Inside Highlights

"Nobody spends somebody else's money as wisely as he spends his own." —Milton Friedman

Wealth Creation Strategies

Tax and Financial Strategies

 Issue #20, February - April 2005

Health Savings Accounts: A Paradigm Shift in Health Care

"Under socialism, bureaucratic decisions are substituted for consumer decisions."
—Anon.

"As the price of any product approaches zero, the demand tends to approach infinity."
—Llewellyn H. Rockwell, Jr.

What is a Health Savings Account?

A Health Savings Account (HSA) is a tax-favored account from which funds can be drawn tax-free to pay for out-of-pocket uncovered medical expenses. It must be paired with a special High Deductible Health Plan (HDHP), which is insurance coverage with a minimum deductible of $1,000 and maximum of $2,500 for single people, $2,000 and $5,000 for families (annually adjusted for inflation after 2004). The HDHP cannot require total annual out-of-pocket expenses, including the deductible, of more than $5,000 for single coverage and $10,000 for families. The HSA can be funded each year with an amount up to the annual deductible of the HDHP (plus, for 2004, a $500 "catch-up" payment for those 55 and over, increasing by $100 per year until 2009).

What do I save by investing in an HSA?

Contributions to HSAs reduce Adjusted Gross Income (AGI), which results in tax savings even for those who don't itemize deductions. Reductions in AGI are more powerful than itemized deductions because they can reduce Social Security income subject to tax and increase an array of other deductions and credits. These include allowable rental real estate losses, educational deductions, the Earned Income Credit, the Low Income Savers Retirement Credit, deductible portions of IRAs, allowable Roth IRAs and child tax credits. These additional benefits can result in savings far in excess of what the nominal marginal tax bracket may indicate. Fortunately, if it's already set up, we have until April 15 to fund the previous year's HSA, which means we may be able to reap some surprising tax windfalls with small increases in HSA deposits.

What can my HSA pay tax-free?

Funds deposited in an HSA can be used to pay for any qualifying out-of-pocket medical costs, including deductibles, co-payments and such generally uninsured medical expenses as eyeglasses, over-the-counter medications, chiropractic care and acupuncture. While long-term care insurance premiums can be paid via an HSA, optional cosmetic surgery is excluded. Once set up, qualifying medical expenses may continue to be paid by an HSA even when the account owner no longer has a High Deductible Health Plan.

Am I eligible for an HSA? How do they differ from MSAs?

Unlike its predecessor, the Medical Savings Account (MSA), almost anyone can deduct contributions to an HSA. There are only four exceptions: (1) a person claimed as a dependent on someone else's tax return (such as children), (2) individuals eligible for Medicare, (3) those covered by a non HDHP plan, and (4) those with no plan at all. A spouse not covered by his or her spouse's non-HDHP plan can have his or her own HSA. "Non HDHP" plans do not include the normal medical coverage under auto and other property insurance, insurance for specific maladies (such as cancer insurance), and insurance providing a fixed payment for hospitalization. In addition, a qualifying HDHP plan, while generally prohibited from paying medical expenses until the yearly deductible is satisfied, can pay for any and all "preventive care." Such care includes routine prenatal and well-child care, immunizations (both adult and child), and certain prescription drugs used to prevent heart attacks, treat obesity or help the participant quit smoking. A number of surprising programs, tests and procedures are also considered "preventive," including tobacco cessa-

tion and obesity programs, annual physical examinations including related tests, and screening for a wide variety of maladies. Coverage for screening is allowed for many cancers, heart and vascular diseases, addictions, diabetes, pediatric conditions, glaucoma, hearing impairments and dental diseases. Congress may have felt that the long-term savings from such screening may exceed the immediate costs by a large multiple. Even many politicians have come to realize that an ounce of prevention is worth a pound of cure.

MSAs were far more limited in scope, availability and flexibility. While they were limited to employers having no more than 100 employees, there is no such limitation for HSAs. Contributions to MSAs were limited to 65% to 75% of the annual deductible, with no "catch-up" provisions for those 55 and over. While the number of nationwide participants was limited to 750,000 in what Congress considered an "experiment", there is no limit as to the number of people allowed HSAs. Contributions to MSAs had to be made by December 31; however, like IRAs, HSA owners have until April 15 to make and deduct contributions for the preceding year. Unlike IRAs, however, there are no income limitations for deductible contributions to HSAs.

Are there any special rules for the first year of an HSA?

