earnings are reflected in the tax base necessary to generate income tax in the 35% or 39.6% brackets, since the full FICA employment tax base in 2014 is \$117,000, and any salary reduction contribution would thus effectively be replaced by other earnings. In that case, the employee's share of the benefit would be limited to the Medicare tax (i.e., 1.45% vs. 7.65%). However, it is possible under various scenarios for the full benefit to be achieved, as in situations where the balance of earnings comes from sources not subject to FICA taxes or in the case of dual-income spouses where HDHP coverage is obtained by a lower-earning spouse.

176. *See supra* Part II.A.4 (discussing HSAs rules and regulations).

177. *See id.* (discussing the ramifications of self-employment and HSAs).

HSA.¹⁷⁸ Graduated tax rates produce the same effects in retirement savings funded through tax-deductible contributions, with higher marginal tax savings (and incentives) for those in higher tax brackets. For a healthy, high-earning individual who is otherwise contributing maximum allowable amounts to tax-favored retirement savings,¹⁷⁹ contributing to an HSA may effectively expand one's potential retirement savings by as much as \$7,500 in 2014. Given that post-retirement distributions from an HSA are taxed in the same manner as other taxable retirement distributions,¹⁸⁰ the current HSA regime is open to the criticism that it expands tax-avoidance opportunities that are particularly attractive for the comparatively well-off.¹⁸¹

Moreover, to the extent that properly structured HSA contributions enjoy FICA tax exemptions, HSAs may present a preferred method for retirement savings that is particularly attractive for those whose earnings do not exceed the FICA tax base. Given that contributions and distributions are both exempt from FICA taxes, while regular retirement savings contributions are subject to FICA taxes, the HSA presents another avenue for tax avoidance.¹⁸²

The FICA exemption from HSA participation incentivizes participation by every employee, and particularly those who are earning below the current \$117,000 FICA wage base limit.¹⁸³ Such

178. See, e.g., Paul Fronstin, *Employer and Worker Contributions to Health Reimbursement Arrangements and Health Savings Accounts, 2006-2012*, 34 EMPLOYEE BENEFIT RESEARCH INSTITUTE NOTES 16, 18 (Feb. 2013) (stating, “[g]enerally, lower-income people with an HSA are less likely to make contributions to the account than higher-income people.”)

179. See INTERNAL REVENUE SERVICE, COLA INCREASES FOR DOLLAR LIMITATIONS ON BENEFITS AND CONTRIBUTIONS, www.irs.gov/Retirement-Plans/COLA-Increases-for-Dollar-Limitations-on-Benefits-and-Contributions (last visited Feb. 17, 2014) (summarizing current dollar limitations for various retirement savings plans after applicable inflation adjustments).

180. See *supra* notes 78, 80 and corresponding text (detailing how retirement distributions are taxed).

181. See Monahan, *supra* note 7, at 840 (discussing the tax-avoidance opportunities created by the new health care plans); see also Calvin Johnson, *Ordinary Medical Expenses*, TAX NOTES, Nov. 18, 2013, at 780 (criticizing HSAs to the extent they permit ordinary medical expenses to be paid with after-tax money, but justifying exclusions for insurance to the extent of extraordinary cost levels). See also *id.* at 779 (stating, “[a]n exclusion of [health insurance premiums] properly taxed is another subsidy with the abhorrent patten in that the subsidy is more valuable for the health of the rich, in higher tax brackets, than it is for the poor.”)

182. See I.R.C. § 223(f)(4) (2014) (detailing the 20% penalty on preretirement non-medical distributions from an HSA). This penalty might be viewed as a rough compensating measure for the FICA tax exemption on a qualified contribution. But if the penalty does not apply, as in retirement distributions, these amounts go essentially untaxed. Moreover, the penalty is not dedicated to Social Security/Medicare purposes, as is arguably the case for other FICA tax collections.

183. *Supra* note 174 and accompanying text.

an incentive is not otherwise possible in a system rooted in the benefits from income tax deductions, which leaves a large portion of the earning population untaxed. As discussed above, the employer's share of those FICA savings may also incentivize a benefit structure that includes a cafeteria plan to facilitate those benefits.¹⁸⁴

As a policy matter, creating a special savings vehicle for medical expenses also has value to the extent that at least some high-earning and lower-earning individuals share a common tendency to spend what they earn, rather than saving for future needs which include health and retirement. This dedicated pool of liquidity helps ameliorate that problem.¹⁸⁵

Moreover, by providing ownership rights to individuals, HSAs move some citizens toward more responsible behavior for their own health care needs, which has spillover effects for reduced healthcare spending.¹⁸⁶ As explained by Bankman and his colleagues in a recent paper, providing tax-deductible treatment for out-of-pocket medical spending – a practice that is highly similar to an HSA – produces two countervailing effects. On one hand, expanding deductibility for healthcare costs likely increases demand for healthcare by reducing its cost compared with other goods, which must be purchased with after-tax dollars.¹⁸⁷ On the other hand, this also moves health spending decisions from within health insurance plans to the private realm, which effectively reduces the demand for healthcare by avoiding the moral hazard that occurs in connection with health expenditures covered by a third-party payor.¹⁸⁸ According to Bankman and his colleagues, the literature shows the second effect to be larger, thus making welfare enhancement likely.¹⁸⁹ Although HSAs accelerate tax benefits to the year of contribution, rather than waiting for the year of payment to allow a deduction,¹⁹⁰ the HSA also shifts the locus of payment outside of the insurance environment, which arguably permits the same kind of welfare-enhancing outcome.¹⁹¹

184. *See supra* Part II.A.4. (explaining HSA impacts on employment taxes).

185. *But see* Monahan, *supra* note 7, at 842 (criticizing HSAs as targeting those who already have savings habits).

186. *See* Joseph Bankman, et al., *Reforming the Tax Preference for Employer Health Insurance*, 26 *TAX POLICY AND THE ECONOMY* 43, 47-48 (2012) (analyzing the ramifications of a tax deduction for out of pocket spending).

187. *See id.* at 48 (predicting an increase in demand as health care costs are reduced in relation to other goods and services).

188. *See id.* (comparing health care spending patterns within insurance plans to out of pocket spending).

