

August 31, 2009
- by Roger A. McEowen

Overview

For some farm families, the cost of health care is a major expense. In some instances, at least one of the spouses may deem it necessary to find off-farm employment for the purpose of obtaining health insurance for the family.¹ For these families health insurance is very important, and a consideration of the various planning options associated with health insurance is critical.

The present health care “reform” debate is missing a major point – significant and real health care reform was enacted into law in late 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Act).² This reform didn’t involve a nationalization of health care in the U.S. as does legislation currently under consideration by the Congress,³ but it was very significant. The 2003 Act authorized the creation of private, individually-owned Health Savings Accounts (HSAs). An individual with an HSA can pay for unreimbursed medical expenses (e.g., deductibles, copayments and services not covered by insurance) on a tax-advantaged basis. They foster competition for medical services based on price, are fully portable (i.e., the HSA owner owns the account and is not dependent on an employer for health insurance coverage), and significantly reduce bureaucratic red tape. Since their availability beginning in

2004, they have dramatically grown in adoption.⁴

The Present Health Care “Reform” Debate

Presently, the Congress is considering legislation that would establish a system of government-run, nationalized health care⁵ by virtue of creating a “public plan” as a means for creating a single-payer (government) system.⁶ The Bill, H.R. 3200 (known as “America’s Affordable Health Choices Act of 2009”), is massive (over 1,000 pages in length) and is a difficult read.⁷

The following section contains a brief synopsis of the major points of H.R. 3200:

Establishment of a “Health Choices Commissioner.” The Bill establishes a “Health Choices Commissioner” that the President will be appointed to run a new “Health Choices Administration.” The Health Choices Administration will be part of the Executive Branch of the federal government.⁸ According to the Bill, the function of the Health Choices Commissioner is to establish standards for health insurance coverage, the conditions of coverage and review provider networks (e.g., negotiate price and service) before entering into contracts.⁹ The established standards will be applicable to both employer-sponsored insurance and insurance that is purchased

through a newly-created” Health Insurance Exchange” to be operated through the Health Choices Administration. The Bill also establishes a “Qualified Health Benefits Ombudsman” to provide individuals with assistance in “choosing a qualified health benefits plan in which to enroll” from among Commissioner-approved plans.¹⁰ In determining the services and conditions that “approved” health insurance must cover, the Health Choices Commissioner must consult with State attorneys general, State insurance regulators, the National Association of Insurance Commissioners and Indian tribes and tribal organizations, among other entities.¹¹ The Health Choices Commissioner is empowered to conduct audits (either random or based on complaints) to ensure compliance with the mandated standards and conditions and can recover the cost of conducting such audits (the Bill does not appear to limit cost recovery to situations where wrongdoing is found).¹² Penalties for non-compliance can be imposed,¹³ and it does not appear that the Bill provides a procedure for appeal of an adverse determination.

Establishment of a “Health Insurance Exchange.” The Bill establishes, under the direction of the Health Choices Commissioner, a Health Insurance Exchange for the provision of a “qualified health benefit plan,” including a “public option.”¹⁴ The Bill specifically states that “all individuals” are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan, unless they are enrolled in another health insurance plan.¹⁵ There is no explicit prohibition on illegal aliens participating in the proposed “public option.” While the Bill does state that illegal aliens are ineligible for government “affordability credits” (taxpayer subsidies that will, at least initially, allow individuals to purchase private insurance),¹⁶ the Bill does not appear to contain any enforcement mechanism. Even though the Bill does contain a procedure for the government to determine income eligibility for health insurance benefits,¹⁷ there is no comparable detail for determining immigration status. An amendment was offered by Rep.

Heller (R-NV) in the Ways and Means Committee which would have applied the same eligibility verification procedures that are in place for Medicaid, but the amendment was defeated on a straight party-line vote.

The portion of the Bill establishing the public option requires that the “public health insurance option” must comply with the Bill’s requirements that are applicable to other insurance plans that are offered through the Health Insurance Exchange.¹⁸ There is no mention as to whether the “public option” (government plan) is subject to other state and federal regulatory and tax rules that govern private insurers.¹⁹

Note: The Bill specifies that the payment rates for the public option for services and health care providers as established by the Secretary of Health and Human Services are not subject to either administrative or judicial review.²⁰

The government’s “public option” would also likely not be subject to tort-based lawsuits (as are private insurers) arising out of death and/or injury based on wrongful denial of coverage. Under the Federal Tort Claims Act,²¹ the federal government cannot be sued for the discretionary conduct of its agents while acting within the scope of their employment. The legal issue is whether courts would determine that a coverage decision is a discretionary decision of an agent.

