# ARTICLE

# EQUITABLE HEALTH SAVINGS ACCOUNTS: BRIDGING THE LEFT-RIGHT DIVIDE

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*This Article offers the first comprehensive legal-policy critique of existing Health Savings Accounts ("HSAs"), arguing that the current approach is redistributively regressive, thus exacerbating inequality, and also fails to accomplish stated healthcare goals. We propose an alternative—Equitable Health Savings Accounts—which uses cash grants as a tool to address both of these problems. Equitable HSAs are a market-based social program that calibrates size and delivery of a government subsidy to help the least well-off and to facilitate participation in healthcare markets. Equitable HSAs can serve as a model for using cash grants to bridge the gap between Republican social policy proposals that generally carry a market libertarian flavor and Democratic proposals that are focused on redistribution and social safety nets. Contrary to conventional political wisdom and academic commentary on the tradeoff between equity and efficiency, these goals need not be mutually exclusive. Rather, as our Equitable HSA proposal demonstrates, cash grants can strengthen market forces, allowing policymakers to harness the benefits of markets to achieve policy goals while engaging in redistribution.*

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## I. Introduction

Polarization of the two major political parties reflects in part their differing views of the value of reliance on market forces. The parties disagree as to whether government can play a useful role in setting ground rules for competition and redistributing resources from the wealthy to less well-off groups. On the progressive side are those who focus on egalitarian outcomes, and thus advocate for social policies that redistribute resources downward from the top economic rungs. On the market libertarian side are those who focus on efficiency and advocate social policies that minimize tax burdens and government intervention.[1] Democrats are generally—and increasingly—more aligned with the former, while Republicans are generally more aligned with the latter.[2]

This left-right divide also characterizes debate over healthcare policy. One recent manifestation of this ideological divide is Republican advocacy for, and Democratic resistance to, Health Savings Accounts ("HSAs").[3] Current policy provides a tax deduction for contributions to HSAs made by individuals and families enrolled in certain high-deductible health insurance plans. Investment gains on funds in an HSA account are exempt from taxation; the accounts are intended to cover medical expenses and can be used for some other purposes as well. Republicans have made HSAs a centerpiece of various health reform plans, including proposals debated during their 2017 effort to repeal the Affordable Care Act ("ACA"), a 2018 bill endorsed by Republicans on the House Ways and Means Committee, and the healthcare reform agenda recently produced by the Trump administration.[4] But Democrats remain steadfastly opposed to expanding HSAs on distributional grounds. They argue that HSAs primarily benefit higher-income people who are able to use HSAs as a vehicle for tax-preferred savings.

Despite these disagreements, it is clear that there are potentially significant benefits to increasing individuals' savings for healthcare expenditures. Whether or not the ACA is retained or the country moves to a "Medicare-for-all" or a "single-payer" plan—progressive Democratic desiderata with uncertain political prospects—there will almost certainly be a continuing

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[1] *See generally* Liam Murphy & Thomas Nagle, The Myth of Ownership: Taxes and Justice (2002).

[2] *See generally* Joseph E. Stiglitz, Rewriting the Rules of the American Economy: An Agenda for Growth and Shared Prosperity (2015).

[3] *See* 26 U.S.C. § 223 (2012); Carol Rapaport, Cong. Research Serv., RS21573, Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison (2013), https://fas.org/sgp/crs/misc/RS21573.pdf [https://perma.cc/5TMJ-HCS2].

[4] *See* Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017); Restoring Access to Medication Act of 2018, H.R. Rep. No. 115-850 (2018); U.S. Dep't of Health and Human Servs., U.S. Dep't of the Treasury & U.S. Dep't of Labor, Reforming America's Healthcare System Through Choice and Competition (Dec. 2018) (responding to Executive Order 13813, which directed those departments to collaborate to produce a report setting out market-oriented healthcare policy options).

need for policymakers to consider out-of-pocket costs.[5] A recent report by the Federal Reserve found that 23% of adults had a "major unexpected out-of-pocket medical expense" in the prior year, and 25% passed on at least one healthcare intervention due to affordability during the same period.[6] Moreover, ten percent of adults (twenty-four million individuals) reported they owed debt on out-of-pocket medical expenses incurred in the previous year, and forty-four percent said they "could not cover an emergency [medical] expense costing $400" or could only cover it by borrowing money or selling something.[7]

We believe HSAs hold the promise of addressing the problem of inadequate savings to cover out-of-pocket healthcare expenses, and can be designed to meet equity/distribution concerns raised by their progressive critics.[8] We propose "Equitable Health Savings Accounts," which is a market-based, consumer-driven social program that relies on cash grants, and that calibrates the government subsidy to help the least well-off and to facilitate participation in healthcare markets. We critique the current HSA policy, showing that unless HSAs are redesigned to provide benefits to a larger population, they will continue to fall short of achieving the stated goals of advocates.

Our proposal introduces targeted cash grants to allow people with few economic resources of their own to benefit from HSA subsidies. Along with other reforms we propose, this expansion of HSAs to a larger portion of the population will advance the Republican goal of stimulating market forces in healthcare provision and the Democratic goal of more egalitarian healthcare policies.

After we detail our proposal, we turn to a broader consideration of Equitable HSAs as an example of how cash grants can—when properly designed—be used to promote market-oriented objectives along with egalitarian goals.[9] Attacks from each side of the political spectrum often

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[5] Out-of-pocket costs refer to the costs incurred by patients to cover healthcare services that are not covered by insurance. *See* Peter A. Ubel, *Can Patients in the United States Become Savvy Health Care Consumers?*, 92 N.C. L. Rev. 1749, 1757 (2014). These costs include deductibles, which are the amounts a patient must spend before health insurance begins to cover costs, and co-pays and co-insurance, which are flat fees or percentage shares that patients are charged for particular types of services covered by insurance. *Id.* These "out-of-pocket" costs do not refer to the patients' share of the cost of insurance coverage (i.e., the premiums paid for insurance). *Id.*

[6] Bd. of Governors of the Fed. Reserve, Report on the Economic Well Being of U.S. Households in 2016 2 (2017), https://www.federalreserve.gov/publications/files/2016-report-economic-well-being-us-households-201705.pdf [https://perma.cc/U7BM-6ZWF].

[7] *Id.*

[8] This article focuses on healthcare expenditures not usually covered by insurance. It assumes the continuation of the ACA or other federal programs to subsidize hospital and provider costs on basic healthcare services.

[9] *See infra* Part IV; *see also* Ari Glogower & Clinton G. Wallace, *Shades of Basic Income*, *in* Sharing the Gains of the U.S. Global Economy: Proceedings of the New York University 70th Annual Conference on Labor (2018) (discussing cash grants to augment or replace existing social safety net programs). Conversely, explicitly redistributive policies

miss the point that market-based social policy need not be distributively regressive or constructed in a way that furthers (or exacerbates) existing inequalities. It is a matter of context and design features whether market-based policies are neutral or fair in their distributional consequences.[10]

As illustrated by our Equitable HSA proposal, cash grants can provide a practical yet elegant tool for melding market-based policy with redistributive goals—simple for the government to administer, simple for recipients to use in the desired way, and effective. Our focus here is limited to conditional cash grants, by which we mean cash grants that are available to a limited portion of the population and with strings attached, but this discussion also sheds further light on recent debates about the potential efficacy of universal basic income proposals, which involve large, unconditional cash grants.[11]

This Article proceeds as follows. Part II evaluates current HSAs in terms of their failure to consider income effects, which undermines stated policy goals to promote participation in healthcare markets. Part III sets out our proposal for Equitable HSAs as a replacement for the existing HSA regime. Part IV pursues a broader discussion of the implications of Equitable HSAs, arguing that cash grants can provide a practical, effective mechanism for bridging the policy divide between right and left in healthcare and other contexts. This Part considers potential advantages and disadvantages of cash grants as a tool for carrying out social policy, from both an egalitarian perspective and a market libertarian perspective. Part V concludes.

## II. Current HSAs: A Redistributively Regressive Regime

As currently configured, participants in high-deductible health insurance plans[12] are permitted to receive a tax deduction for contributions to HSAs, and investments in HSAs are allowed to grow tax-free.[13] An individual can contribute up to $3450 to an HSA, and a family that files a joint return can contribute up to $6900; these amounts are adjusted annually for inflation.[14] Around twenty million Americans have HSA-eligible health

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can be designed to harness the power of private markets, and, in some situations, reliance on private markets can improve redistributive effects.

[10] *See generally* Richard Revesz, *Regulation and Distribution*, 93 N.Y.U. L. Rev. 1489 (2018).

[11] *See generally* Annie Lowery, Give People Money (2018).

[12] A high-deductible plan is defined as a health plan which has an annual deductible that is at least $1350 for self-coverage and $2700 for families. 26 U.S.C. § 223(c)(2)(A) (2012); Rev. Proc. 2018-18, 2018-10 I.R.B. 392. Additionally, the sum of annual "out-of-pocket" expenses envisioned by the plan (with the exclusion of premiums) and the annual deductible cannot exceed $6650 for self-coverage and $13,300 for family coverage. *Id.*

[13] The deduction is permitted for direct contributions by the beneficiary, or for contributions made on a beneficiary's behalf on a "pre-tax" basis; these alternative mechanisms are functionally the same, allowing contributions to reduce the amount of income that is subject to tax each year. *See* 26 U.S.C. § 223(a).