189. *See id.* (estimating that moving health care spending out of insurance plans would increase welfare).

190. *See supra* notes 68-69 and accompanying text (highlighting income tax advantages of HSAs).

191. *See also* William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 *U.*

Ironically, while the ACA has suffered criticism for its tendency toward government intrusion into health care involving the scope and extent of insurance coverage, ACA provisions described above may also be moving more people toward greater personal responsibility for their own healthcare spending that is not covered by insurance. Though this offers some promise, it also presents some concerns to the extent that otherwise insured persons may still face significant personal costs without HSA balances to fund them.¹⁹²

By incorporating preventive care requirements into the integrated HDHP insurance,¹⁹³ the ACA also removes the theoretical concern that restoring cost responsibility through a consumer-directed approach might cause under-consumption of preventive care, which could increase healthcare costs.¹⁹⁴ However, the ACA's approach to preventive care also works against the ACA's goals to expand insurance coverage. Employers with religious or other conscientiously held objections to providing insurance that includes coverage for items such as contraception and sterilization are contesting these requirements. Whether an HDHP/HSA regime can provide a solution for these moral dilemmas is discussed in part IV, below.

D. Excise Taxes on "Cadillac Plans": Another Nudge toward HDHPs?

In addition to imposing shared responsibility penalties for large employers who fail to offer affordable healthcare coverage to their employees,¹⁹⁵ the ACA also targets employers that offer coverage that is deemed too generous. Section 9001 of the ACA enacted section 4980I of the Code, which imposes a 40 percent excise tax on any "excess benefit" associated with employer-sponsored health coverage beginning in 2018.¹⁹⁶

MEM. L. REV. 279, 369-70 (2009) (suggesting that consumer-driven health care will increase transparency in the health care system and lead consumers to select less costly alternatives when making health care choices).

192. See Monahan, *supra* note 7, at 831-32 (anticipating potential difficulties of managing chronic health conditions if/when deductible cannot be waived for treatment of such conditions).

193. See 42 U.S.C. § 300gg-13(a) (requiring coverage of certain preventive care recommended by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration).

194. See Monahan, *supra* note 7, at 831 (addressing concerns that individuals using CDHPs may put off preventive care either to avoid paying high deductibles or because of insufficient HSA funds). "The issue of forgoing preventive care can be addressed through a plan design that waives the deductible for such care . . ." *Id.*

195. See generally I.R.C. § 4980H (providing for assessment of penalties on large employers who fail to provide at least "minimal essential coverage").

196. See generally I.R.C. § 4980I(a) (creating a tax on excess benefits

The excise tax computation focuses on the cost of “applicable employer-sponsored coverage,” which means “coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).”¹⁹⁷ The “excess benefit” is that which exceeds annual dollar limits of \$10,200 for self-only coverage and \$27,500 based on other coverage, with certain upward adjustments in these limits based on premium cost experiences.¹⁹⁸ The excess benefit amount is determined on a monthly basis based on the difference, if any, between the aggregate cost of the applicable employer-sponsored coverage over one-twelfth of the applicable annual limitation.¹⁹⁹

In addition to health insurance premiums, the total cost of employer-sponsored coverage considered in computing this excess benefit amount also includes other healthcare costs. Generally speaking, it does not matter whether the employer or employee pays for employer-sponsored group coverage.²⁰⁰ Under specific rules, if employer-sponsored coverage includes a health FSA, salary deferrals from the employee plus any employer contributions are included in computing the cost of employer-sponsored coverage.²⁰¹ Employer contributions to an HSA are likewise specifically targeted for inclusion.²⁰² Thus, the tax reaches into amounts that employers are typically funding, directly or indirectly through salary deferrals, on a tax-favored basis.

As noted, the excise tax is based on group health plan coverage. However, the statute also targets employer contributions to an HSA for this purpose. HSAs are generally not considered to be group health plans.²⁰³ However, if an employer offers an HSA

provided by employers).

197. See I.R.C. § 4980I(d)(1)(A) (defining “applicable employer-sponsored coverage” as that which would not be included in the employee’s gross income). Exclusions are available for stand-alone plans covering dental or vision benefits. See I.R.C. § 4980I(d)(1)(B)(ii) (exempting dental and vision plans).

198. See I.R.C. § 4980I(b)(2), (3) (providing for the calculation of the monthly excess amount and the annual limitation of the excess benefit). Certain other adjustments may also be applied, including those for age and gender features of the plan, and expanded limits for insureds who are engaged in high risk professions. See I.R.C. § 4890I(b)(3)(C)(iii), (iv) (allowing for the adjustments for the age, gender and high risk categories). For years after 2018, cost of living adjustments apply incrementally to the adjustment computed for 2018. See I.R.C. § 4980I(b)(3)(C)(v) (establishing the calculation for incremental increases after 2018).

199. I.R.C. § 4980I(b)(2).

200. I.R.C. § 4980I(d)(1)(C).

201. I.R.C. § 4980I(c)(2)(B).

202. I.R.C. § 4980I(c)(2)(C). Archer MSA contributions are likewise included for legacy users of these accounts. *Id.*

203. See 75 Fed. Reg. 37188, 37190 (stating, “Both MSAs and HSAs

through a cafeteria plan using a salary reduction agreement, there is arguably room to convert those salary reduction amounts into an employer contribution – as this is what otherwise happens within a cafeteria plan.²⁰⁴ On the other hand, the excise tax rules specifically target salary deferral agreements for health FSAs, but refer only to employer contributions for HSAs, which arguably suggests that an employee's contributions to and HSA would not be included in the excise tax base.²⁰⁵ The scope of the excise tax base thus remains somewhat uncertain on this account.