Note: The Bill does state that the “public option” must satisfy state licensing requirements.²² However, as a general rule of law, state laws do not apply to the federal government unless a waiver from their inapplicability is provided for in federal law. There appears to be no specific mention in the Bill that would subject the public option to state law,²³ except that Sec. 225 of the Bill states that state law applies to the selection of providers under the public option. That would appear to mean that

the public option can only include providers that have been approved by a particular state.²⁴

Note: As of late August, there was controversy as to whether the final version of the Bill would contain a “public option.” Whether the Bill contains such an option is largely irrelevant. Under the Bill, the government retains the power to levy fines for persons having health insurance plans that the government does not approve and, as noted above, allows government-sanctioned plans to operate with various exemptions from taxes and regulations applicable to private plans.

Establishment of the Center for Comparative Effectiveness Research. Under the massive spending bill signed into law in early 2009 (known as the American Recovery and Reinvestment Act), substantial funding was included for Comparative Effectiveness Research – purportedly to evaluate the relative merits of various medical treatments. The Bill establishes the Center for Comparative Effectiveness Research which is comprised of a 17-member board that will “conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care service and procedures...”²⁵ The Center is funded by funds contained in a newly created Comparative Effectiveness Research Trust Fund (which is initially funded with \$90 million for fiscal year 2010).²⁶

Mandatory disclosure of tax return information. The Bill requires the IRS to disclose certain tax return information to the Health Choices Commissioner (including taxpayer identity, filing status, modified adjusted gross income, number of dependents claimed and “other information as is prescribed by regulation.”²⁷ The tax return information is to be used to determine eligibility for “affordability credits” (for lower-income individuals and families).²⁸ There is no

specified limit on what can be disclosed – the Commissioner can request as much information as necessary to verify information provided in an application for affordability credits.²⁹

Note: A separate provision in the Bill authorizes the Social Security Administration to obtain tax return data on any person who is likely to be eligible for a low-income prescription drug subsidy but has not applied for it.³⁰

Additional tax on persons without “acceptable” health coverage. For individuals without “acceptable” health coverage,³¹ the Bill imposes a tax equal to 2.5 percent of the excess of an individual taxpayer’s modified adjusted gross income over the amount of gross income triggering a filing requirement for the taxpayer (based on filing status), limited by the average premium (as determined by the Secretary in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which the tax year begins.³² Reporting is also required to verify that the taxpayer has “acceptable” coverage in place,³³ with a penalty imposed for failure to file the required information. Employers also must have approved health plans in place or face a tax-penalty.³⁴

Income tax surcharge. For tax years beginning after 2010 and ending before 2013, the Bill imposes an additional tax on individuals of one percent on individual income in excess of \$350,000 but less than \$500,000; 1.5 percent on income in excess of \$500,000 but less than \$1,000,000; and 5.4% on income in excess of \$1,000,000.³⁵ For tax years beginning after 2012, the 1 percent and 1.5 percent rates are doubled.³⁶

Codification of the economic substance doctrine. The Bill codifies the economic substance doctrine.³⁷

IRS penalties for innocent mistakes. The Bill imposes penalties for income-tax underpayments on a strict liability basis.³⁸ For transactions that lack economic substance, penalties are increased and such transactions are subject to a “more likely than not” test rather than a “substantial authority” standard or “reasonable basis plus disclosure” test.³⁹

Imposition of additional payroll tax. The Bill requires employers to either provide insurance to employees in accordance with government standards or pay up to an 8% additional payroll tax.⁴⁰

2003 Health Care Reform - HSAs

As mentioned above, an HSA is one way for individuals to pay for unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a tax-advantaged basis. Adoption of HSAs has grown significantly – from covering 438,000 individuals as of November 2004 to an estimated 25-30 million persons by 2010.⁴¹

HSA tax advantages can be significant — contributions are deductible (or excluded from income that is taxable if made by an employer), withdrawals are not taxed if used for medical expenses,⁴² and account earnings are tax-exempt. Unused balances may accumulate without limit.⁴³

What is an HSA? An HSA is a tax-exempt trust or custodial account established for paying qualified medical expenses (current or future) of the account beneficiary. Accounts may be established with banks and insurance companies or with other entities approved by the IRS to hold Individual Retirement Accounts (IRAs) or Medical Savings Accounts (MSAs). HSAs are private accounts that are not tied to an individual’s employment.