The allowable contribution is pro-rated based on the number of months a participant is enrolled in a qualified HDHP. For years subsequent to 2004, the allowable contribution is also pro-rated based on the number of months the HSA is open. For 2004 only, participants have until April 15, 2005 to fund a new HSA up to the allowable maximum based on the period of time the person was enrolled in an HDHP during 2004. Qualified medical expenses must be incurred only after an HSA has been established. However, for 2004 only, payments for qualifying 2004 expenses incurred after enrolling in an HDHP are exempted. For example, a taxpayer enrolling in an HDHP on June 1, 2004 is given until April 15, 2005 to set up and invest up to seven-twelfths the normal HSA limit (for the seven months she had the HDHP), and may reimburse any allowable medical costs incurred after May.

Can I get my employer to chip in?

While MSAs had to be funded either by the employer or employee, HSAs can be funded by either or both in any combination, as well as by a salary reduction agreement or "cafeteria" plan. This provides far greater flexibility to large employers, allowing for experimentation to see what combination of contributions and deductibles works best. Large employers and their employees may both benefit by switching to HDHPs with HSAs, which the employer may partially or completely fund. Whole Foods Markets recently introduced high deductible plans with an HSA that they largely fund. The results have been dramatic: overall medical costs fell 13% from the previous year and hospital admissions plummeted by 22%. The company estimated it spent the same amount per employee for all health coverage as before, including even its deposit into the HSA, in a period during which traditional health insurance premiums increased by almost 14%.

While an employer who makes contributions to employees' HSAs must make comparable contributions available on behalf of all employees with comparable coverage during any one period, the flexibility afforded under the HSA rules are far greater than under the old MSA rules. In addition, employer contributions are free not only of income tax, but also Social Security and Medicare tax, further reducing the after-tax cost of HSAs to both employers and employees.

Can I spend it all? Should I spend it all?

The HSA is the employee's to use as he or she wants, regardless of who funds it. It can be kept and used indefinitely. While contributions can be made only until one is eligible for Medicare, acquires a non-HDHP insurance plan or becomes uninsured, funds can be spent on any qualifying medical expense until nothing is left. Such expenses include not only those for which Medicare doesn't pay, but also Medicare Part A & B premiums and non-Medicare insurance premiums other than Medigap policies. Upon the death of an HSA owner, the spouse (if the named beneficiary) can take over the HSA as his or her own. Non-spouse beneficiaries are immediately taxed on any balance in the HSA, except amounts used for qualifying medical expenses of the decedent within one year of death. The HSA is also an asset that can pass between spouses in the event of divorce. The Ownership Society that Mr. Bush seems to hope to leave as his legacy provides us with rights that will increase our long-term security, as opposed to giving a false sense of security at the expense of economic freedom.

The Ownership Society allows you full ownership over the HSA as long as the funds are spent, at some point, on qualified medical expenses. You have only to pay taxes at your tax rate on funds used for non-medical expenses if age 65 or over, and tax plus penalties if under age 65. Planning opportunities similar to those for IRAs and other retirement plans may crop up, including the non-medical use of funds in low-income years; however, such funds cannot be re-deposited except through normal allowable contributions.

What should I invest my HSA funds in?

While only a few banks offered to play trustee for MSAs (of which there were too few), many brokers and mutual funds are already offering HSAs. Although inappropriate for people who spend most of their HSA each year, some, particularly high-income earners ineligible for IRAs, may view them as retirement vehicles. Many of us, however, will likely regularly use the funds deposited into an HSA and prefer the ease of payment for medical expenses afforded by a bank debit card or check-

book. Many will seek to forgo the reimbursement paperwork required of a stock account HSA. In addition, many will likely prefer to avoid market risk, opting instead for the safety of a bank account for what may be a near-term need of the funds. On the other hand, some young people with few current medical expenses may opt for the stock market approach, hopefully growing their HSAs over many years before regularly dipping into them.

Do HSAs also save state income taxes?

Some states (including, as usual, California) have not yet conformed to the new federal rules. For state income tax purposes, this means that an HSA contribution isn't deductible and the earnings are taxable, potentially creating a bit of an accounting nightmare. It is hoped that readers will lead the charge in demanding that their state conform to federal HSA rules.

This is particularly important in bellwether states such as California. The state legislature under former Governor Gray Davis voted to require large companies to provide health insurance coverage for all employees. Fortunately, voters overturned this mandated coverage in the recent election, which would have used the heavy hand of inflexible government rules to require low deductibles, low co-payments and further decrease market incentives to reduce overuse of scarce medical resources. Such required coverage would likely have increased demand for a total government takeover of medicine, especially by companies forced to provide such coverage. If you want to get an idea of what such a system would look like if government run, consider the Postal Service, the Transportation Safety Administration (can you imagine the uproar if a private company engaged in the practices that have recently been reported?) and an educational system that struggles to teach even the basics.