The tax will be imposed on a “coverage provider”, which for employer-sponsored coverage under a group health plan means the insurance issuer, not the employer.²⁰⁶ To the extent that there is more than one “coverage provider,” the tax will be allocated between them.²⁰⁷ This will occur, for example, when the employer offers a health FSA through a cafeteria plan which is integrated with other employer-provided coverage, triggering liability for tax from both the insurer and the employer.²⁰⁸ However, the employer will be responsible for computing the tax and notifying the government and insurance coverage provider of the amount due.²⁰⁹

Although the stated annual limits for 2018 may seem rather generous by today's standards – \$10,200 (individual) and \$27,500 (family) – even modest annual increases in healthcare costs over the next several years could easily push many existing plans offered by employers into excise tax territory.²¹⁰ However, even though insurers would nominally be responsible for a portion of the tax, those costs would likely be shifted to the employers and ultimately to their employees in the form of lower wages.²¹¹

The Code prescribes that the targeted annual figures for 2018 are to be adjusted upward to the extent that cost increases for a benchmark plan, the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan, exceed 55 percent between 2010 and 2018 – a compounded annual rate of approximately 5.6 percent.²¹² Thereafter, inflation adjustments

generally are not treated as group health plans because the amounts available under the plans are available for both medical and nonmedical expenses”).

204. *Supra* note 53, and accompanying text.

205. *Compare* IRC § 4980I(c)(2)(B) (including employer contributions to Health FSAs under salary reduction arrangements in cost of applicable employer-sponsored coverage) *with* IRC § 4980I(c)(2)(C) (including only employer contributions to HSAs).

206. I.R.C. § 4980I(c)(2)(A).

207. I.R.C. § 4980I(c)(3).

208. Amy B. Monahan, *Why Tax High-Cost Employer Health Plans?*, 65 TAX L. REV. 749, 755-56 (2012).

209. I.R.C. § 4980I(c)(3), (4).

210. Monahan, *supra* note 208, at 758.

211. *Id.* at 756-57.

212. $1.0568 = 1.546$. It should be noted that this requires the 2018 BCBS premium to be priced based on the benefits available in 2010. But changes in medical practices could present a significant challenge in the event that

based on the general price level, rather than specific price adjustments for health insurance costs, could result in further divergence between health plan costs and the adjusted annual limits.²¹³ However, if we assume conservatively that no additional adjustment to the annual limits for 2018 will occur and project that policy rates grow at the adjustment limit contemplated by the statute – 55% over 2010 levels – the projected BC/BS policy costs would nearly reach the excise tax limit for self-only coverage, while leaving several thousand dollars for family coverage. This is illustrated in figure 5, below:

Figure 5: BC/BS Standard Benefit Option Under Federal Employees Health Benefits Plan

	2010 Cost (a)	Inflated Cost (155%) (b)	2018 Excise Tax Limit (c)	Difference (c)-(b)
Standard Option - Self Only	\$6,458.88	\$10,011.26	\$10,200.00	\$188.74
Standard Option - Self & Family	\$14,588.64	\$22,612.39	\$27,500.00	\$4,887.61

Of course, these premium amounts omit costs incurred through other health benefit delivery mechanisms, including health FSAs, which may add to the total excise tax base. While family coverage policies have a bit more room than singles for their costs to grow before hitting the excise tax, the message is clear: this is no idle threat for employers.

Some employers are already contemplating the tax and looking at ways to avoid it.²¹⁴ Wellness programs might help if employees respond to them and insurance rates track downward as a result of lower claims. However, raising deductibles and imposing more costs on employees is also an effective approach with predictable results, at least in the short run.²¹⁵ This trend could also lead to further interest in HDHP coverage, which as shown in figure 2, above, delivers premium cost savings over comparable PPO plans.

certain drugs, treatments, or other care practices are no longer used.

213. I.R.C. § 4980I(b)(3)(C)(v). Monahan, *supra* note 208, at 762-63.

214. See, e.g., Reed Abelson, *High-End Health Plans Scale Back to Avoid 'Cadillac Tax'*, N.Y. TIMES, May 27, 2013, www.nytimes.com/2013/05/28/business/cadillac-tax-health-insurance.html (showing that employers are already taking precautions to avoid the tax).

215. See *id.* (Showing an example of a couple whose deductible was raised from \$500 to \$2300 on account of employer adjustments in advance of the excise tax). See also Monahan, *supra* note 208, at 761-62 (noting “the structure of the excise tax makes it highly likely that employers will reduce the premiums of their group plans to a level below the excise tax threshold”).

Unfortunately, the excise tax will deprive employers of the ability to deliver an adequate buffer to help their employees bear the extra out-of-pocket costs through contributions toward tax-favored accounts and arrangements. Given that the excise tax reaches employer contributions to HSAs, the marketplace may favor migration to employees funding their own HSAs in order to address the marginal increase in their share of healthcare costs.²¹⁶ Employers would remain free to pay their employees a higher wage to fund those costs without paying a 40% excise tax, but employers and employees alike would potentially pay employment taxes on those earnings, even if employees gain an income tax benefit from their contributions.²¹⁷

It remains to be seen whether the excise tax threat will in fact drive health care costs down.²¹⁸ Proponents of this tax suggest that by moving costs from an employer-based insurance system in which patients are effectively insulated from any direct effects of their healthcare consumption to an environment in which consumers experience more of consequences from their healthcare consumption will ultimately result in cost savings.²¹⁹ This resembles the argument for cost savings through consumer autonomy that underlies the HSA.

Unfortunately, the excise tax is designed in such a way that it does not recognize that HSAs funded through employer contributions can also generate the same kind of savings, while avoiding some of the burden on employees. A better design might allow flexibility, for example, by reducing premium costs through higher deductibles but permitting employer contributions to an HSA to be excluded from the excise tax base (perhaps at least for

216. And as noted above, that migration may require moving outside of cafeteria plans, if the excise tax is interpreted to cover employee contributions to an HSA under a salary deferral agreement.

217. See *supra* note 88 and accompanying text (explaining that an employer's contributions to an employee's HSA are not deductible as HSA or medical expenses).

218. See generally Monahan, *supra* note 208, at 758-66 (showing a useful discussion of the complexities of whether the excise tax will drive healthcare costs down).

219. See Monahan, *supra* note 208, at 760-61 (summarizing part of his argument as shown below).

The argument is that as all of these individuals with overly-generous health insurance overconsume medical care, overall health care spending per insured individual rises, which in turn forces insurance companies to raise premiums. To halt the ever-increasing premiums, therefore, one could change the tax treatment of employer-sponsored health insurance to stop encouraging overly-generous plans. Less generous plans would lead to less medical consumption which in turn would lead to lower health insurance premiums, which would lead to more individuals being able to afford insurance. In addition, less generous plans should also lead to higher cash wages.