Who may have an HSA? To establish and contribute to an HSA, an individual must have a qualifying high-deductible health plan (HDHP) and no disqualifying coverage (i.e., not covered

by other health insurance).⁴⁴ Whether someone has a qualifying HDHP is determined as of the first of each month. Thus, a person might be eligible to contribute to an HSA in some months but not others.⁴⁵ Typically, a quick call to the insurer should answer the question of whether a policy is a qualified HDHP. Individuals cannot be enrolled in Medicare (a form of disqualifying coverage), which generally occurs at age 65,⁴⁶ and cannot have received Veterans Administration medical benefits (another form of disqualifying coverage) within the past 3 months. Also, individuals are not eligible to have their own HSA if they may be claimed as a dependent on another person’s tax return.⁴⁷ An individual need not have earned income to contribute to an HSA (unlike the rules for contributions to IRAs).

Individuals may keep their HSAs once they become ineligible. Thus, individuals do not lose their HSAs (or the right to access them) by turning age 65 or by obtaining insurance with a low deductible. However, they could not make contributions until they become eligible once again.

An individual family member may have a separate HSA provided that the eligibility rules are satisfied. The family member can also be covered through the HSA of someone else in the family. For example, a husband may use his HSA to pay his wife’s expenses even though she has her own HSA. Also, an individual may have more than one HSA.

What is a qualifying HDHP? An HDHP must have a deductible above a certain minimum level and limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level. In addition, an HDHP must provide general coverage. That means that substantially all of its coverage cannot simply cover only a particular disease or provide substantially certain specific other coverage (e.g., vision care).

- **Annual deductible.** For self-only coverage, the annual deductible in 2009

must be at least \$1,150; for family coverage, it must be at least \$2,300. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.⁴⁸ But the minimum deductible requirement does not apply to “preventive care.” According to the IRS, preventive care does not include services or benefits intended to treat existing illnesses, injuries, or conditions, but an exception is allowed when the treatment is incidental to the preventive care service and it would be unreasonable or impracticable to perform another service.⁴⁹ Conversely, prescription drugs are not exempt from the minimum deductible, whether they are treated like other benefits in the high-deductible insurance plan or have different deductibles and co-pay requirements.

Note: There is a safe harbor list of preventative care that an HDHP can provide as “first-dollar” coverage before the minimum deductible is satisfied. The list includes annual physicals, screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs and obesity weight loss programs.

- **Out-of-pocket limit.** For self-only coverage, the annual limit on out-of-pocket expenditures for covered benefits must not exceed \$5,800 in 2009. For family policies, the limit must not exceed \$11,600. These amounts will be adjusted for inflation (rounded to the nearest \$50) in future years.⁵⁰
- **Disqualifying coverage.** While covered by a qualifying HDHP, individuals generally must not have other coverage that is not high deductible and provides coverage for any benefit under their high deductible plan. For example, individuals with a qualifying HDHP are not eligible to establish or contribute to

an HSA if they are also covered under a spouse’s low deductible policy for the same benefits. But if the spouse’s policy were high deductible, the individual could contribute to his or her own HSA.

However, eligible individuals may have “permitted insurance,” which is insurance under which substantially all coverage relates to liabilities incurred under workers’ compensation laws, tort liabilities, or liabilities related to ownership or use of property (such as automobile insurance); insurance for a specified disease or illness; or insurance that pays a fixed amount per day or other period of hospitalization. In addition, eligible individuals may have “other coverage” (through insurance or otherwise) for accidents, disability, vision care, dental care, or long-term care.

Eligible individuals may also have Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs), provided these accounts are for limited purposes (for example, dental services or preventive care), or provide reimbursement for services covered by the HDHP only after the minimum deductible is met, or is a “retirement” HRA – only provides reimbursement after an employee retires.