[14] *See* Rev. Proc. 2018-27, 2018-20 I.R.B. 591; Rev. Proc. 2018-18, 2018-10 I.R.B. 392; *see also* 26 U.S.C. § 223(b)(1), (b)(2), (g)(1). The I.R.S. originally announced that the joint filing limit for 2018 would be $6900, but the Tax Cuts and Jobs Act passed in late 2017

plans.[15] Because funds in an HSA remain the property of the account holder/contributor, they can be carried over from year to year, even if the contributor moves to a non-qualifying insurance plan (i.e., to a plan other than a high-deductible plan).[16] HSA funds can be withdrawn and used for any qualifying medical expenses, a category which includes prescription drugs, doctors' visits, procedures and the like,[17] but which excludes payments for medical insurance and over-the-counter medications.[18] Currently, HSA account holders can withdraw amounts for non-healthcare spending, subject to income tax and an additional excise tax of twenty percent.[19]

To proponents of HSAs, the accounts are an exemplar of the promise of "consumer-driven" healthcare, working to give patients decisional autonomy and control over costs throughout the healthcare system.[20] These advocates seek to expand HSAs by increasing the amounts that can be contributed and allowing the accounts to be used for a wider range of medical expenses than present law permits.[21] By allowing and encouraging indi-

changed the inflation adjustment formula, so the I.R.S. reduced the limit to $6850, but then changed it back to $6900 due to administrative concerns related to employers and employees having already set automatic contributions for the year based on the $6900 amount. *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054; Rev. Proc. 2018-27, 2018-20 I.R.B. 591; *see also* JOINT COMM. ON TAX., JCX-69-17, MACROECONOMIC ANALYSIS OF THE CONFERENCE AGREEMENT FOR H.R. 1, THE "TAX CUTS AND JOBS ACT" (Dec. 22, 2017).

[15] *See* AM.'S HEALTH INS. PLANS, 2016 SURVEY OF HEALTH SAVS. ACCOUNT-HIGH DEDUCTIBLE HEALTH PLANS (Feb. 2017), https://www.ahip.org/wp-content/uploads/2017/02/2016_HSASurvey_Draft_2.14.17.pdf [https://perma.cc/5BD4-NWXS]; NAT'L CONFERENCE OF STATE LEGISLATURES, STATE ACTIONS ON HEALTH SAVINGS ACCOUNTS AND CONSUMER-DIRECTED HEALTH PLANS, 2004-2017 (Oct. 10, 2017), http://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx [https://perma.cc/RJC9-GH5M].

[16] As a result, there are substantially fewer than 20 million households currently making contributions to HSAs—some of which are holding balances from earlier contributions.

[17] 26 U.S.C. §§ 213(d), 223(d)(2) (2012).

[18] *Id.* § 223(d)(2) (there are certain exceptions, such as payments for COBRA coverage).

[19] *Id.* § 223(f)(2), (f)(4).

[20] Wendy Netter Epstein, *Price Transparency and Incomplete Contracts in Health Care*, 67 EMORY L.J. 1, 27–28 (2017) (assessing the challenge of price transparency in "consumer-driven" healthcare generally, and providing a summary of the growth of consumerism in healthcare policy generally, and HSAs specifically). *See generally* Scott A. Becker, *Health Savings Accounts: The Next Generation in Health Insurance*, 62 BENCH & B. MINN. 22 (2005); *Health Savings Account (HSA)—Creative Cost Savings for Health Care*, 8 LAW. J. 6 (2006); Angel B. McCall, *Health Savings Accounts May Reduce Health Insurance Costs*, 34 COLO. LAW. 57 (2005); David S. Wakelin, *Health Savings Accounts: The Start of Something Big?*, 20 ME. B.J. 116 (2005).

[21] *See, e.g.*, Restoring Access to Medication Act of 2018, H.R. Rep. No. 115-850, 115th Cong. (2018). Republicans in the House Ways and Means Committee proposed a bill that would allow people to use HSA funds to purchase over-the-counter medical and feminine products. *See also* Representative Pat Tiberi, *Consumer Directed Health Plans with HSAs Are Growing in Popularity*, JOINT ECON. COMM. (Mar. 22, 2017), https://www.jec.senate.gov/public/index.cfm/republicans/2017/3/consumer-directed-health-plans-with-hsas-are-growing-in-popularity [https://perma.cc/MA7W-RBUU]. Senate Republicans in summer 2017 proposed to increase the amount that can be put into HSAs, and to allow HSA funds to be spent on insurance premiums and nonprescription drugs. American Health Care Act of 2017 (AHCA), H.R. 1628, 115th Cong. (2017). President Trump's transition team endorsed HSAs as a replacement for the Affordable Care Act. *See* Lauren R. Roth, *Redefining "Medical Care"*, 27 CORNELL J.L. & PUB. POL'Y 65, 67 (2017).

viduals and families to price-shop, HSAs introduce price sensitivity for products and services that might otherwise be insulated from such forces. But to critics, HSAs are merely a tool for providing tax deductions and tax-favored investments to the very people who least need special tax benefits in meeting their healthcare needs.[22] Research has provided support for both sides, showing that HSAs do indeed reduce healthcare costs,[23] although the immediate source of the reduction is reduced healthcare consumption, which may not be a good thing.[24]

HSAs promote the patient-as-consumer model through a few different mechanisms. First, with high-deductible plans generally, patients have their personal funds at stake for ordinary healthcare costs, so patients should be more discerning and price-sensitive than if they simply had a flat co-pay under a non-high-deductible plan. The idea is that simply making patients price-aware may have an effect on pricing throughout the system. Second, and related, patients are not locked into using only those providers that are "in network," so patients are encouraged to shop between providers and to consider alternative courses of treatment in ways they might not be able to if choices were more limited as is likely under a standard plan. The theory is that by giving consumers greater control over how their dollars are spent, HSAs allow market forces to improve the healthcare delivery system.[25]

The current tax benefits of HSAs are potentially significant, but not all those benefits are focused on accomplishing stated healthcare policy goals. First, all contributions to HSAs up to the limit are deductible from gross income.[26] This deductibility should encourage participation in HSAs, and perhaps by extension encourage participation in high-deductible plans. The

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[22] Timothy Stoltzfus Jost, *Is Health Insurance a Bad Idea? The Consumer-Driven Perspective*, 14 Conn. Ins. L.J. 377, 387 (2008) ("[I]t seems to be bringing us tax subsidized retirement savings for the rich, high deductible health plans and financial misery for the poor."); *see* Roth, *supra* note 21, at 69; *see also* Timothy Stoltzfus Jost, Health care at Risk: A Critique of the Consumer-Driven Movement 146 (2007); Michael Hiltzik, *Health Savings Accounts: Another Conservative 'reform' nostrum that chiefly benefits the rich*, L.A. Times (Nov. 18, 2016), http://www.latimes.com/business/hiltzik/la-fi-hiltzik-hsa-20161118-story.html [https://perma.cc/86KQ-PAVX].

[23] *E.g.*, Paul Fronstin & M. Christopher Roebuck, The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income, Emp. Benefit Res. Inst. Issue Brief No. 425, 17 (Aug. 2016), https://www.ebri.org/pdf/briefspdf/EBRI_IB_425.Aug16.HSAs.pdf [http://perma.cc/5BHA-S783].

[24] *See id.* The Employee Benefit Research Institute report finds that HSAs lead to fewer doctor visits overall, but the decrease is much larger among lower-income earners (people earning less than $50,000) as compared to higher-income earners (people earning more than $100,000). *See id.* at 1. HSAs also reduce use of prescription drugs without regard to differences in income levels. *See id.*

[25] *See* David Pratt, *Healthy and Wealthy and Dead: Health Savings Accounts*, 19 St. Thomas L. Rev. 7, 9–14 (2006) (describing in detail the requirements for HSA accounts and the mechanics of qualifying for, and making use of, an HSA); *see also* Edward A. Zelinsky, The Origins of the Ownership Society: How the Defined Contribution Paradigm Changed America 60–63 (2008) (describing the origins of HSAs in "medical savings accounts," which were established by Congress in 1996 for certain employees of small businesses).

[26] 26 U.S.C. § 223 (2012).

HSA deduction is widely available because it is an above-the-line deduction,[27] but (as discussed below) taking advantage of the deduction requires having access to a qualifying healthcare plan and having funds available to set aside for medical expenses.

Contributions to HSAs are also deductible from the Federal Insurance Contributions Act ("FICA") tax base, meaning that HSA contributions are not subject to Social Security and Medicare taxes. For example, consider a single individual earning the social security maximum of $128,400 in 2018, who contributes the maximum $3450 to an HSA and the same amount to a 401(k). Each contribution will reduce her taxable income by the full $3450, reducing her federal income tax liability by $828. The HSA contribution will also reduce her payroll tax base, saving her 6.2% Social Security tax and 1.45% Medicare tax, for a total of $264 in additional savings. This deduction for FICA purposes is not available for 401(k) or IRA contributions. This differential treatment for FICA purposes may sound insignificant, but if that amount is invested through the HSA for forty years and earns a 10% annual return (less than the stock market average over the last forty years), that $264 has a present value of nearly $12,000. For high-income individuals whose income exceeds the Social Security threshold, the benefit is reduced: these taxpayers save the 1.45% Medicare tax only, yielding Medicare tax savings of about $100 per year for a family.[28]

The second tax benefit is that gains on investments made with HSA funds are tax-free.[29] For example, if an HSA has a cash balance of $2000 from contributions in a previous year, the account owner can invest those funds in stocks or bonds or other assets. If the investment yields a 10% return on the year—$200—and the owner sells the stock, the $200 would, under usual income tax rules, be included in income (i.e., the gain on stock is realized and recognized because the stock is sold at a gain). However, under the HSA rules, the $200 is not included in income. Indeed, if the $200 gain is used for qualifying healthcare costs at any time, that gain is never subject to tax.