Why are HSAs a good idea?

I am among the most ardent critics of President Bush's propensity to spend funds the government doesn't have. However, I am a huge supporter of his idea of an Ownership Society. As economist Milton Friedman puts it, "Nobody spends somebody else's money as wisely as he spends his own." Expenditures for medical care have proven this, almost to the point of breaking the system, even if we have the most advanced medicine on the planet. Few people have any incentive to be "smart" shoppers of medical care, carefully weighing costs vs. benefits as we do for virtually all our other purchases. Because someone else is paying so many of our medical bills, we are often unaware of the cost and usually don't even care.

The problem of hiding the cost of health care from consumers resulted from a classic case of "the law of unintended consequences," wartime wage and price controls-during WW2. Price controls over wages, which many employers sought to dodge in order to hire better-qualified employees, didn't cover medical insurance premiums for which the employer footed the bill. Since out-of-pocket medical expenses were paid with after-tax dollars, the incentive to purchase insurance covering all medical costs from the first dollar became irresistible. Medical consumption began its progression toward an all-you-can-eat buffet.

Medicare and Medicaid, whose birth was a central tenet of Lyndon Johnson's "Great Society," further decreased the incentive on the part of patients to make cost-conscious decisions. With third-party payers responsible for 90% of the bill, market incentives have evaporated. If third parties paid for our automobiles, we'd all be driving Mercedes, after waiting ten or twenty years to get them.

Health Savings Accounts are a bold attempt to reverse the heavy hand of government paternalism by reducing the demand for government services. Since we are far more likely to carefully watch our own money, expenditures for health care should grow slower than when shopping with other peoples' credit cards. I'd suggest that if everyone were required to combine an HDHP with an HSA, overall expenditures could even drop, resulting in medical cost deflation, but I'd probably be laughed at. I will however say that, in the aggregate, we are likely to get a lot more for our money.

If HSAs are such a good idea, why hasn't my employer offered an HDHP?

HSAs have taken off slowly since introduced at the beginning of 2004 via the Medicare Act providing prescription drug benefits for seniors on December 12, 2003. However, the rules were initially unclear and the learning curve took its toll (this article, for example, has been in the works for a year and relied on over 40 sources). Most large employers designed their insurance options for 2005 by mid-2004, but the Treasury department took that long to respond to questions about their administration. Therefore, the big rollout should occur in 2006. Congress predicted that one million accounts would be opened in 2004 and three million by 2013. My prediction, based on the typical human response to incentives and the desire to save taxes, is that this expectation will be exceeded my many multiples. South Africa's experience can be used to base such a prediction. After Nelson Mandela's government deregulated South Africa's private insurers in 1994, plans similar to our HSAs quickly captured two-thirds of their market.

HSAs seem overly complicated. Why not just socialize the whole system?

Consider our own form of socialism, Medicare, which often pays too much for the wrong things and too little for the right ones. It pays a fixed amount to treat a specific diagnosis or perform a given procedure, regardless of outcomes. By making sure its doctors prescribe the most effective antibiotic for pneumonia patients, for example, Intermountain Health Care, with a network of 21 hospitals in Utah and Idaho,

figures that while saving 70 lives per year, they lose money on those patients, for which Medicare pays about $5,000 each. When a pneumonia patient deteriorates so much she needs a ventilator, Intermountain collects $19,000 under the Medicare system-and makes money. Duke University's Medical Center improved the health of heart patients by taking an innovative approach to treatment, which dramatically reduced hospitalizations. The more their innovations improved health, the more they lowered costs-and the more money the center lost in treating Medicare patients. According to one study, so many patients are being over-treated or not being treated early and properly, an estimated third less could be spent on Medicare with similar overall outcomes, if there was a more rational allocation of payments for scarce medical resources. Medicare already controls prices which, if not for the safety valve afforded by non-Medicare enrollees, would likely result in dramatic shortages of certain kinds of care. Even Presidential candidate Howard Dean back in 1993 said, "Medicare is the best argument I know why the federal government should never be allowed to run a health-care program. You'd destroy the health-care system in this country if you had Medicare for everybody."

Consider, too, the government-run health systems in other countries, which spend far less than we do on medical care. Yet, our share of government spending on medical care for just the elderly and indigent via Medicare and Medicaid is roughly equal to the share of government spending on everyone in Japan, Britain and Holland (each at about 7% of Gross Domestic Product). If our system is so much better, why do we spend far more as a nation on health care than do countries whose governments pay a greater percentage of all medical care? There are many reasons, of which these are but a few:

1. We have the most and most advanced technology on the planet.

For example, the number of MRI (Magnetic Resonance Imaging) scanners is mind numbing when compared with others. There are more such scanners in the greater Pittsburgh area alone than in all of Canada. Socialism saves money through non-investment. We are far and away the world's leader in biotechnology and medical care equipment technology.