Contributions to an HSA. Contributions to an HSA must be in cash and may be made by eligible individuals, as well as by other individuals or entities on their behalf. Thus, individuals may contribute to accounts of eligible family members, and employers may contribute to accounts of eligible employees.⁵¹ Contributions can also be made by state governments. Contributions by one individual or entity do not preclude contributions by others, provided that the total of all contributions (aside from those classified as rollover contributions) does not exceed annual contribution limits.

Two types of contributions may be made to HSAs — regular and catch-up. Both have annual limits that are calculated on a monthly basis. For regular contributions, the annual contribution limit in 2009 for self-only coverage is \$3,000. The annual limit for family coverage is \$5,950.⁵² Individuals who are at least 55 years of age but not yet enrolled in Medicare may contribute an additional \$1,000 (for 2009 and 2010 (as established by statute)). For each month during the year when individuals are eligible (i.e., covered by an HDHP as of the first day of the month), they may contribute (or have others contribute on their behalf) up to one-twelfth of the applicable annual limit.⁵³

Beginning in 2007, however, individuals who are eligible during the last month of the year are treated as if they were eligible for the entire year, thus allowing them to contribute up to the annual limit.⁵⁴

Contributors cannot restrict how HSA funds are to be used. For example, employers may not limit HSAs just to certain medical expenses, even for funds they contribute. Account owners always can make withdrawals for any purpose, though nonqualified withdrawals are subject to taxation.

Contributions to HSAs may be made at any time during a calendar year and until the filing date (without extensions) for federal income tax returns, normally April 15 of the following year. Thus, contributions could occur over a 15 1/2 month time span (e.g., from January 1, 2009, through April 15, 2010), provided they do not exceed the allowable annual limit.

HSA contributions may be made through cafeteria plan salary reduction agreements; that is, benefit arrangements established by employers under which employees accept lower take-home pay in exchange for the difference being deposited in their account.

Individuals may make one-time contributions to their HSAs from their individual retirement accounts (IRAs), subject to the contribution limits for the year of the transfer. Also, limited,

one-time rollovers from termination balances in FSAs or HRAs are allowed.⁵⁵

Account owners may rollover balances from one HSA to another without being restricted by the annual contribution limits or affecting new contributions. If the owner withdraws funds and deposits them in another account, only one rollover is allowed each year. Deposits must be made within 60 days in order for the transfer to be considered a rollover. If, instead, an HSA trustee transfers funds to another account, there is no limit on the number of rollovers allowed each year. HSA trustees are not obligated to accept either owner or trustee rollovers.

As already noted, an employer is also allowed to contribute to an employee's HSA in accordance with a comparability requirement — contributions must be the same dollar amount or the same percentage of the HDHP annual deductible, adjusted to reflect the proportion of the year the employee has worked.⁵⁶ Varying employer matching contributions (which might differ by how much an employee puts in) satisfy the comparability requirement only if employee contributions are made through a cafeteria plan. If employers allow some employees to transfer FSA or HRA balances to their HSAs, they must allow any eligible individual covered under their HDHPs to do so. Other special rules also apply to employer contributions.

Note: Self-employed persons, partners and S corporation shareholders are generally not considered employees and cannot receive an employer contribution. But, of course, they can make contributions on their own.

Contributions to an HSA that exceed the annual contribution limit must be withdrawn or be subject to an excise tax. Also, a pro-rata portion of earnings on the HSA account must be withdrawn. The withdrawn amount is subject to income tax (but no 10 percent penalty).

Tax treatment of HSA contributions. The amount contributed to an HSA is deductible for federal income tax purposes. The deduction is

“above-the-line”; that is, it is made in determining adjusted gross income. Also, the deduction may be taken by taxpayers who claim the standard deduction as well as those who itemize.

Contributions made by employers are excluded from gross income of employees in determining their income tax liability. In addition, employer contributions are exempt from Social Security and Medicare taxes for both employers and employees.⁵⁷ But for self-employed persons, contributions are not taken into account in determining net income from self-employment. That means they are not exempt from Social Security and Medicare taxes.

Tax treatment of HSA withdrawals.

Withdrawals from HSAs are tax-free if used to pay for qualified medical expenses that are incurred on or after the establishment of the HSA.⁵⁸ Tax-free withdrawals can be made for the qualified medical expenses of persons covered by the HDHP, the spouse of a covered individual (even if the spouse is not covered by the HDHP) and any dependent of a covered person (even if the dependent is not covered by the HDHP).