Together, the deduction for contributions and the exclusion of gains on HSA investments have been estimated to add up to approximately $2.2 billion of foregone revenue for the federal government in 2016; a sum expected

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[27] Deductions from gross income—i.e., deductions made to arrive at what the tax code calls "Adjusted Gross Income," commonly referred to as "above-the-line" deductions—have historically been more valuable than so-called below-the-line deductions—i.e., deductions made from Adjusted Gross Income to calculate taxable income. All qualifying taxpayers are permitted to take above-the-line deductions. In contrast, below-the-line deductions are only permitted for the subset of taxpayers who take itemized deductions.

[28] Like 401(k) contributions and IRA contributions, for high-income earners, HSA contributions are not included in the base for calculating the 3.8% net investment income tax. *See* 26 U.S.C. § 1411.

[29] *Id.* § 223(e).

to rise to $4 billion dollars by 2020.[30] For comparison, the revenue cost of the exclusion from income for employer-provided health insurance is between $155 billion and $189 billion each year—that is, the HSA tax benefit is modest in comparison.[31]

HSAs are susceptible to criticism on distributional grounds because high-income earners are the primary group that takes advantage of the HSA tax subsidy. This is in part the result of the distribution of resources resulting from other markets: people with lower incomes have less money available to commit to use for healthcare generally. An HSA thus exacerbates the existing distribution in practice by making a tax benefit realistically available only to higher income households.

But to the extent the problem is that among participants in HSAs, greater benefits are available to those with higher incomes as compared to lower incomes, this is purely a matter of program design. The amount of the tax benefit from HSA contributions is based on each taxpayer's marginal tax rate, which means the federal government provides a larger HSA subsidy to people in higher tax brackets. This effect is referred to in the tax policy literature as the "upside-down" subsidy effect.[32] For example, a taxpayer in the top federal income tax bracket, i.e., a couple making over $600,000 per year, is taxed at the top 37% marginal rate. Because of the tax rate, the government in essence subsidizes 37% of any deductible expenditure. Thus, if the individual contributes $1000 to an HSA, the contribution saves the taxpayer $370 of federal income tax liability, even as the HSA contribution constitutes less than 0.2% of that couple's taxable income. On the other hand, a taxpayer earning $50,000 per year is in the 22% tax bracket; so making the same $1000 contribution saves just $220 per year, for a contribution of 2% of her taxable income, a much more significant sum.

The contribution limits bring the upside-down subsidy problem into stark relief: under current policy, for a couple with income in excess of $600,000 the government provides a subsidy of $2915.[33] This is nearly four times as much in dollar terms as a lower-income individual, who, *if* she can make the maximum HSA contribution, receives less than $680 in subsidy.[34] Obviously the subsidy is even less for those in lower tax brackets who con-

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[30] Staff of Joint Comm. on Tax'n, 115th Cong., JCX-3-17, Estimates of Federal Tax Expenditures for Fiscal Years 2016-2020, at 38 (Jan. 30, 2017). Note, however, that these estimates pre-date the legislation Congress enacted at the end of 2017 that reduced tax rates. Lower tax rates make the deduction reduce revenue by less, which means that, relative to this new baseline, HSAs will be less costly to the government. These lower rates also potentially reduce the incentive effect of the deduction.

[31] *Id.* at 37.

[32] *See, e.g.*, Stanley S. Surrey & Paul R. McDaniel, Tax Expenditures 103 (1985).

[33] This is calculated as the $6900 maximum deductible contributions, which for a taxpayer in the top marginal tax bracket yields a deduction of thirty-seven percent, plus the 1.45% Medicare payroll tax, plus the 3.8% net investment income tax, for a top marginal tax rate of 42.25%, and a total tax savings of $2915 on account of the contribution.

[34] This is calculated as $3450 multiplied by the sum of twelve percent (the second lowest bracket, which applies to taxable income between $9526 and $38,700 for an individual), plus

tribute less, and it is reasonable to assume that people with lower incomes will more often contribute less than the maximum amount. Moreover, because contributions to HSAs are deductible above-the-line (reducing adjusted gross income ("AGI")), HSAs are not currently subject to income-based limits that have often applied to below-the-line deductions (applying only after AGI is calculated).[35]

For HSAs to work, the rules must require HSA funds to be spent on healthcare expenses (ideally expenses that are consistent with realizing the benefits of consumer-driven care). Otherwise, the revenue costs to the fisc and the tax benefits connected to HSAs—that is, deductible contributions and tax-free returns—will not be effective at promoting the healthcare goals of HSAs. Indeed, current HSA policy does not ensure that HSA funds are limited to healthcare expenses. This is because HSA funds can be withdrawn for any purpose, without penalty, by anyone over the age of sixty-five.[36] Allowing withdrawals without penalty essentially turns HSAs into supplemental 401(k) or IRA accounts, because the key benefit of those accounts becomes deferral of income tax liability.

HSAs have become a significant investment vehicle for many high-income people because of this feature, quite aside from any healthcare-related benefits.[37] In essence, they allow the wealthy (those who can afford to make large contributions to an HSA over a long period of time) and the fortunate (those who do not have significant healthcare costs prior to age sixty-five) an additional route for tax-preferred retirement savings, beyond the favorable treatment accorded 401(k) accounts and IRAs. Further, unlike IRAs, deductible HSA contributions are not phased out above a certain income threshold.[38] HSAs as structured thus work counter to the purposes of Congress's general retirement savings policy of both not devoting government revenue to encourage additional savings by people with high incomes and the stated healthcare policy goal of encouraging price-sensitive healthcare spending.

Moreover, in some respects, HSAs are even more advantageous retirement savings vehicles than 401(k) accounts and IRAs. Most significantly, unlike 401(k) accounts and IRAs, there are no required withdrawals from

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the 6.2% Social Security tax, plus the 1.45% Medicare payroll tax, for a total marginal rate of 19.65%.

[35] Additionally, below-the-line deductions have often been subject to limitations that disallow certain deductions and reduce the amount of deduction for high-income earners. *See* 26 U.S.C. § 67 (2012) (allowing miscellaneous itemized deductions only to the extent that those deductions exceed two percent of adjusted gross income); *see also id.* § 68 (reducing all itemized deductions by three percent of the amount that AGI exceeds a certain threshold). Each of these provisions were temporarily repealed starting in 2018, but remain on the books and will come back into effect unless Congress acts before 2026.

[36] *Id.* § 223(f)(4)(A), (C). Non-healthcare withdrawals for individuals below age 65 are subject to income tax. *Id.* § 223(f)(1), (2).

[37] *See generally* LIVELY HSA: INVEST IN YOUR HEALTH, https://livelyme.com/ [http://perma.cc/8TZL-6F3Y].

[38] *See supra* note 27 and accompanying text.

HSAs. The traditional tax-favored retirement accounts must be drawn down starting at age seventy and one-half, ensuring that the accounts are used for retirement consumption and not for estate planning purposes.[39] In contrast, HSAs have no withdrawal requirements—distributions are totally discretionary regardless of the age of the beneficiary. When the account holder dies, the balance in the HSA is included in the income of the beneficiary, similar to IRA accounts.[40]

For high-income people with extra disposable income, HSAs can be used purely as a savings vehicle. Consider the following example: a household earns $1 million of income each year (placing the household in the 37% tax bracket), has $5000 of out-of-pocket medical expenses each year, contributes $5000 to an HSA, and through that HSA can invest and earn 10% each year. If the household uses the HSA funds each year to pay for medical expenses, the total tax savings each year will be $1850. But if the household instead leaves the $5000 balance in the HSA each year, then the tax benefit begins to multiply. The $5000 earns $500, which is also tax-deferred. As described above, when the earners in the household reach age sixty-five, they can withdraw the HSA funds without penalty, and pay income tax at that time. Rather than receiving the savings benefit only for funds that are in excess of their annual out-of-pocket health costs, the HSA acts purely as a savings vehicle.[41]

HSAs are an example of a policy that would benefit from renewed attention to distributive equity. If the threshold policy goal is to incentivize contributions to HSAs and thus promote out-of-pocket spending on healthcare in a manner that exhibits greater price sensitivity, it would make sense to create stronger financial incentives—or provide financial resources—for the lower-income people who are less able or likely to make contributions if left to their own devices.[42] Instead, under current policy, the skewed distribu-

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[39] Required withdrawals are a portion of the account balance, based on actuarial factors. *See* 26 U.S.C. § 401(a)(9).

[40] *Id*. § 223(f)(8)(B). Thus the deferral benefit ends at the time of death of the account holder. Note that when the beneficiary is a spouse, the deferral benefit continues and the account continues to be treated as an HSA. *Id.* § 223(f)(8)(A).

[41] For people with less disposable income, the savings feature may nonetheless serve a healthcare function: it allows them to save tax-free for a future expensive adverse health event. *See* Emily M. Mitchell & Steven R. Machlin, U.S. Dep't of Health & Human Servs., MEPS Statistical Brief #506, *Concentration of Health Expenditures and Selected Characteristics of High Spenders, U.S. Civilian Noninstitutionalized Population, 2015* (Dec. 2017), https://meps.ahrq.gov/data_files/publications/st506/stat506.pdf [http://perma.cc/P6FR-CBFP] (reporting that the top 5% of the population accounted for 50.8% of total healthcare expenditures). Another study found that in 2016, just 10% of the population accounted for 49% of out-of-pocket healthcare costs, with an average out-of-pocket expense of $3482. Diana Farrell & Fiona Greig, J.P. Morgan Chase & Co. Institute, Paying Out-of-Pocket: The Healthcare Spending of 2 Million US Families, at 18 fig.12 (Sept. 2017). This suggests that for a small portion of the population in any given year, it is helpful to have savings well in excess of the median out-of-pocket cost. *See infra* Part III.