Id. at 760-61.

lower-paid employees). This would therefore allow the employer to avoid both the excise tax under section 4980I and the shared responsibility payment for failing to offer affordable coverage under section 4980H. Otherwise, it appears that the excise tax has the potential of making employer-sponsored healthcare less affordable for many wage earners who are ineligible for subsidies through Exchanges but must face rising deductibles and out-of-pocket costs as a consequence of the current excise tax regime.²²⁰

IV. AN ADDITIONAL ROLE FOR HSAs: RESOLVING MORAL DILEMMAS AND EXPANDING FREEDOM?

HSAs may also have additional social utility besides providing funds for payment of medical care and, if unused, for retirement. As Professor Zelinsky has suggested in a recent essay, these accounts may also be useful in solving moral conflicts that arise over healthcare needs in a pluralistic society.²²¹ The so-called “HHS mandate”, which includes access to contraception and sterilization services among the preventative care services required to be covered at no cost to insureds,²²² presents a vivid example of emerging conflicts rooted in divergent moral beliefs about appropriate healthcare.²²³ Some insureds (and employers) desire this kind of insurance coverage, but others object because of intractable moral problems presented by a requirement to purchase and/or provide compliant insurance coverage.²²⁴

A combination of tax penalties coupled with a paucity of other insurance options to avoid this moral conflict puts serious economic pressure on objectors to offer conforming insurance to their employees. The ACA imposes penalties on large employers who choose not to offer insurance to their employees.²²⁵

220. See David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669 (2012) (showing other discussion of consequences of the ACA on low- and moderate-income workers).

221. See Edward A. Zelinsky, *The Hobby Lobby Problem and the HSA/HRA Solution*, TAX NOTES, Sept. 9, 2013, at 1 (suggesting that HRAs may also be used in this way, but this requires an independent administrator).

222. See Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services, 77 Fed. Reg. 8725, 8725 (Feb. 15, 2012).

223. See Morse, *supra* note 65, at 232-37 (outlining a brief history of this requirement and the emerging conflicts over its implementation).

224. *Id.* at 237-47.

225. See I.R.C. § 4980H (employer shared responsibility penalty). The applicable date for these employer penalties has shifted from the date provided in the statute, including the recent announcement of a one-year delay for all employers until 2015. See I.R.S. Notice 2013-45, 2013-31 I.R.B. 116 (stating a further announcement that employers with 50-99 employees would enjoy another year of delay until 2016). See Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8543, 8543 (Feb. 12, 2014) (explaining that qualifying employers may be subject to penalties for

Alternatively, an employer who offers nonconforming coverage may face a penalty of \$100/day/affected individual, which will likely prove even more onerous than the shared responsibility payment for not providing insurance at all.²²⁶ Individuals who wish to buy insurance (including employees who were dropped from employer coverage on account of the mandate) face a similar moral dilemma, in that they potentially face penalties for not buying insurance²²⁷ and no real option to purchase insurance coverage that does not violate their moral or religious convictions.

The regulations implicitly recognize moral dimensions of this coverage requirement by carving out a limited exemption for religious employers, which many religious organizations dismissed as inadequate because the scope of that exemption essentially would not include many religious nonprofit organizations.²²⁸ An accommodation for religious nonprofit employers was eventually broadened, so that they could become exempt from any direct requirement to “contract, arrange, pay, or refer for contraceptive coverage.”²²⁹ However, the accommodation rules require the religious organization to self-certify its religious objection to coverage to either its insurer or its third-party administrator (for a self-insurance plan), and in this case the insurer or administrator becomes responsible for providing these benefits at no cost to either the insured or to the covered employee.²³⁰

For some nonprofits, this accommodation also proves inadequate to address their concerns, and litigation has ensued.²³¹

failing to offer affordable coverage to full-time employees).

226. See I.R.C. § 4980D(b) (2005). As between the failure to offer insurance at all and the offer of nonconforming coverage, the latter is likely to pack the largest impact on the employer. See, e.g., *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1140-41 (10th Cir. 2013) (showing annual penalty under section 4980D(b)(1) for Hobby Lobby would approach \$475 million/year vs. \$26 million for dropping healthcare coverage), cert. granted, 134 S. Ct. 678 (2013); see also Steven J. Willis, *Corporations, Taxes, and Religion: The Hobby Lobby and Conestoga Contraceptive Cases*, 65 S.C. L. REV. 1, 11-13 (2013) (questioning financial sustainability of 4980D tax in *Hobby Lobby* and noting that the “economic futures” of such employers who choose not to comply “appear grim” if relief is not granted.)

227. I.R.C. § 5000A.

228. Morse, *supra* note 65, at 242-44.

229. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39869, 39874 (July 2, 2013).

230. See *id.*, (explaining that if a religious organization certifies an objection to directly providing contraception, the insurance or the administrator must provide the benefit).

231. See THE BECKET FUND FOR RELIGIOUS LIBERTY, www.becketfund.org/hhsinformationcentral/ (last visited February 11, 2014) (providing a current listing of these cases); see also *Ave Maria Foundation v. Sebelius*, ___ F. Supp. 2d ___, No. 13-cv-15198, 2014 WL 117425 at *4 (E.D. Mich. 2014) (noting “substantial division of opinion” and citing cases concerning the free exercise claims raised by nonprofits; further noting “As the split of authorities suggests, neither side is guaranteed victory”).

Recently, a nonprofit corporation controlled by and operated by the Little Sisters of the Poor, a Catholic order dedicated to serving the elderly, brought a challenge to the accommodation that has gained considerable notoriety. Although a federal district court refused to grant relief to the Sisters from the certification requirements,²³² the United States Supreme Court has issued a temporary injunction from enforcement pending appeal.²³³ The Sisters' moral concern includes their required participation in "a scheme, the sole purpose of which is to provide contraceptives, sterilization, and abortifacients to [their employees and other beneficiaries]".²³⁴ Requiring the Sisters to provide a plan, sign the certification, serve the certification upon the insurer or administrator, and so forth connects them to the delivery of mandated items to the organization's plan beneficiaries in a way that violates their religious beliefs – and even others outside their faith share this concern.²³⁵

Of course, for-profit firms also face similar conflicts between their religious or other conscientiously held beliefs and the HHS mandate, also causing many of these firms to seek relief through litigation.²³⁶ The courts of appeals have delivered inconsistent results,²³⁷ and the Supreme Court will soon be taking up some of these legal arguments surrounding the scope of religious rights in

232. See, e.g., *Little Sisters of the Poor Home for the Aged v. Sebelius*, __ F. Supp. 2d __, No. 13-cv-2622-WJM-BNB, 2013 WL 6839900 (D. Colo. 2013) (refusing to grant an injunction initially).