Withdrawals not used for qualified medical expenses are included in gross income in determining federal income taxes and are also subject to a 10% penalty tax.⁵⁹ The penalty is waived in cases of disability or death and for individuals age 65 and older. There is no requirement (as there is for qualified retirement plans) that individuals begin to spend down account balances at a certain age. In addition, there is no time limit on when HSA withdrawals are made to pay (or reimburse payments for) qualified expenses, provided adequate records are kept.⁶⁰ Thus, withdrawals can be used to reimburse prior years' expenses as long as they were incurred on or after the date the HSA was established.

Note: The HSA trustee must report all distributions annually to the individual (Form 1099SA). The trustee is not required,

however, to determine whether distributions are used for qualified medical purposes. The account owner will report on their tax return the amount of the distribution used for qualified medical expenses on IRS Form 8889.

Amounts remaining in the account at year's end are not lost (as they are in an FSA). This feature of an HSA provides an incentive for account holders to wisely spend their funds on medical care and shop around for the best value for their health care expenditures.

Treatment of HSAs at Death. If a surviving spouse is the designated beneficiary of an HSA, it becomes an HSA for that widow or widower. If someone other than a surviving spouse is the designated beneficiary, the HSA is terminated as of the date of death and the fair market value becomes taxable income to that person.⁶¹ If there is no designated beneficiary, the remaining assets become part of the decedent's estate and the fair market value becomes taxable income to the estate and will be reported on the final return of the decedent. In these instances, amounts included in gross income are reduced by qualified expenses incurred by the deceased before death and paid by the recipient of the HSA within 1 year.

Administrative Details

The IRS has proposed model forms that banks, insurance companies, and other approved entities can use as trust or custodial agreements with eligible individuals. The proposed agreements, which are not mandatory, provide a safe harbor definition of these institutions' responsibilities. Among other things, the proposed forms clarify that trustees and custodians may rely on account owners' representations about their age, that they are covered by a HDHP, and that their contributions do not exceed the maximum allowed. In addition, the proposed forms state that trustees and custodians are not responsible for determining whether distributions are used for medical expenses.

HSA funds may be invested in investments approved for IRAs, such as bank accounts, annuities, certificates of deposit, stocks, mutual funds, and bonds. However, trustees and custodians need not make available all of these options. There is no requirement that funds be invested in vehicles that do not lose value. HSA funds may not be invested in life insurance contracts or most collectibles (*i.e.*, tangible property).

Administration and account maintenance fees may be withdrawn from the HSA (in which case they will not be considered taxable income) or paid separately (in which case they will not be taken into account with respect to contribution limits).

Trustees and custodians may place reasonable restrictions on the frequency and minimum amount of HSA distributions.

Conclusion

For many farm families, consideration of the use of HSAs for handling medical expenses should be a part of the overall family financial, estate and business plan. Utilization of an HSA for family medical coverage carries with it the possibility of substantially reducing the cost of health care for the family. Planning techniques with as many tax benefits as those associated with HSAs are rare.

Questions have been raised whether H.R. 3200 disallows HSAs. The Bill does not explicitly refer to HSAs, but the impact that the Bill could have on private insurance companies over time as a single-payer system is established could portend doom. The most recent version of the Bill as reported out by the House Energy and Commerce Committee on July 31, 2009 does not refer to HSAs. An amendment to the Bill offered by committee member Rogers (R-MI) would have clarified that qualified health benefits plans that could be offered through the health insurance exchange created under the Bill included HSAs, but Democrats defeated the amendment. The House Ways and Means

Committee did suggest that its version (reported out on July 17, 2009) would make HSAs illegal (along with Flexible Spending Accounts and Medical Savings Accounts). Such a move would be most unfortunate.

The fiscal condition of the country⁶² indicates that the health insurance reform should focus on private ownership of health insurance policies that can be selected from several different plans that offer coverage for only catastrophic losses. Additional coverage should be optional and personally paid by the individuals desiring such additional coverage. The idea that health care should be first-dollar coverage is misplaced, and is not an aspect of other types of insurance (e.g., auto insurance doesn't cover routine maintenance costs). Consequently, health insurance should only be used to cover catastrophic losses. The role of the government should be to establish incentives and rules to encourage responsible personal behavior that lowers the likelihood of the need for medical care. The authorization of HSAs beginning in 2004 was a major step in the right direction.