[42] *Compare* David M. Schizer, *Limiting Tax Expenditures*, 68 Tax L. Rev. 275, 280 (2015) (arguing that tax incentives should vary with income), *with* Lily L. Batchelder et al.,

tion of benefits of HSAs further undermines the market-based healthcare goals of the policy. Redistribution is not an animating purpose of existing HSA policy, but the issues described above make clear that disregarding distributional effects has undermined the market-based forces that HSAs are intended to foster. The remainder of this Article considers how cash grants can be used to strengthen HSAs and might serve as a model for integrating redistribution with market-based policies.

## III. Equitable HSAs: Redistribution Using Markets

We propose replacing the existing HSA regime with Equitable HSAs. This new version of HSAs will cover out-of-pocket costs that are not likely to be covered by an insurance program, so as to facilitate participation by individuals, including those at the lower end of the income spectrum. The proposal consists of a multipart subsidy: a cash grant of $300-$1000 per individual for low-income people, and a tax credit worth the same amount to higher income people. All gains on funds in Equitable HSA accounts will be exempt from income tax so long as the funds are used for healthcare expenditures. This multiform subsidy allows lower-income people to enter the market and incentivizes higher-income people to set aside money for healthcare spending. We also propose to loosen the prerequisites for accessing an HSA—a high-deductible plan would not be necessary—while imposing more stringent requirements to ensure that HSA funds are actually spent on healthcare. As discussed below, Equitable HSAs could be complementary to other more fundamental changes in healthcare finance and delivery. This proposal is not intended to displace other elements of current healthcare policy; it is not intended as a substitute for elements of the ACA, nor as an alternative to proposals such as Medicare-for-All.

The remainder of this Part details our proposal and various design options for Equitable HSAs. The key provisions are summarized on Table 1, below. We recognize that there are alternative ways to use the HSA concept to introduce broad-based consumer-driven healthcare in a manner that is mindful of distributional effects. The key insight here is that the combination of a market-based mechanism and a subsidy to allow participation in the market can make Equitable HSAs more effective at achieving both the market and redistributive goals that regularly feature in healthcare debates, thus making the policy appealing across a broad political spectrum.

### *A. The Proposed Equitable HSA: Cash Grants and Tax Credits*

Equitable HSAs provide three different forms of government subsidy, separately targeting lower-income households and higher-income house-

*Efficiency and Tax Incentives: The Case for Refundable Tax Credits*, 59 Stan. L. Rev. 23, 24–25 (2006) (arguing that tax incentives should, as a default, be flat across income levels).

holds. First, for lower-income households, Equitable HSAs offer a cash grant designed to bring them into the HSA program by providing a significant subsidy as a portion of pre-tax income, and in a form that is easy to utilize and thus induces their participation in healthcare markets. Second, a different form of subsidy—a credit of 100% or 50% depending on income level—is provided for higher-income people, which is designed to induce these people to participate in HSAs, and also results in a nominally equal subsidy amount across income levels. Third, for everyone who owns an HSA, gains on funds carried over year to year in the account are excluded, so long as the funds are eventually used for healthcare purposes. A broader range of spending options (as compared to current policy) and more stringent limitations on non-healthcare uses of HSA funds—to ensure that the HSA subsidy accomplishes intended healthcare policy goals—accompany these subsidies.

We propose a subsidy amount varying with household size. We suggest a subsidy of at least $300 per individual or dependent in the household, which is slightly more than the median per capita out-of-pocket healthcare expenditure in recent years.[43] Such a subsidy would allow lower-income people to prepare for health shocks (whereby they are subject to unexpectedly high costs in one or a few years).

For low-income people, the cash grant is deposited annually and directly into the individual's or household's HSA account (perhaps via an HSA debit card). This cash grant would be available in full to anyone earning below 400% of the poverty line (above which the grant would phase out, as described below and in the Appendix), which is the top cutoff for premium tax-credit assistance under the ACA.[44] Households that are between four and ten times the poverty line would not receive any grant but instead would

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[43] *See* Philippe Gwet & Steven R. Machlin, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEPS Statistical Brief #495, *Out-of-Pocket Health Care Expenses in the U.S. Civilian Noninstitutionalized Population by Age and Insurance Coverage, 2014* (Oct. 2016), https://meps.ahrq.gov/data_files/publications/st495/stat495.shtml [https://perma.cc/2EJR-85Y6] (reporting median out-of-pocket expenditure of $204 per person in 2014); *see also* Philippe Gwet & Steven R. Machlin, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEPS Statistical Brief #507, *Out-of-Pocket Health Care Expenses for Non-Elderly Families by Income and Family Structure, 2015* (Jan. 2018), https://meps.ahrq.gov/data_files/publications/st507/stat507.pdf [https://perma.cc/EJ74-3NC6] (reporting median out-of-pocket expenditures of $451 per family in 2015, with families broadly defined to include one- and two-adult households with and without children). For families consisting of one adult, the median out-of-pocket expenditure was $242; for two or more adults with no children ("or more" presumably allowing for adult dependents), it was $869; and for two adults with one or more children the median was $721. *See also* FARRELL & GREIG, *supra* note 41, at 10 (reporting median out-of-pocket expenditures per family of $276 in 2016). Other surveys use different inputs to arrive at out-of-pocket costs; for example, the Bureau of Labor Statistics Consumer Expenditure Surveys estimate out-of-pocket healthcare expenses by combining amounts paid to providers of care and to insurers. *See* ANN C. FOSTER, HOUSEHOLD HEALTHCARE SPENDING: COMPARING ESTIMATES FROM THE CONSUMER EXPENDITURE SURVEY AND THE NATIONAL HEALTH EXPENDITURE ACCOUNTS, 2013-2016, at 7 (2018).

[44] *See Federal Poverty Level (FPL)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-FPL/ [http://perma.cc/3DNZ-A2MW].

receive a credit to match or partially match amounts that they contribute to the HSA.[45] For the highest-income households, no grant or credit would be available—those households do not need a government subsidy to be able to save—but they are permitted to make contributions of their own funds to the HSA, and returns on those funds are exempt from income tax. For the lowest-income individuals and families,[46] the Equitable HSA subsidy will allow them to save for out-of-pocket costs that are not covered by Medicaid, programs like the ACA, or other insurance. The cash-grant subsidy amount could be used on any qualifying medical expense in the current year, and it would carry over to subsequent years as well.

The subsidy amount for Equitable HSAs proposed here is $300 (regardless of income or household size). Assuming a subsidy amount of $300 per person, for a household of four earning up to $100,000, the total HSA grant would be $1200 per year. For a household of two, the HSA grant of $600 would be available if their incomes total less than $33,000. These households would also be permitted to make additional contributions to the HSA up to the deductible amount in their insurance plan.

Households earning above the cash grant threshold would be eligible for an annual tax credit for HSA contributions up to the lesser of $300 per taxpayer or dependent in the household, or a total amount equal to the deductible for the health insurance plan the household is enrolled in. For a family of four earning $125,000 (which is well above the phaseout level) and enrolled in a health insurance plan with a $10,000 deductible, the credit would be worth up to $300 per person, or $1200. If the family made contributions to the HSA of $2400, that with the $1200 credit would leave $3600 in the HSA. They could then make additional contributions of up to $6400 to cover the $10,000 deductible for the year. All contributions are of after-tax funds; no deduction is permitted (and thus the upside-down subsidy effect found in existing HSAs is eliminated). The credit amount would be deposited into the account at the time of the contribution and, as with the direct cash grant, the amount could be used with an account-specific HSA debit card on any qualifying medical expense in the current year. As with cash grant amounts, any unused portion could be carried over to future years.

For households earning more than ten times the poverty line (around $160,000 for a couple; around $250,000 for a family of four), the credit phases out. For these households, the HSA is available but provides only a means to defer tax on gains, i.e., no deduction is available for contributions.

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[45] The details of the phaseout are further elaborated in the Appendix.

[46] Households qualifying for Medicaid are incomes below 139% of the federal poverty line in states that expanded Medicaid under the ACA, and those with incomes below 100% in other states. The 139% cut-off for a single individual in 2018 is $48,560; for a married couple, the cut-off is $65,840; and for a family of four, the cut-off is $100,400. *See* HENRY J. KAISER FAMILY FOUND., WHERE ARE STATES TODAY? MEDICAID AND CHIP ELIGIBILITY LEVELS FOR CHILDREN, PREGNANT WOMEN, AND ADULTS (Mar. 28, 2018), https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ [https://perma.cc/L9PT-UAAJ].

These households can contribute up to the amount of their plan deductible. So, for example, a family of four earning $300,000 with an insurance plan deductible of $10,000 can contribute up to $10,000 to the HSA, but the family receives no immediate tax benefit on these contributions.[47] (Some alternative design options related to transition issues are discussed in further detail in the Appendix.)

In the absence of evidence that willingness to make contributions to HSAs varies with income,[48] the proposed structure sets the appropriate subsidy level and makes that subsidy amount available to most taxpayers, while adjusting the mechanism for delivering the subsidy so that lower-income people are not prevented from participating due to lack of resources. This approach should address progressivity concerns of those who have traditionally opposed HSAs. At the same time, an important feature of consumer-driven healthcare is that patients should be attentive to costs in making decisions about their healthcare. Giving money to people who would not otherwise have any ability to act as healthcare consumers and encouraging higher-income people to contribute their own money promotes participation in consumer healthcare markets across varying income levels (instead of working effectively for some but not others, depending on their income).

[47] Phasing out the tax credit subsidy is consistent with retirement savings policies such as IRAs, in which the tax benefits phase out entirely for the highest earners. *See* DENNIS R. LASSILA & BOB G. KILPATRICK, EMPLOYEE COMPENSATION AND BENEFITS TAX GUIDE ch.10 (LexisNexis ed. 2018).

[48] The variation of elasticities of taxpayers along the income spectrum regarding different behaviors remains contested and is a fertile area for future empirical research. *See infra* notes 68–69 and accompanying text.