233. *Little Sisters of the Poor for the Aged v. Sebelius*, Denver, Colorado, 134 S.Ct. 1022 (granting an injunction pending appeal).

234. *Little Sisters of the Poor*, 2013 WL 6839900, at *14.

235. See Editorial, *Obamacare overreach tramples Little Sisters: Our view*, USA TODAY, Jan. 12, 2014, available at www.usatoday.com/story/opinion/2014/01/12/obamacare-contraception-little-sisters-of-the-poor-editorials-debates/4446007/ (asserting that the government's insistence on forcing the Little Sisters to choose between giving up their ministry of service to the dying poor or violating the very religious beliefs that cause them to dedicate themselves to that mission is "a political loser," "constitutionally suspect" and "ultimately unproductive" according to this nonsecular newspaper).

236. See *Becket Fund For Religious Liberty*, *supra* note 27 (listing pending cases).

237. See, e.g., *Hobby Lobby Stores*, 723 F.3d at 1147 (granting injunction to for-profit corporation whose owners objected to HHS mandate on religious grounds); *Conestoga Wood Specialties Corp. v. Secretary*, 724 F.3d 377, 389 (3d Cir. 2013), *cert. granted*, 134 S. Ct. 578 (2013) (affirming the denial of preliminary injunction on ground that for-profit, secular corporation could not assert free exercise claim); *Gilardi v. Department of Health and Human Services*, 733 F.3d 1208, 1224 (D.C. Cir., 2013) (rejecting corporate standing, but allowing shareholder standing and reversing district court's denial of an injunction for the benefit of the individual owners of an S corporation); *Autocam Corp. v. Sebelius*, 730 F.3d 618, 628 (6th Cir. 2013) (rejecting shareholder standing and corporate free exercise claim); *Korte v. Sebelius*, 735 F.3d 654, 687 (7th Cir. 2013) (finding standing for both corporation and owners and finding substantial burden on religious exercise).

the corporate context.²³⁸ It is likely that the courts will eventually answer these legal questions concerning scope of protections for religious freedom. However, those legal decisions will probably not resolve the moral and political conflicts rooted in this kind of mandated coverage. As recent polls indicate, Americans are deeply divided on these matters,²³⁹ and these divisions are likely to continue for years to come.

The government has asserted that mandated coverage supports its policy goals of (1) safeguarding the public health and (2) ensuring that women have equal access to health care.²⁴⁰ The government also believes that the cost is a barrier to access for some women, and it has chosen the insurance mandate as a means to reduce this barrier for all insured women.²⁴¹ However, the current legal scheme to support these policies produces a conflict between interests in sexual liberty and religious liberty, in which religious liberty interests are forced to concede.

Many employers apparently agree with these policy goals and willingly provided contraception coverage prior to the ACA.²⁴² Likewise, many employees desire such coverage and may be pleased with the effects of the law. But those who object – both nonprofit and for-profit employers, as well as individuals with religious or conscientious objections to purchasing such coverage – are losers in this scheme. They will effectively be coerced by penalties and other economic disadvantages to participate in a

238. *Hobby Lobby Stores*, 723 F.3d at 1147; *Conestoga Wood Specialties*, 724 F.3d at 389.

239. See Public Poll, *51% Oppose Health Law's Contraceptive Mandate*, RASMUSSEN REPORTS (Dec. 1, 2013), available at www.rasmussenreports.com/public_content/politics/current_events/healthcare/december_2013/51_oppose_health_law_s_contraceptive_mandate (reflecting a national scientific poll conducted that asked likely voters this question: "Should businesses be required by law to provide health insurance that covers all government-approved contraceptives for women without co-payments or other charges to the patient?" 51% said "No", while only 38% said "Yes"); Lucy Madison, *Poll: Most Say Employers Should Be Allowed Not To Cover Contraception*, CBS NEWS (Dec. 14, 2012), www.cbsnews.com/news/poll-most-say-employers-should-be-allowed-not-to-cover-contraception/ (finding that 57 percent of Americans believe that faith-based employers should be exempted from the HHS Mandate and 51 percent of Americans believe that all employers should be exempted from the Mandate); Ryan Steusloff, *Majority Oppose HHS Mandate*, WILSON PERKINS ALLEN OPINION RESEARCH BLOG (Nov. 27, 2013), www.wparesearch.com/uncategorized/majority-oppose-the-hhs-mandate/ (discussing that a third of likely voters polled found that 59 percent oppose the HHS Mandate, while 35 percent approve). Notably, this poll also showed that a majority of women ages 18 to 54 (54%) oppose the mandate. *Id.*

240. Coverage of Certain Preventive Services Under the Affordable Care Act, *supra* note 229, at 39872.

241. *Id.* at 39873.

242. See *id.* (explaining that most insurance policies predating the ACA already covered these items). However, some of that coverage may have been attributed to requirements under state law, rather than the ACA. *Id.*

scheme that provides the means to deliver goods and services that they find morally abhorrent.

If the courts ultimately overturn the current legal scheme in favor of the religious freedom rights of employers and others who dissent, this will change the identity of the winning and losing interests in some cases. Employers who desire to provide coverage for such items will presumably continue to do so, but some employees of the successful objectors may be disappointed that their employer's religious liberty interest apparently trumps their desire for coverage. Those employees would remain free to seek out other employers who provide such benefits, but this admittedly places them at a disadvantage compared to the current regime. Employees of firms who object to employer-provided coverage for morally objectionable items also face a dilemma of accepting that objectionable coverage (and paying for their share of it) or pursuing an even more costly option, including going without insurance or changing their employers to achieve moral harmony on the matter of insurance coverage. And of course, self-employed individuals or others without employer-provided insurance may likewise find it difficult, if not impossible, to seek out coverage that does not violate their convictions due to the mandate.