¹ The present tie between health insurance and employment began when the Roosevelt Administration placed a freeze on wages during World War II in an attempt to combat inflation triggered by government spending and monetary policy. With the inability to offer higher wages in competition for fewer available workers (due to the U.S. entry into WWII), employers offered other incentives including health insurance. The Congress further distorted the market by making employer contributions to employee health plans tax-deductible. This tax incentive resulted in comprehensive health insurance being provided via employment. Without such government distortions of the health insurance marketplace, basic health insurance plans would cover only catastrophic events and persons desiring additional coverage would pay for that additional coverage. As a result, health care services would operate in a more competitive marketplace and health costs would be lower. Thus, the key to any true health reform is to break the tie between health insurance and employment - to provide incentives for persons to own their own health insurance policies.

² P.L. No. 108-173, Sec. 1201(a), *enacting* I.R.C. §223, effective January 1, 2004.

³ H.R. 3200, as reported out by the House Energy and Commerce committee on July 31, 2009. Hereinafter referred to as “Bill”.

⁴ See the text of endnote 41, *infra*.

⁵ The Lewin Group (a health and human services consulting firm with consultants drawn from academia, industry and government whose mission is to deliver objective analyses) estimates that the Bill would reduce the number of persons with private insurance by 83.4 million and that the new government-run plan would cover 103.4 million persons. Given the regulatory and tax structure facing the remaining private plans which is inapplicable to the government-run plan (see the text accompanying endnotes 18-24, *infra*), the Bill represents a first-step toward a single-payer system, with the federal government (taxpaying public) serving as the payer. See, Shells and Haught, “Analyses of the July 15 Draft of the American Affordable Health Choices Act of 2009,” The Lewin Group (Aug. 2009).

⁶ Practically every session of Congress since 1939 has proposed some form of nationalized health care. While such proposals have been repeatedly rejected, Medicare and Medicaid were enacted into law in the mid-1960s. Medicare was intended to be funded with “Hospital Insurance” (HI) premiums as an addition to the FICA tax. The hospitalization rate of the FICA tax has risen from 0.7 percent in the 1960s to its present rate of 2.9 percent on the first \$106,800 of wages. According to the Office of Management and Budget, this tax covers approximately 40 percent of present Medicare spending with 21 percent paid from premiums of beneficiaries and 39 percent from general revenues (the taxpaying public). Medicaid is funded 50/50 by the federal and state government revenues (the taxpaying public). Adjusted for inflation, data compiled by the Office of Management and Budget show that Medicare and Medicaid spending has increased by 2,735 percent since funding began in 1967.

In addition, Medicare and Medicaid, over time, have reimbursed doctors a smaller portion of their fees. Private insurance has provided a larger reimbursement, and uninsured persons not eligible for Medicare or Medicaid pay full price. This has caused health care costs to rise over time more than would be the case without government interference in the market. An attempt to reign-in the increasing costs of Medicare was made by the Congress in 1988 via

passage of the Medicare Catastrophic Coverage Act (Pub. L. No. 100-360) which required that higher-income retirees pay an increased portion of their extended health care benefits. The elderly objected to the new law and Congress responded by essentially repealing the law in 1989. This fact goes a long way to explaining why there is virtually no discussion of Medicare reform today.

Increased malpractice lawsuits by virtue of an expansive definition of liability have also increased health care costs to an extent that the U.S. Department of Health and Human Services estimates that the increased cost results in the denial of health insurance coverage to between 2.4 and 4.3 million people (out of the approximately 13.5 million that are chronically uninsured (including illegal immigrants) – according to U.S. Census Bureau Data).

Consequently, any real reform of health insurance must include tort reform. However, such reform appears to not be politically possible at the present time. In recent elections, the Association of Trial Lawyers of America (ATLA) has been one of the top Political Action Committee contributors to Democrat candidates running for U.S. House and Senate positions. On average, over eighty percent of the funds spent by ATLA were received by Democrat candidates.

⁷ This article reviews H.R. 3200, as reported out by the House Committee on Energy and Commerce on July 31, 2008. It is noted that during debate and consideration of the legislation in the Congress various provisions of the legislation are subject to change.

⁸ Bill, Sec. 141.