TABLE 1: COMPARISON OF HSAS AND EQUITABLE HSAS

| **Features of Policy** | **Health Savings Accounts (Current Policy)** | **Equitable Health Savings Accounts** |
|---|---|---|
| Initial Subsidy Amount | $0 to $2553 per household depending on family size and income (higher subsidy for higher income because subsidy is in the form of deduction). | $0 to $300 per individual, varying based on income (cash subsidy for low-income people; limited and diminishing tax credit for households with income over 4x the federal poverty line; no subsidy for incomes over 10x the federal poverty line). |
| Deferral Benefit | Unlimited deferral of tax on balances (greater subsidy for higher-income account holders who pay out-of-pocket for healthcare expenses). | Deferral of tax on balances, but requirement that at least 70-80% of healthcare costs each year must be covered from HSA funds, or lose tax benefits for the year. |
| Use of Funds for Medical Expenses | Funds can be withdrawn for qualifying medical expenses such as medications, doctors' visits, and procedures. | Broadens what funds are allowed to be used for, including over-the-counter medications and treatments such as weight loss treatments, fertility treatments, and dental services. |
| Penalties for Non-Medical Expense Withdrawals | Funds withdrawn for other uses are subject to income tax and additionally taxed at 20%. | Withdrawals for any expenses other than qualifying healthcare costs are subject to a 100% penalty up to the subsidy amount and withdrawals beyond the subsidy amount must be included in income and subject to an additional penalty of 20%. |
| Use of Funds Over Age Sixty-Five | Funds can be withdrawn for any purpose without any tax or penalty by any account holder over age sixty five. | Penalties remain applicable over age sixty-five; funds can be used without penalty for Medicare supplement premiums (and out-of-pocket medical costs). |
| Treatment When Account Holder Dies | Beneficiary includes HSA balance in income; no penalties for non-healthcare expenditures by beneficiary. | Beneficiary can continue to use HSA funds as HSA funds (with limitations described above), or include in income and pay 20% penalty to remove restrictions. |

### *B. Design Options and Subsidy Conditions*

In order to focus the subsidy on the desired outcomes—subsidizing healthcare expenses and promoting consumer-driven healthcare—we propose adjusting the withdrawal rules for HSAs to limit HSA expenditures to healthcare needs and to prevent conversion of HSA funds to non-healthcare purposes.

First, the proposed Equitable HSA assumes the availability of Medicare or programs like the ACA. If these programs remain in place, to qualify for the HSA subsidy, the covered individuals must procure insurance providing adequate basic coverage.[49] This includes, for example, covering preventive care and screenings that are proven to have long-term health benefits and promoting long-term savings by catching problems early. Additionally, the Equitable HSA might require that insurance provides for annual wellness checkups, including preventive care evaluations, and basic preventive care services such as immunizations.[50] This approach calibrates the proposed equitable HSA subsidy with broader federal healthcare policy.

Note that, in contrast to current HSA policy, we do not require participation in a high-deductible plan.[51] Although we do require insurance that covers minimum basic services and some preventative care,[52] this aspect of the proposal could be further relaxed. For example, the uninsured could be permitted to benefit from the subsidy as well. If low-income uninsured persons could qualify for HSAs, the cash subsidy would give them some assistance to deal with out-of-pocket costs. This additional cash in the hands of price-sensitive consumers could help the development of healthcare markets, bolstering the patient-driven care model.

Second, the definition of allowable HSA expenditures could be broadened to include healthcare-related expenses that could benefit from renewed market forces—for example, over-the-counter medicines and treatments.[53] This step would require allowing HSA funds to be spent on healthcare procedures and products that often are not presently covered by insurance—for example infertility treatment, weight-loss procedures, dental services, and over-the-counter medications and products. HSAs would thus be able to help

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[49] These requirements might simply be "essential health benefits" similar to those prescribed by the ACA under 48 U.S.C. § 18022 (2012). For a description of coverage requirements under the ACA, see *What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ [https://perma.cc/X8FQ-FKYQ].

[50] These requirements are conditions for the type of insurance coverage that a person must have in order to qualify for the Equitable HSA subsidy.

[51] *See supra* note 12.

[52] *See supra* notes 49–50 and accompanying text.

[53] The Senate Republicans' 2017 proposal included loosening rules to allow HSA funds to be spent on insurance premiums and nonprescription drugs. *See* Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017).

consumers deal with out-of-pocket costs generally not covered by insurance.[54]

Third, most qualifying healthcare spending must be attributed to the HSA account each year. Under current rules a high-income family might add to its HSA balance each year while paying for healthcare costs out of pocket with after-tax dollars. This helps convert the HSA into a pure savings vehicle, with tax-favored dollars eventually subsidizing non-healthcare spending. For HSA account holders with plenty of excess cash and few tax-deductible savings vehicles, this may be a smart approach. But this practice could be eliminated with little administrative difficulty by requiring that most (say seventy to eighty percent) qualifying healthcare spending must be done with HSA funds. Some gaming would still be possible, but this would make it more difficult and would focus HSA dollars on healthcare spending purchases.[55]

Fourth, Equitable HSAs will end the practice of using HSAs as a vehicle for retirement planning by requiring HSA funds to be spent only on healthcare for the life of the account owner. Extending the healthcare limitation on HSA spending beyond age sixty-five partially addresses the unintended use of HSAs for retirement planning. To facilitate this rule, HSA spending limitations should be liberalized to allow the funds to be used on Medicare, Medicare supplement premiums, and out-of-pocket costs for individuals. Withdrawals for non-healthcare purposes should be subject to a one hundred percent penalty up to the subsidy amount (including any gains on the subsidy principal),[56] and withdrawals beyond the subsidy amount must be included in income and subject to an additional penalty of twenty percent.[57] Like current HSAs, amounts not spent on healthcare in the year of contribution could be carried forward indefinitely and could be invested with tax-free returns.[58] But Equitable HSAs should either maintain the require-

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[54] *See supra* notes 5–7 and accompanying text.

[55] There is potential value in inducing economy on the part of taxpayers, an effect which may be enhanced by allowing taxpayers to recoup some of the savings to the government of reduced healthcare spending. The policy mechanisms for achieving the right balance in this respect require further consideration.

[56] This will prevent recipients of both the cash grant and the credit from using the funds for purposes other than healthcare at any time. The penalty amount should be adjusted to reflect tax free gains as well (an adjustment which could be based on an approximation of market returns, or on actual returns to the account holder).

[57] For example, assume that a joint filing taxpayer with income over 400% of the poverty line and a $3000 deductible contributes $2400 in year 1 and receives a $600 credit, but has no healthcare spending. She will carry a balance of $3000 into year 2. Further assume that the $3000 earns a 10% return, growing to $3300, and the taxpayer withdraws $1000 and spends it on non-healthcare goods. The taxpayer will be subject to a 100% penalty on the first $660 (the $600 subsidy amount plus the $60 gain on that subsidy). On the additional $340 she will have an inclusion in year 2 income of $240 (the remaining tax-free gain), plus a penalty of $68 (a 20% penalty on the $340 amount). This treats the subsidy amounts as the first amounts withdrawn at any time and discourages any non-healthcare withdrawals.

[58] Currently, gains in HSA balances carried over year to year are shielded from taxation. 26 U.S.C. § 223(e) (2012). Our proposal strengthens the penalty provisions for withdrawals

ment of using HSA funds for healthcare expenditures only, even after the HSA account is transferred to a successor of a decedent, with the penalty provisions described above continuing to apply, or the penalties and tax should be imposed on the decedent as ordinary income at the time of death.[59] This will eliminate the use of HSAs as an unrestricted estate planning tool.[60]

### *C. Cost*

This Section provides rough cost estimates for each of the three primary elements of the proposed Equitable HSA subsidy—cash grants, credits, and deferral/exclusion of gains.[61]

*Cash Grants*. The primary cost of Equitable HSAs is the cash grant subsidy. If the subsidy amount is $300, and the cash grant is available only for persons with health insurance coverage, the cost to the federal government would be approximately $50 billion per year.[62] If every household with earnings below 400% of the poverty line qualifies for the cash grant (which would be the case if there is no requirement for insurance coverage), the cost to the federal government would be approximately $56 billion each year. If the grant amount is $1000 per person, then the cost ratchets up to $167.5 billion per year with 100% uptake.

*Credits.* The cost of our proposed HSA tax credits for households with income above 400% of the poverty line depends on how much those households contribute to HSAs. If half of these households contribute to HSAs to

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for non-healthcare expenditures to help ensure that these tax-free gains are spent consistent with the purposes of HSAs.

[59] This might be structured as an election one way or the other, to avoid the potentially harsh result of penalty and liability in the case of premature death. Thanks to Gregg Polsky for highlighting this concern.

[60] For an example of how HSAs can be used as an estate planning tool, see 26 U.S.C. § 223(f)(8) (permitting HSA funds to be transferred to a beneficiary without penalty beyond generating taxable income for the beneficiary).

[61] *See generally* STAFF OF JOINT COMM. ON TAX'N, 115TH CONG., JCX-67-18, ESTIMATED BUDGET EFFECTS OF H.R. 6311 (2018) (providing cost estimates for recently-proposed changes to existing HSAs); STAFF OF JOINT COMM. ON TAX'N, 110TH CONG., JCX-66-08, TAX EXPENDITURES FOR HEALTH CARE (2008), (describing HSAs and cost estimates for HSAs generally).