People of good will can assign different weights to the respective harms identified above. Differential assessments are evident from the divergent results emerging in the case law noted above, which the Supreme Court may ultimately need to resolve. While some judges recognize a sufficient connectedness between the legal imposition and a substantial impact on religious liberty to grant relief, others find that link too attenuated to be cognizable.²⁴³

The characterization of the benefit required under the law seems potentially important in assessing the burden or harm associated with providing it. If insurance benefits are viewed as another form of compensation for services, some appear willing to dismiss the employer's moral concern because the legal obligation merely involves a form of payment in compensation for the employee's labor. Under this approach, the employee effectively becomes an autonomous moral agent and the act of payment is effectively treated as though it is devoid of moral consequences – at least under the law.²⁴⁴ As one dissenting judge explained in a

243. *Compare Korte*, 735 F.3d at 687 (finding in the majority that there is a substantial burden on the free exercise of religious exercise and rejecting government's "attenuation" argument that mandate is "too loosely connected to the use of contraception to be a substantial burden on religious exercise) *with id.* at 705 (dissenting view that qualitative assessment of coercion in this case is consistent with judicial role, and produces the opposite outcome).

244. *See* John H. Garvey & Amy V. Coney, *Catholic Judges in Capital Cases*, 81 MARQ. L. REV. 303, 318-19 (1998) (discussing that the concepts of formal and material cooperation of evil would challenge this simplistic

approach, as they recognize the possibility that wrong may come from either intentionally agreeing with the evil end chosen by the other (formal cooperation), or materially assisting in that end while disagreeing with the outcome (material cooperation). While formal cooperation is always wrong, acts such as payment are designed toward a good – such as helping the employee meet his material needs for food, shelter, etc. – and in this sense are subjected to a balancing approach between the good desired and the collateral consequences that might otherwise ensue. *Id.* This differential treatment and balancing of goods has been described as follows:

A person formally cooperates with another person's immoral act when he shares in the immoral intention of the other. Imagine a tenant who, coveting the apartment of his Jewish neighbor, gives his name to the Nazis. Formal cooperation is always immoral. Material cooperation involves an act that has the effect of helping a wrongdoer, where the cooperator does not share in the wrongdoer's immoral intention. Imagine a grocer who sells food to a glutton, or a letter carrier who delivers an extortionate threat. Material cooperation is only sometimes immoral. We judge this by a kind of moral balancing test—weighing the importance of doing the act against the gravity of the evil, its proximity, the certainty that one's act will contribute to it, and the danger of scandal to others.

Id.; see e.g., Peter P. Meringolo, *Catholic Moral Teaching and Natural Law: Changing the Way We Think About and Teach Professional Ethics*, 44 LOY. U. CHI. L.J. 1067, 1081 (2013) (discussing further cooperation of evil challenging such simplistic approaches). The article comments as follows:

The key issue when analyzing cooperation with evil is whether the cooperator intends—either as a means or an end—the wrongdoing calculated by the principal agent. Intentional furtherance of the illicit activity is called formal cooperation and is always prohibited. Unintentional, or material cooperation, is not always prohibited, but rather, is analyzed on a case-by-case basis based on a variety of factors, including how and to what degree the action of the cooperator intersects with and contributes to wrongdoing, the severity of the loss that would be suffered by cooperator if she fails to cooperate, the type of evil action(s) planned, and the risk of causing scandal to third persons.

Id.; see, e.g., Daniel J. Rudary, Note, *Drafting a “Sensible” Conscience Clause: A Proposal for Meaningful Conscience Protections for Religious Employers Objecting to the Mandated Coverage of Prescription Contraceptives*, 23 HEALTH MATRIX 353, 363-64 (2013) (discussing further the idea of material cooperation and evil). The note comments as follows:

While the Church teaches that the guilt of sin is normally incurred by individual behavior, it also forbids actions that, while not specifically sinful, lend “material cooperation” to morally dubious conduct. This cooperation may be formal or material. Formal cooperation occurs when one takes part in the sinful act of another and thus shares the principal's intent to commit the offense in question. Material cooperation, on the other hand, does not involve sinful intent. Rather, it occurs when one gives assistance to another's sin by an act that is in and of itself not morally wrong. Such material cooperation may be immediate or mediate. One gives immediate material cooperation to the sin of another when he or she takes part in the other's sinful act—albeit the cooperator does not share the mens rea of the principal. Mediate material cooperation, on the other hand, occurs when one performs an act that is “preparatory to another's sin.” Accordingly, the Church would consider facilitating access to contraception to be at least mediate material cooperation because it facilitates conduct that is inherently

recent case that granted relief from compliance to a for-profit employer:

[W]hat the companies are providing is a form of employee compensation, like wages. Handing over a paycheck to an employee may materially facilitate the purchase of any number of (perfectly legal) goods and services—alcohol, lottery tickets, cigarettes, adult pornography, contraception, abortion, and *Harry Potter* books, to name a few—that are contrary to an employer's religious beliefs. Of course, an employer typically does not know how an employee will spend his wages. (Neither does he typically know what healthcare decisions his employee is making.) But what if he does know? Suppose an employee announces, “As soon as I get my paycheck, I am going to have an abortion.” Or suppose it is well known at the workplace that a particular employee drinks himself blind at a local tavern every Friday night after he gets paid. Can the employer withhold the paycheck on the grounds that turning it over will materially assist an act that he finds morally intolerable? Without explaining why, the plaintiffs concede that an employer cannot do this. They do not contend that the possibility, or even the foreknowledge, that an employee can and will use her wages to engage in an activity proscribed by the plaintiffs' religious beliefs substantially burdens their free exercise rights, notwithstanding that the payment of wages to the employees *will* facilitate the objected-to activity.²⁴⁵

This analysis rejects any moral concerns based on a connection between the payment and the behavior of the employee. However, this jurist also went on to question her own analogy if payment was not in cash, but in kind:

How is the provision of health insurance different? One difference is that the employer plays some role in establishing and administering the health care plan, as opposed to supplying the employee with a voucher that the employee can use to purchase his own insurance elsewhere. But the insurance is nonetheless a component of compensation that the employee has earned—an employee accepts less in salary or hourly pay in exchange for benefits like health insurance, and, in most cases, contributions have been withheld from the employee's paycheck to further defray the costs of that insurance. The fact that the employer in administering the plan is treated as a fiduciary, with a corresponding obligation to act in the *employee's* interest is

sinful. Theologians, however, have argued that the HHS mandate actually threatens Catholic employers with immediate material cooperation in evil, as they would be paying for health plans that provide direct access to “free” contraception.)