⁹ Bill, Secs. 142(a)(1), 201, 203-204. There is no requirement in the Bill that the Health Exchange Commissioner subject the public option to the same bidding and contractual process as private insurance plans are subject to.

¹⁰ Bill, Sec. 144.

¹¹ Bill, Sec. 143(a).

¹² Bill, Sec. 142(b).

¹³ Bill, Sec. 142(d).

¹⁴ Bill, Sec. 201.

¹⁵ Bill, Sec. 202(a).

¹⁶ Bill, Sec. 246.

¹⁷ Bill, Sec. 245.

¹⁸ Bill, Sec. 221.

¹⁹ Private insurers are subject to numerous state and federal restrictions. In addition, private insurers (based on their tax status) must pay both federal and

state tax as well as other miscellaneous fees and levies.

²⁰ Bill, Sec. 223(f).

²¹ 28 U.S.C. §§171, 1346.

²² Bill, Sec. 204(b)(1).

²³ It is also not clear under the Bill whether the public option would be subject to state-mandated requirements for specific benefits and providers as are private insurance companies. Sec. 203 of the Bill does state that such state requirements “shall continue to apply” to plans that are offered through the Health Insurance Exchange, but a question can be raised as to that language creates a “requirement” as set forth in Sec. 221 of the Bill (which establishes the public option).

²⁴ Given that the drafters of the Bill made a specific reference to state law requirements with respect to plan providers, and made no specific reference to state law rules concerning the governing tax or regulatory structure with respect to the public option, it would seem that the public option would *not* be subject to state law.

²⁵ Bill, Sec. 1401.

²⁶ Bill, Sec. 1802. The Trust Fund is created pursuant to I.R.C. §9511.

²⁷ Bill, Sec. 431.

²⁸ *Id.*

²⁹ Bill, Sec. 245(B)(2)(a)(i).

³⁰ Bill, Sec. 1801(a).

³¹ As defined in Bill, Sec. 401(d).

³² Bill, Sec. 401(a)-(b), *adding* I.R.C. §59B.

³³ Bill, Sec. 401(b).

³⁴ Bill, Sec. 411.

³⁵ Bill, Sec. 441, *adding* I.R.C. §59C.

³⁶ *Id.*

³⁷ Bill, Sec. 452.

³⁸ Bill, Sec. 453. The ability of the IRS to waive penalties and interest is severely limited under the Bill.

³⁹ *Id.*

⁴⁰ Bill, Secs. 311-313. The 8 percent additional rate applies to employers with wages paid to employees (in the aggregate) of more than \$400,000. For employers that pay aggregate wages in excess of \$250,000 but \$400,000 or less, the additional payroll tax varies from 2% to 6%. Bill, Sec. 313.

⁴¹ U.S. Treasury Department HSA policy estimates. The U.S. Treasury also estimates that the number of persons covered by HSAs could rise to as much as 45 million due to fears over passage of H.R. 3200, the “Americas’ Affordable Health Choices Act of 2009” (nationalized, government-run health care). Data also

indicates that HSAs have made health insurance accessible for many people that previously could not afford coverage, with account owners just as likely to be older and sicker as younger and healthy.

⁴² A qualified “medical expense” is defined by I.R.C. §213(d).

⁴³ Accordingly, an HSA can be a viable way to pay for medical costs associated with pre-existing conditions. Over \$1 billion dollars have been invested in HSAs according to data reported by Inside Consumer-Directed Care (ICDC) in their Feb. 24, 2009, newsletter. The data is based on information reported by more than 60 financial firms and has also been reported by the U.S. Treasury Department.

⁴⁴ Although other health coverage is permissible for persons with HSAs if the other coverage is for a specific disease or illness, or is insurance for accidents, disability, dental care, vision care or long-term care. A person can have an HSA and remain eligible for VA benefits, unless VA benefits have actually been received in the last three months.

⁴⁵ For example, if someone first enrolled in an HDHP on February 15, the HSA eligibility period would begin on March 1 of that year.

⁴⁶ Individuals remain eligible to establish and contribute to HSAs after becoming eligible for Medicare, provided they do not enroll in either Part A or Part B.

⁴⁷ Thus, children cannot establish their own HSA, but can be included in a parent’s HSA. Tax dependency is determined on a yearly basis and may not be known until the end of the year.