[62] Calculated as follows: approximately 87.4% of the U.S. population with income below 400% of the poverty line currently has health insurance coverage, and approximately 59% of the U.S. population has income below 400% of the poverty line, meaning a total of 167.5 million people would qualify for the $300 subsidy (based on a total population of 325 million). U.S. CENSUS BUREAU, *Health Insurance Coverage in the United States: 2016*, tbl.4 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf [https://perma.cc/7G8F-HQZ4]; HENRY J. KAISER FAMILY FOUND., DISTRIBUTION OF THE TOTAL POPULATION BY FEDERAL POVERTY LEVEL (ABOVE AND BELOW 400% FPL) (2016), https://www.kff.org/other/state-indicator/population-up-to-400-fpl/ [https://perma.cc/JMJ4-F3JL]. This calculation ignores the (likely) incentive effect whereby uninsured persons will procure health insurance in order to qualify for the cash grant subsidy. Thanks to David Kamin for pointing out that in this respect the cash grant HSA can act as a form of the now-defunct individual mandate. This analysis also assumes that all health insurance is qualifying health insurance; this should be true under the ACA, with the exception of grandfathered plans which are permissible but in some cases do not include coverage of some essential health benefits.

qualify for the full subsidy amount of $300 per person, then the total subsidy cost would be $17.5 billion, which would prompt HSA contributions totaling at least $35 billion.[63]

*Deferral and Exclusion of Gains*. The deferral benefit potentially applies to all HSA participants, but cost estimates vary greatly depending on how much each household carries over each year. In any year, the cash grant covers median out-of-pocket costs, meaning that half of individuals should be able to carry forward some balance. If that group carries forward one-third of their balance, the total carryforward will be approximately $18 billion. Among the higher-income groups, a reasonable (though rough) estimate is that they will carry forward five-sixths of their balances in any given year, a total of approximately $42 billion.[64] Among the highest-income group, which receives no subsidy for contributions, if one-third of households participate and contribute $300 per person, they will carry forward approximately $2.4 billion per year. Thus, the deferral benefit will accrue on approximately $62 billion of additional funds in the first year, with something on the same order of magnitude in future years, though reduced by expenditures in high out-of-pocket cost years.[65] If the return on these funds is 5%, the budget cost of deferral will be something on the order of $465 million, although that cost will be recovered if those funds are not used for medical purposes and are thus subject to taxation later.[66]

The total budget cost is thus something on the order of magnitude of $70 billion each year. The proposed cost is not trivial, but it is well within the range of expenditures that HSA advocates in Congress proposed for expanding the current, inequitable HSAs as part of the effort to repeal Obamacare.[67] With a larger subsidy of $1000 per person, the cost of our proposal would be in the vicinity of $225 billion to $230 billion each year.

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[63] This calculation assumes that the elimination of the subsidy for households earning about 10x the poverty line applies to approximately the top 5% of individuals, thus leaving 36% of total persons in the income range that qualifies for the proposed HSA credit.

[64] This is based on half of those households spending less than $300 per person, and all of those households having a balance of $900 per person in order to qualify for the full credit.

[65] *See supra* note 41 (discussing uneven distribution of high out-of-pocket costs across the population and across time).

[66] This $465 million estimate is based on total carryover of $62 billion in the first year and an overall average effective income tax rate of 15%, *see* TAX FOUND., SUMMARY OF THE LATEST FEDERAL INCOME TAX DATA, 2017 UPDATE, https://taxfoundation.org/summary-federal-income-tax-data-2017/ [https://perma.cc/MS64-GE7U], and will increase each year as additional funds are saved and carried over. For point of reference, recent estimates indicate that retirement plans and accounts (IRAs, defined contribution plans, and defined benefit plans) have combined assets of around $15 trillion, and the budget estimates for the combined cost of current contributions and deferral of gains is around $218 billion for 2017. *See* STAFF OF JOINT COMM. ON TAX'N, 115TH CONG., JCX-34-18, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2017-2021 (2018).

[67] *See, e.g.*, STAFF OF JOINT COMM. ON TAX'N, 115TH CONG., JCX-27-17, ESTIMATED REVENUE EFFECTS OF THE TAX PROVISIONS CONTAINED IN TITLE II OF H.R. 1638, THE "AMERICAN HEALTH CARE ACT OF 2017," AS PASSED BY THE HOUSE OF REPRESENTATIVES (2017) (estimating annual costs of $45 billion to $104 billion per year for a variety of health-related policy changes, including around $3 billion per year of additional incentives for existing HSAs).

### *D. A Call for Additional Research*

The lack of data on HSAs—who uses them, how they are used, and how effective they are at achieving their stated policy goals—is, frankly, surprising.[68] To evaluate the efficacy of HSAs, we need to understand the responsiveness across income levels of would-be account holders to using HSAs and how this varies depending on whether there is a government subsidy, the size of the subsidy, and how the subsidy is administered, as well as whether account holders will in fact engage in price-shopping for healthcare services and products.[69]

## IV. Considering Cash Grants as a Model for Social Policy

### *A. Advantages and Disadvantages*

The linchpin of the Equitable HSA is the cash grant, which allows more people to participate as price-sensitive consumers in the healthcare market and creates a redistributive aspect to the policy. The term "cash grant" refers, very generally, to currency remitted from the government to an individual or entity. These payments could be made periodically or all at one time in a lump sum. They could be made by transferring funds into a bank account, by making funds available on a cash or debit card, or even by providing physical currency.

We assess below the merits of using cash grants to achieve social policy goals. We distinguish cash grants from in-kind benefits as well as from government benefits that offset other liabilities. For example, the non-refunded portion of the Earned Income Tax Credit ("EITC")[70] is credited against tax

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[68] There is some research, but many questions remain. *See* Kate M. Bundorf, Consumer-Directed Health Plans: Do They Deliver?, Robert Wood Johnson Found. Research Synthesis Rep. No. 24 (2012) (impact of CDHPs on healthcare services use and spending); Paul Fronstin & M. Christopher Roebuck, Quality of Health Care After Adopting a Full-Replacement, High-Deductible Health Plan With a Health Savings Account: A Five-Year Study, Emp. Benefit Res. Inst. Issue Brief No. 404 (2014); Buntin M. Beeuwkes et al., *Health care Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans*, 17 Am. J. Managed Care 222 (2011); Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 Q.J. Econ. 1261 (2017); Thomas C. Buchmueller, *Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Directed Health Insurance*, 87 Milbank Q. 820 (2009); Paul Fronstin et al., *Medication Utilization and Adherence in a Health Savings Account-Eligible Plan*, 19 Am. J. of Managed Care 400 (2013); Amelia M. Haviland et al., *How Do Consumer-Directed Health Plans Affect Vulnerable Populations?*, 14 F. Health Econ. & Pol'y 1 (2011); Emmet B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 J. Am. Med. Ass'n 1666 (1996). These studies show conflicting results—in some instances, higher income HSA users reduced healthcare spending more than lower income users, and vice versa.

[69] Very few studies have looked at elasticities and effects of HSAs across income levels. *See* Fronstin & Roebuck, *supra* note 23, at 6–7 (summarizing the limited prior research).

[70] 26 U.S.C. § 32 (2012).

liability that would otherwise be owed but does not consist of an actual transfer from the government to an individual. As a result, we would not include this portion of the EITC in our definition of a cash grant.[71] Examples of existing cash grant programs include the refundable portion of the EITC,[72] the refundable portion of the Child Tax Credit,[73] and payments made under the Temporary Assistance for Needy Families program.[74]

The standard argument for cash grants is that cash is the best way to satisfy preferences of the recipients "because preferences vary and individuals tend to have better information about their own situations than does the government."[75] People are best positioned to determine their own specific needs and wants, and cash assistance allows them to address their own challenges with maximum flexibility. According to this view, cash grants can minimize administrative costs, making government expenditures more effective.

A related benefit of cash grants, particularly appealing to libertarians, is that cash grants give the recipient a measure of decisional autonomy, which has value in and of itself. Because the sums in the grant can be exhausted, the recipient presumably will act more responsibly in making expenditures than if he or she did not face a budget.

Where goods or services are already exchanged in efficient private markets, a cash grant may be the most effective way to give people access to the range of items available in those existing markets. For example, consider a food subsidy: there already exists a well-developed market for consumer food purchases, with competing supermarkets, extensive distribution networks, and adequate supplies provided by local, national, and international producers. A food subsidy could be provided in-kind, in which case the government might create a parallel distribution system to deliver food to individuals who meet certain qualifications. But the government would also need to determine how much food each family needed and what sort of food would be appropriate. Since food is perishable, this would be an ongoing process, not simply an annual or even monthly distribution. Alternatively, a

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[71] We recognize that cash grants, at some level of abstraction, are indistinguishable from features of the tax code that reduce tax liability and from in-kind welfare benefits. *Compare* Daniel N. Shaviro, *Welfare, Cash Grants, and Marginal Rates*, 59 S.M.U. L. Rev. 835, 840 (2006) (arguing that "cash grant" is in practice shorthand for "non-income-conditioned cash or in-kind grant," a broad definition that includes economic equivalents), *with* David A. Weisbach & Jacob Nussim, *The Integration of Tax and Spending Programs*, 113 Yale L.J. 955 (2004) (advocating converting the Supplemental Nutrition Assistance Program ("SNAP"), which provides in-kind benefits through a process that involves certifying SNAP vendors, into a cash grant program for administrative convenience).

[72] 26 U.S.C. § 32 (2012); Leslie Book, David Williams & Krista Holub, *Insights from Behavioral Economics Can Improve Administration of the EITC*, 37 Va. Tax Rev. 177 (2018).

[73] 26 U.S.C § 24. *See generally* Jacob Goldin & Zachary Liscow, *Beyond Head of Household: Rethinking the Taxation of Single Parents*, 71 Tax L. Rev. 367 (2018).

[74] Near-cash grants, for example Section 8 housing vouchers which operate as cash to the voucher holder, share some or all of the benefits and detriments that we explore here. However, for simplicity in this discussion, we set vouchers aside.