Id.

²⁴⁵ *Korte*, 735 F.3d at 715-16 (Rovner, J., dissenting) (emphasis in original).

consistent with the notion that the insurance, while provided by the employer, belongs to the employee.²⁴⁶

Although Judge Rovner would have dismissed the employer's concerns that the administrative and fiduciary role that is thrust upon them substantially burdens their free exercise of religion, that role nevertheless concerns some employers, including the religious nonprofits challenging the mandate. Surely there are limits to this suspension of moral considerations when employers are required to deliver noncash benefits, as the acquisition of the noncash benefit could clearly involve the employer in morally objectionable behavior.²⁴⁷

But if we look for a point of agreement with Judge Rovner, we may recognize that her analysis raises a fair point – paying cash compensation to employees who earn it is a good thing that should not be expected to cause the employer the same degree of moral concern as a payment in kind – the seeds of a solution to this disagreement could emerge.

Professor Zelinsky suggests that either an HSA or an HRA could play a role in resolving this dilemma based on pursuing this compensation analogy:

Once those wages are paid, employees may spend the money as they please. The [Employer], by example and persuasion, may try to encourage employees to avoid alcohol. However, if [an] employee wants to purchase and consume alcoholic beverages, that is the employee's prerogative. Similarly, if an employee wants to expend her wages purchasing a morning-after form of contraception such as [E]lla or Plan B, the employee is free to do so.

This analysis draws an important line: The employer's religious rights give way to employees' autonomy once wages have been paid to the employees. This, in turn, suggests a broader solution to the problem raised by [HHS mandate cases by for-profit employers]: Let every employer with religious objections to contraceptives fund an independently administered HSA or HRA for all employees. Employees can use these HSA or HRA funds to defray any of their medical expenses, including, but not limited to, the items to which the employer objects.²⁴⁸

246. *Id.* at 716 (footnotes and citations omitted) (emphasis in original).

247. For example, suppose a future healthcare law required employers to provide sex surrogate services for the purpose of stress reduction for their employees. It is obvious that purchasing coupons from brothels for one's employees would present a moral hazard for the employer, even if the employee had complete autonomy not to use them. Interjecting an intermediary to make the purchases for the employer would not remove the problem of participation in a scheme involving moral objections on many levels, ranging from the support of sex trafficking to particular objections to nonmarital relations.

248. Zelinsky, *supra* note 221, at 5.

This proposal assumes that by restricting the employer's burden to that of making a payment to an account for the benefit of the employee, this will shift the locus of moral responsibility to the employee and resolve the moral objections of the employer. In the case of a payment to an HSA, this position is particularly strong, since an HSA is owned and controlled by the employee and administered by an independent trustee or custodian; the employer has no role in administering how these funds are distributed once the payment is made. Moreover, the HSA can be used for all kinds of medical care, as a source for retirement savings, or for any purpose whatsoever if the employee is willing to incur a penalty on the distribution when applicable. In this sense, an employer contribution to an HSA is really very closely analogous to the payment of cash compensation, albeit to a different employee account than the checking account to which a payroll deposit is otherwise made.

An HRA, on the other hand, might continue to present a concern to the extent that the employer is involved in administration and payment of the funds directly to the provider, thus potentially incorporating the employer directly into a morally objectionable transaction. Professor Zelinsky suggests that the HRA should be administered independently from the employer to avoid this concern.²⁴⁹ However, the restricted purpose of the HRA, including the requirement that it must be used only for medical expense and that no other property rights inure to the employee, arguably removes it further from the analogy to cash compensation.

Of course, mere existence of an HSA does not necessarily solve the government's policy concern that cost may deter some women from procuring contraception benefits contemplated by the HHS mandate. The HSA must be funded with cash, which will facilitate future payments by the employee. Employee contributions to an HSA are tax-favored, but they are still costly. When compared to insurer-provided benefits, an HSA will provide cold comfort to employees who desire contraception unless the employer makes a contribution to the account.

Government regulators and objecting employers would both have to be willing to adapt their positions in order to allow an HSA to provide a viable solution. First, objecting employers may need to accept the responsibility to make a nominal cash contribution – say \$500 or \$1,000 – to an HSA for their employees (or an HRA, if that option does not trouble them).²⁵⁰ This HSA contribution would be part of a revised benefit plan that would include HDHP coverage (which is essential for HSA participation) that did not

249. *Id.*

250. See Zelinsky, *supra* note 221, at 6 (suggesting \$250 may be adequate for this purpose).

conform to the contraception mandate. By restructuring their employee benefit packages in this way, these employers would be allowed to avoid otherwise applicable penalties, including the shared responsibility penalty under section 4980H for not offering health insurance and the more onerous penalty under section 4980D for offering nonconforming coverage.

Some objectors might argue that this contribution is akin to a financial penalty imposed on exercising one's religious beliefs, but that characterization would be inapt. First, as noted above, the required contribution would merely involve a change in form of the employee benefits package, which would not necessarily increase the employer's costs. The employer would merely be changing its coverage to a HDHP that did not offend its beliefs coupled with a cash contribution to an HSA. Alternatively, if the employer preferred an HRA it could use another health insurance plan. The source of the funding could come from reducing the employer's contribution toward health insurance coverage, or from reducing the employee's cash compensation if the employer chose to do so. In this way, the alternative would not merely be substituting a new form of coercion upon the free exercise of religion.

Second, this alternative need not even require an objector to self-identify as religious in order to achieve relief. While this option may have special utility for accommodating an employer's religious beliefs, it should be available to everyone, not just those with religious objections to contraceptive and sterilization coverage. Even employers who do not personally object to such coverage might choose to provide insurance options for their employees that do not wish to purchase insurance with contraceptive and sterilization benefits.²⁵¹ This approach would therefore expand the freedom for all employees to choose the coverage that suits them, both in terms of their desired healthcare needs and their conscientiously held religious commitments.