⁴⁸ For 2010, the minimum deductible for an HDHP will be \$1,200 for self-only coverage and \$2,400 for family coverage. Only usual, customary, and reasonable charges for covered benefits are taken into account in determining whether deductibles are met. Premiums are not included in meeting the deductible, although co-payments may be at the option of the HDHP.

⁴⁹ “Preventative care” can include certain drugs and medications when taken or used by a person who has developed risk factors for a disease that has not yet manifested itself or to prevent reoccurrence of a disease (e.g., cholesterol-lowering medication for a person with high cholesterol).

⁵⁰ For 2010, the amounts will be \$5,950 and \$11,900 respectively. These limits are not ceilings on all out-of-pocket expenditures for health care. Premiums for the HDHP and other insurance would be extra, as would payments for benefits not covered by

insurance. Even for covered benefits, the limits would apply only to payments for usual, customary, and reasonable charges. On the other hand, both deductibles and co-payments must be taken into account in determining whether the limits are exceeded.

⁵¹ Employer contributions are not taxable income to the employee.

⁵² The limits will be adjusted for inflation (rounded to the nearest \$50 in future years. For 2010, the contribution limit will be \$3,050 for self-only coverage and \$6,150 for family coverage. Also, the annual limitations are reduced by the amount of any contribution an individual makes to a Medical Savings Account (MSA) in the same year. MSAs are precursors to HSAs, and were authorized beginning in 1996. Eligibility was limited to people who either were self-employed or were employees covered by a high deductible insurance plan established by employers with 50 or fewer workers.

⁵³ For example, an individual with three months of HDHP coverage for the year whose HDHP has an annual deductible amount of \$1,600 will result in a maximum contribution of 3/12ths of \$1,600 or \$400. Also, contributions need not actually occur monthly. For instance, one contribution can be made for the entire year, provided it does not exceed the sum of the allowable monthly limits.

⁵⁴ Individuals who make additional contributions under this rule must maintain their HSA eligibility for the following year (except in cases of disability or death); otherwise, the additional contributions are included in gross income in determining federal income taxes and also are subject to a 10% penalty tax.

⁵⁵ Individuals who make additions to their HSAs under these circumstances must maintain their HSA eligibility for the following year (except in cases of disability or death); otherwise, the additions are included in gross income in determining federal income taxes and also are subject to a 10% penalty tax.

⁵⁶ If an employer contribution is not comparable for all employees, an excise tax of 35% of the amount of employer contributions to employees' HSAs is levied.

⁵⁷ Social Security taxes are 6.2% of wages up to \$106,800 in 2009. Medicare taxes are 1.45% of total wages. In addition, employer HSA contributions are exempt from federal unemployment insurance taxes. If employees contribute to their HSAs through salary reduction cafeteria plans, the contributions are

considered to be made by the employer and are exempt from these three employment taxes.

⁵⁸ If HDHP coverage is effective any day other than the first day of the month, the HSA cannot be "established" until the first day of the following month. Also, qualified medical expenses generally include expenditures for a spouse and dependents, even if they are not eligible to have an HSA themselves. Payments for health insurance are generally not qualified medical expenses. Thus, accounts cannot be used to pay some or all of the premiums of the associated HDHP. However, payments for four types of insurance are considered to be qualified HSA expenses: (1) long-term care insurance, (2) health insurance premiums during periods of continuation coverage required by federal law (e.g., COBRA), (3) health insurance premiums during periods the individual is receiving unemployment compensation, and (4) for individuals age 65 years and older, any health insurance premiums (including Medicare Part B premiums) other than a Medicare supplemental policy.

⁵⁹ Qualified medical expenses also include expenses for COBRA continuing coverage, any costs associated with health plan coverage while receiving unemployment compensation and qualified long-term care insurance premiums.

⁶⁰ An HSA account holder should maintain receipts to prove that withdrawals from an HSA were for qualified medical expenses and were not otherwise reimbursed (and to prove that the HDHP deductible was met).

⁶¹ This rule applies even if the non-spouse designated beneficiary is someone whose medical expenses could have been paid from the account (such as a dependent child).

⁶² During the first half of 2009, the federal budget deficit has ballooned to unprecedented levels. The Congressional Budget Office and the Joint Committee on Taxation have released a preliminary, informal estimate that passage of H.R. 3200 would cause the budget deficit to explode even further – by an additional \$239 billion from 2010-2019.