[75] Louis Kaplow, The Theory of Tax and Public Economics 175 (2008).

cash grant allows consumers to plug directly into the existing private food distribution network. Indeed, for precisely this reason, the Supplemental Nutrition Assistance Program ("SNAP")[76] is administered by providing debit cards for use at certified grocery stores.[77]

Additionally, where a private market is a desirable way to set prices or to prompt production, cash grants can provide the means for people to participate in the market and thus can help *make* a market exist. The introduction of Equitable HSAs allows for this to occur. In fact, advocates for HSAs often state that they want to *introduce* market forces (or stronger market forces) into the provision of healthcare products and services.[78]

Cash grants have drawbacks as well. Most obviously, the flip side of the flexibility that cash grants provide to the recipient is that cash grants make it challenging for policymakers to control precise behaviors, particularly as compared to in-kind benefits. This problem is most pronounced where the desired behavior is very specific, and a substitute behavior will not achieve the policy goal. For example, if the desired outcome is for the beneficiary to visit a doctor and receive an immunization shot, an unrestricted cash grant, even one limited to healthcare expenditures, would not be as effective as a provision conditioning the grant on proof that required immunization occurred. This would, of course, require developing an administrable enforcement mechanism for that requirement.

But the imposition of strict and specific requirements on cash grants starts to frustrate some of the benefits of cash grants. Program administration becomes more cumbersome and expensive, and the benefits of flexibility and autonomy start to fade. In the immunization example, while a highly circumscribed cash grant might be possible, perhaps a better solution would be to directly fund the immunization via insurers or healthcare providers so that a patient can show up at the doctor's office and receive shots without paying. In these circumstances, an in-kind system seems preferable.[79] Still, in these contexts, technology, such as debit cards with restricted uses, can be helpful. Nonetheless, the greater the restrictions, the more the cash grant starts to look like a voucher.

Cash grants also face political challenges. Even modest cash grants can stoke suspicion and resentment that has turned public opinion against grants at times. One source of skepticism concerning cash grants is that recipients

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[76] 7 U.S.C. §§ 2011–2036 (2012).

[77] *See* Rep. Rosa L. DeLauro, *Why America Should Save SNAP*, 52 HARV. J. ON LEGIS. 267, 271 (2015).

[78] For example, Kevin Brady (R-Tex.), the chair of the House Ways and Means Committee, recently emphasized "individual choice" and "competition" in advocating for expansion of HSAs. *Chairman Brady Opening Statement at Markup of Health Bills*, HOUSE COMM. ON WAYS & MEANS (Jul. 11, 2018), https://waysandmeans.house.gov/chairman-brady-opening-statement-at-markup-of-health-bills/ [https://perma.cc/UG89-B8SC].

[79] *See generally* KAPLOW, *supra* note 75, at 176 (discussing how government interventions can give rise to positive externalities and suggesting that many initiatives, including immunization, may be better pursued through in-kind benefits than through cash transfers).

will misuse the money—perhaps in a manner that, beyond simply failing to accomplish the policy goal, fully undermines or moves away from the desired outcome. This precise issue is a perennial critique of the SNAP program.[80]

### *B. Guidelines for Cash Grants as Social Policy*

This Section provides guidelines for using cash grants to achieve social policy goals. The subsidy amount and form of delivery should be deliberately set to facilitate participation in the target market. Failure to make the subsidy amount fit the task in this way is one of the fundamental problems with existing HSAs. For example, under current policy, the subsidy amount bears no relation to the deductible amount required for participation in the HSA under a high-deductible plan.[81] Further, because the form of the subsidy (a deduction) essentially requires participants to have extra expendable income and because there is no mechanism to compel spending on medical care, the subsidy is essentially converted into a subsidy for savings.[82]

A better approach starts with the policy goal, identifies the market, and works from there to arrive at the appropriate subsidy. In the case of HSAs, the policy goal is broader access to affordable healthcare. The market (many markets, really) is the market for all out-of-pocket healthcare expenses. Out-of-pocket expenses include amounts paid due to a deductible and amounts paid for goods and services not covered by insurance, such as over-the-counter medication.[83] The subsidy amount is slightly more than the median out-of-pocket expenditure, allowing most people to cover most expenses in most years. This also allows people to use the HSA to save additional money for years when they may have higher expenses.[84] The delivery mechanism is designed to promote market participation. People who lack resources to save for medical expenses receive a cash grant (that is not tied to filing a tax return or some other timing mechanism, which is a mismatch with the nature of the spending). Those who have some resources are encouraged to set aside money for medical expenses. People with plenty of expendable income receive no subsidy.

If the subsidy is miscalibrated, as is the case with existing HSAs, it will be ineffective. Existing HSAs provide billions of dollars in subsidies each year, but those subsidies generally benefit people who already have expend-

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[80] *E.g.*, Anahad O'Connor, *In the Shopping Cart of a Food Stamp Household: Lots of Soda*, N.Y. Times, Jan. 13, 2017, at A1, https://www.nytimes.com/2017/01/13/well/eat/food-stamp-snap-soda.html [https://perma.cc/YDR5-CV6E].

[81] *See supra* notes 12–14, 32–35 and accompanying text.

[82] *See supra* notes 12–14, 32–35 and accompanying text.

[83] These expenses could also include the cost of health insurance. In our Equitable HSA proposal, we implicitly account for the out-of-pocket cost of health insurance and do not require health insurance as a prerequisite for receiving the HSA subsidy.

[84] The mean expenditure is significantly higher than the median expenditure because most out-of-pocket spending is by a small group. *See supra* note 41.

able income, i.e., those who do not need help to become healthcare consumers. The original design concept was that the HSA would only be available to people in high-deductible plans, which presumably would encourage people to act more like consumers than they might otherwise because they have more at stake. But the deductible amount is not calibrated to any particular healthcare needs, nor is the subsidy amount.

Additionally, any conditions attached to the cash grant or other subsidy should reflect the program's substantive policy and distributional objectives. If the purpose of the program is to preserve the benefits of consumer autonomy, administrative requirements need to be kept to a minimum. If the purpose is to promote spending on healthcare, it is not clear why HSA funds should be used for any non-healthcare purpose without loss of subsidy and incurring a penalty.

Regulatory conditions unrelated to core policy goals should be closely scrutinized. For example, in summer 2017, various Republican proposals limited HSAs to high-deductible plans that eliminate coverage for abortions.[85] Had this provision been enacted, it likely would have significantly limited the use of HSAs because many individuals would be reluctant to move to a plan with that restriction, as would many employers. Thus, the use of the market-based policy to regulate behavior in a way that is not targeted to either facilitating the market mechanism or to the redistributive goal could potentially undermine the entire endeavor.

As a general rule, all elements of the policy should be germane to the joint goals of promoting healthcare markets and allowing full participation in those markets through progressive subsidies.

### *C. Broader Policy Implications*

Many market-based policies enacted since the early 1980s have not included the cash grant mechanism and have tended to reduce redistributive benefits by shifting risks from government to private individuals, leaving individuals to fend for themselves more often and in more contexts.[86] Both the shift toward market-based policies and the disregard of distributional effects have been encouraged and reinforced by academic commentators. Most prominently, a fundamental principle of the law and economics movement holds that legal rules should optimize efficiency, and such rules should be set without regard for distributional effects.[87] Under this approach, any

[85] *E.g.*, American Health Care Act of 2017, H.R. 1628, 115th Cong. § 202 (2017), https://www.congress.gov/bill/115th-congress/house-bill/1628 [https://perma.cc/AQJ6-FJAZ].

[86] Examples of market-based policies include 401(k) and 403(b) retirement savings accounts (which have widely replaced defined benefit plans for private and public sector employees alike), and public charter schools, school choice programs, and private school vouchers, all of which are touted as allowing students and parents to shop between schools and incentivizing schools to compete for students, but arguably merely shift the burden of dealing with underperforming schools. *See* 26 U.S.C. §§ 401(k), 403(b) (2012).

[87] *See* Louis Kaplow & Steven Shavell, Fairness Versus Welfare 31–35 (2002).

distributional considerations should be dealt with through the tax and transfer system (i.e., separately and independent of the legal rule regime).[88] Many commentators who are enthusiastic about this framework often focus on the first part—efficiency optimization—and disregard or assume away the equity-redistributive element.[89]

Recently, however, economic inequality has gained greater attention.[90] Support along the ideological spectrum for cash grants as a way to promote market participation with attention to distributional effects offers hope of moving past partisan wrangling whereby progressives and market libertarians are essentially unable to engage with one another because they perceive their policy goals to be mutually exclusive. This unity is particularly surprising in the broad enthusiasm for universal basic income proposals.[91] The Equitable HSA proposal presented here follows this same thread, albeit in a more targeted context.

## V. Conclusion

It is past time for HSAs as they currently exist to be reexamined and reformed. Equitable HSAs can help control costs without sacrificing healthcare consumer autonomy, focusing government subsidies in a way that increases the government's bang-for-its-buck in promoting informed consumption of healthcare services. At the same time, Equitable HSAs can strengthen the progressivity of the tax code. This should be a win-win for proponents of market-based policy solutions, as well as for egalitarians concerned with equity in government aid. Equitable HSAs also help illuminate the utility of cash grants as a policy mechanism that can potentially bridge the divide between Democrats and Republicans on some social programs.

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[88] *See id.*

[89] *See id.* at 32 ("[T]here are sound reasons for much normative economic analysis of law not to take explicit account of the distribution of income."). Of course, some have addressed distributional considerations as well. *See* Revesz, *supra* note 10. *See generally* Robert N. Stavins, *A Meaningful U.S. Cap-and-Trade System to Address Climate Change*, 32 Harv. Envtl. L. Rev. 293 (2008) (arguing for a United States cap-and-trade system for carbon dioxide emissions that would auction carbon dioxide allowances to companies, increasing the auctioned amount over time—the profits of which could, in turn, be redistributed to reduce taxes, reduce the costs of the tax system, and provide other socially beneficial policies).