Such an approach would be dramatically more tolerant than the current scheme, which either subjects objectors to crippling penalties for offering nonconforming coverage designed to enhance the welfare of their employees in other healthcare matters or coerces that objector to drop insurance coverage altogether.²⁵² But it would also be more generous toward employees that disagreed with their employers – and especially so when one considers the scheme that might result if employers obtain judicially-imposed

251. However, this might require additional attention to comparability and/or nondiscrimination rules to ensure that variable HSA contribution packages for different insurance plans would remain compliant with these rules.

252. *See id.* at 3 (observing that “[a] society seriously committed to religious liberty should find a way to accommodate the Greens [i.e., the owners of the for-profit plaintiffs in *Hobby Lobby*] as that society pursues important public policies”).

exemptions from compliance, leaving their employees without access to equivalent preventive coverage.²⁵³

Admittedly, this approach may require some compromises from employees and policymakers, too. Procedures like sterilization are likely to be more expensive than the annual contribution made by the employer.²⁵⁴ The employee might have to save funds within the HSA in order to pay for such benefits, or finance some of the cost from other sources.²⁵⁵ However, for day-to-day expenses like contraception, the HSA will likely provide a means to fund these items without compromising basic needs.

Further, instead of “free” or “no-cost” coverage,²⁵⁶ the HSA approach restores some personal autonomy and accountability for the decision to purchase these items. Admittedly, this may deter some purchases because the individual prefers to save funds for retirement or use them for other forms of healthcare. But some purchasers may also choose a generic brand or less expensive alternative, thus reducing overall costs. Utility maximization that occurs in the context of enhanced consumer autonomy may thus enhance welfare, albeit not entirely in the direction that the government policymakers might prefer. Such is the cost of giving greater freedom in these matters.²⁵⁷

Finally, there is the matter of the self-employed or other individuals who lack employer-provided coverage. Those purchasing insurance through an Exchange or independently may also prefer a policy that does not cover these mandated items.

253. Of course, nothing would prevent an employer who won judicial relief from engaging in private ordering to achieve a similar benefit for employees.

254. As many employers make HSA contributions to coincide with their employee’s pay periods, rather than as a lump sum in advance (which could be lost if the employee leaves his position, since that amount is owned by the employee), the total annual contribution may not be immediately available to an employee.

255. Other possibilities include permitting future distributions to pay for such procedures, effectively using the HSA to make payments on a loan or to otherwise reimburse the employee for funds advanced for this purpose, thereby maximizing tax benefits associated with the account. After all, monthly contraception costs should fall to zero after sterilization.

256. Someone must pay for those goods and services. This approach merely changes the locus of responsibility for payment to a specific payor within the healthcare ecosystem (i.e., the employee’s HSA or HRA), rather than allocating it among the other participants (i.e., insurers, employers, and third-party administrators), who otherwise share a strong likelihood of shifting the ultimate economic incidence of the cost back to employees in any event.

257. Since employers are being granted additional exemptions from their shared responsibility payments under IRC § 4980H for failing to offer insurance at all, it is quite clear that the government already contemplates less than universal coverage for these contested preventive care services). Any negative impact on preventive services from the HSA/HRA alternative discussed above would appear to be even more modest than the impact of these other legal and administrative choices on the total healthcare packages available to people.

They, too, should have that option, if we are to maximize liberty and conscience protections for all concerned.

V. CONCLUSION

Although the ACA has extended the reach of the federal government into the marketplace for health insurance, it may also be expanding opportunities for personal responsibility and autonomy over some dimensions of the healthcare marketplace. As health insurance costs continue to rise, HDHP insurance coverage provides an attractive option to reduce premium costs in exchange for bearing more out-of-pocket costs. Consumer-driven healthcare options – namely the HSA and HRA – provide an attractive solution to the problem of financing this growing amount of out-of-pocket costs.

Tax-favored treatment – extending to both income and employment taxes if plans are carefully designed – incentivizes both employers and employees to participate in funding these accounts. However, self-employed persons continue to face a disadvantage to their employee counterparts, particularly when it comes to employment/self-employment tax incentives.

While health FSAs offer the combination of tax savings and considerable autonomy to consumers, their “use-or-lose” feature coupled with more stringent contribution limits under the ACA make them less attractive than their counterparts, the HSA and HRA. Ultimately, the opportunity to use unspent funds for purposes other than healthcare, which is unique to the HSA, gives the employee the greatest flexibility among these three alternatives, and likely presents the greatest opportunity for enhanced welfare.

However, the opportunity to reap the promise of benefits from consumer-driven approaches – as well to experience any perils from that approach²⁵⁸ – must be tempered by the scope of healthcare spending that is financed directly by consumers through out-of-pocket costs, rather than insurance coverage. As discussed above, only about 14 percent of total healthcare expenditures for 2010 were paid out-of-pocket, and the combined total for HSAs, HRAs, and health FSAs likely represent less than one-seventh of that amount.²⁵⁹ This total covered by HSAs, HRAs, and health FSAs – perhaps 2 percent of total healthcare costs based on 2010 spending levels²⁶⁰ – is likely to increase as more employers and individuals choose higher deductibles in their plans, nudged by a combination of rising costs and looming excise tax penalties for excess coverage. However, it is highly unlikely that these accounts alone will prove sufficient to solve the problem

258. Monahan, *supra* note 7, at 814-39.

259. *Supra* note 6 and accompanying text.

260. \$44.1 Billion (*supra*, note 6) / \$2.186 trillion (*supra*, note 5) = 2.01%.

of growing healthcare costs. Even if the benefits of consumer-directed healthcare are delivered without many of the costs, the sheer magnitude of insured costs (either through government or private sources) will continue to present a formidable challenge in the foreseeable future.

Finally, the combination of a nonconforming HDHP coupled with a partially funded HSA may present a particularly attractive solution for the bitter conflicts emerging over mandated preventive care coverage for contraceptives and similar services. Although this approach might not please everyone, it deserves serious consideration as a step toward enhancing the prospects for more people to enjoy the kind of healthcare they want and need without violating their conscientiously held religious convictions.