[90] Some scholars have begun to reconnect issues of economic inequality with the decades-long move towards reliance on private markets. *See, e.g.*, David Singh Grewal, *The Laws of Capitalism*, 128 Harv. L. Rev. 626 (2014) (reviewing Thomas Piketty, Capital in the Twenty-First Century (2014)). And some have started to push back against the perceived obsession with markets and efficiency in policymaking. *See* Wendy Brown, Undoing the Demos: Neoliberalism's Stealth Revolution (2015).

[91] *See* Glogower & Wallace, *supra* note 9.

## Appendix: Phaseout Options

This Appendix details one possible approach to the transition points between (1) the cash grant subsidy delivery mechanism that is available for low income people, (2) the 100% credit available for higher income people, (3) the 50% credit available to even higher income people, and (4) the phaseout of the 50% credit so that the highest income people do not receive any upfront subsidy for contributions to HSAs.

As represented on Figure 1 and the accompanying table, for a family of four and a subsidy amount of $300 per individual (note that this subsidy amount could be more—we propose up to $1000 per individual), households with income up to $125,000 (which is four times the poverty line) would receive a cash grant of $1200. For each $10 earned above $125,000, the cash grant would be reduced by $1; thus, the cash grant would be entirely phased out once income reaches $137,000. *See infra* Figures 1, 2. Over that same range, a 100% credit would be available, so that an individual contribution of $1 yields a credit of $1. *See infra* Figures 1, 3. This approach incentivizes households to put additional funds into the HSA if they are on the higher end of the cash-grant range, and reduces the "penalty" for increased earnings if they are in the phaseout range. The total subsidy amount remains capped at $1200 (based on same limitation as described above for the cash grant: $300 for each person in the household).

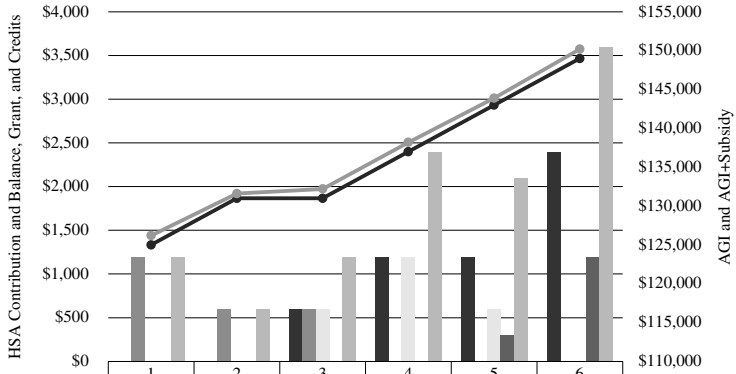
Above the phaseout range, the credit is available at a 50% rate. *See infra* Figures 1, 3, 4. For example, if the family of four introduced above earns $131,000, the cash grant is reduced by $600 ($6000 over the threshold, reducing the cash grant by $1 for every $10 yields $600). If the family contributes $1200 to the HSA, they will receive a cash grant of $600 and a matching credit of $600, so that they have a total of $2400 contributed to the HSA. *See infra* Figure 3.

If income is above the cash grant phaseout range, the credit percentage is 50%: Every $1 contributed to the HSA yields a credit of $0.50. For example, if the family of four earns income of $143,000 and makes a contribution of $1200 to the HSA, they will receive a total subsidy of $900, of which $600 is from the 100% credit and $300 is from the 50% credit. *See infra* Figure 3. If that same family contributes $1800 (or more) to the HSA, they will receive a total credit of $1200, of which $600 is from the 100% credit and $600 is from the 50% credit. *See infra* Figure 4.

A phaseout similar to that illustrated in Figure 4 will occur for households exceeding ten times the federal poverty line. For every $10 over that threshold, the credit amount will be reduced by $1. Thus, if the threshold for a family of four is $250,000, at that precise income level the family can contribute $2400 to the Equitable HSA and receive a tax credit of $1200 at the 50% rate. If the household earns $250,010, the credit will be reduced to $1199. Of course, the household may make additional contributions to the

HSA up to the annual deductible amount of the qualifying insurance coverage, but there is no immediate tax benefit for those contributions.

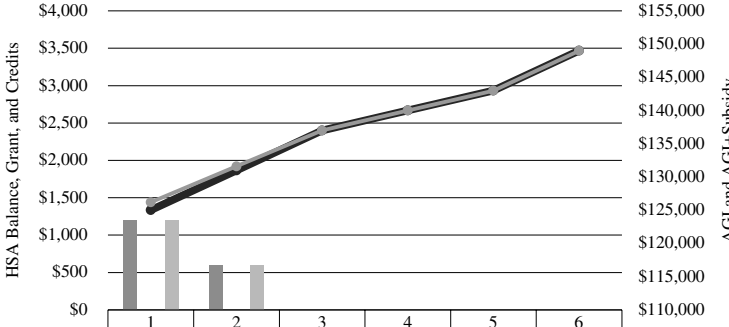
FIGURE 1: EXAMPLES OF PHASEOUT FROM GRANT TO CREDIT




| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Non-Subsidy Contrib. | $0 | $0 | $600 | $1,200 | $1,200 | $2,400 |
| Grant | $1,200 | $600 | $600 | $0 | $0 | $0 |
| 100% Credit | $0 | $0 | $600 | $1,200 | $600 | $0 |
| 50% Credit | $0 | $0 | $0 | $0 | $300 | $1,200 |
| HSA Balance | $1,200 | $600 | $1,200 | $2,400 | $2,100 | $3,600 |
| AGI | $125,000 | $131,000 | $131,000 | $137,000 | $143,000 | $149,000 |
| AGI + HSA Subsidy | $126,200 | $131,600 | $132,200 | $138,200 | $143,900 | $150,200 |

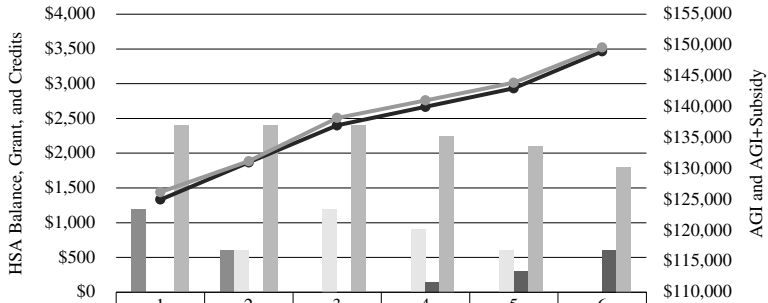


FIGURE 2: NON-SUBSIDY CONTRIBUTION OF $0




| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Grant | $1,200 | $600 | $0 | $0 | $0 | $0 |
| 100% Credit | $0 | $0 | $0 | $0 | $0 | $0 |
| 50% Credit | $0 | $0 | $0 | $0 | $0 | $0 |
| HSA Balance | $1,200 | $600 | $0 | $0 | $0 | $0 |
| AGI | $125,000 | $131,000 | $137,000 | $140,000 | $143,000 | $149,000 |
| AGI + HSA Subsidy | $126,200 | $131,600 | $137,000 | $140,000 | $143,000 | $149,000 |

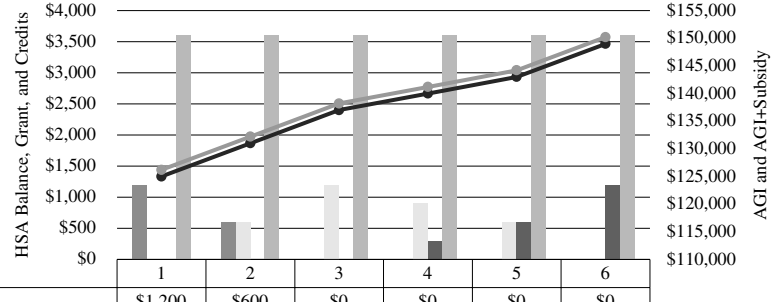
FIGURE 3: NON-SUBSIDY CONTRIBUTION OF $1200




| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Grant | $1,200 | $600 | $0 | $0 | $0 | $0 |
| 100% Credit | $0 | $600 | $1,200 | $900 | $600 | $0 |
| 50% Credit | $0 | $0 | $0 | $150 | $300 | $600 |
| HSA Balance | $2,400 | $2,400 | $2,400 | $2,250 | $2,100 | $1,800 |
| AGI | $125,000 | $131,000 | $137,000 | $140,000 | $143,000 | $149,000 |
| AGI + HSA Subsidy | $126,200 | $131,200 | $138,200 | $141,050 | $143,900 | $149,600 |

Grant 100% Credit 50% Credit HSA Balance AGI AGI + HSA Subsidy

FIGURE 4: NON-SUBSIDY CONTRIBUTION OF $2400




| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Grant | $1,200 | $600 | $0 | $0 | $0 | $0 |
| 100% Credit | $0 | $600 | $1,200 | $900 | $600 | $0 |
| 50% Credit | $0 | $0 | $0 | $300 | $600 | $1,200 |
| HSA Balance | $3,600 | $3,600 | $3,600 | $3,600 | $3,600 | $3,600 |
| AGI | $125,000 | $131,000 | $137,000 | $140,000 | $143,000 | $149,000 |
| AGI + HSA Subsidy | $126,200 | $132,200 | $138,200 | $141,200 | $144,200 | $150,200 |

Grant 100% Credit 50% Credit HSA Balance AGI AGI + HSA Subsidy