2. We subsidize medical care in and for other countries. We subsidize research and development of drugs because other countries, having monopolistic buying power when dealing with pharmaceutical companies, can get away with paying amounts that barely exceed the manufacturing costs for pills. (Any rational manufacturer will, if push comes to shove, make deals to sell some of their products for variable costs plus a small amount, barely covering their marginal costs of production. However, they can't do this with everyone if they expect to pay for fixed costs such as R & D and equipment.) Canadians, therefore, are free-riding on the coattails of Americans, paying little or nothing toward the cost of developing new pills that more effectively treat everything from AIDS to heart disease, make us more comfortable and keep us alive longer. In addition, we pay the cost of treating illegal immigrants, thereby increasing the demand by foreigners to illegally enter our country. (Note: I prefer open borders, so long as we protect ourselves against potential terrorists. However, we need to require that once here, everyone pays his or her own way.)

3. We refuse to put up with queuing. While any American can get a much-needed hip replacement in a matter of days or, at most, weeks, the projected wait for such surgery in British Columbia is 52 weeks. The government itself uses private clinics for Royal Canadian Mounted Police, provincial workers' compensation cases and prison inmates. Ordinary Canadians are prohibited from using private clinics; hence, the Canadian joke: one prisoner asks another, "what are you in for?" "Hip replacement." This is not an isolated example. The average wait time from referral by a general practitioner to specialist in Canada is four months; even for critical diseases such as cancer, the shortest median wait among its provinces is six weeks. Ten thousand breast cancer patients since 1997 in Quebec alone have had to wait more than eight weeks each for post-surgery radiation therapy. They have even managed to create a form of queuing for pharmaceuticals. In order to save funds, Canadian health authorities delay the introduction of new, life enhancing and more expensive drugs. In one recent three-year period during which over 100 new drugs were made available to the American market, only 43 made it to market in Canada.

4. Our medical providers earn more than their counterparts in other countries. A law in Quebec enacted in 1970, a few years after the government takeover of the Canadian medical system, required doctors who objected to the new Medicare law to continue working under penalty of imprisonment and imposed fines of up to $500 per day spent away from their practices. (Their view, then, of a "right to health care" includes enslaving unwilling workers.) A Canadian kidney specialist admitted he could earn five times more in the U.S. While during the first five years of Canadian Medicare there were no strikes, there are now hundreds of thousands of workdays per year lost due to strikes over wages and working conditions.

Monopolies also have a way of increasing rudeness on the part of employees, along with a lack of responsiveness to consumer needs. Remember how difficult it was to deal with your cable company before satellite cable began an earnest marketing campaign to win over consumers? Remember what the U.S. post office was like before the competition of the Internet forced its employees to be more courteous and responsive? A common complaint among Canadians is the frequent rudeness of medical personnel.

High deductible policies for everyone would go a long way to reducing spending by increasing incentives to shop wisely and avoid wastefulness.

However, because our standard of living is higher than almost every other country on the planet, we have more to spend. Some of our medical spending could be considered a "luxury" good: just as societies don't spend a lot on pollution control until basic needs are met, they don't spend a lot on increasing life spans by incremental amounts at the cost of tens of thousands of dollars. As the standard of living increases, there is an increased propensity to spend much of the additional wealth on health needs. The desire for the Fountain of Youth seems a part of human nature, and people are willing to spend enormous sums to find it. Therefore, even if overall spending is not likely to decrease, spending will be far more rational as increasing numbers of people acquire high deductible plans with HSAs. Costs of medical procedures will be increasingly balanced against impacts on health. Consumers are far more likely to demand lower cost solutions to health problems, even increasing the odds they will take their health into their own hands by maintaining a more healthy diet, engaging in healthier lifestyles and experimenting with far less expensive alternative medicine and nutritional approaches. Health Savings Accounts will greatly increase rational behavior among both medical consumers and providers.

HSAs only address demand. What else can be done to reduce the cost of medical care?

1. Huge medical malpractice awards have aggravated the situation. Physicians have an incentive to prescribe every conceivable test, resulting in an estimated $50 billion in annual "defensive" medicine to protect themselves from an out-of-control tort system. In one recent five-year period, awards paid by the nation's 2nd largest medical malpractice insurer more than tripled, while total premiums collected increased by barely over 20%. Underwriting losses of $940 million on $600 million in premiums resulted, followed by a decision to exit the malpractice insurance business. The number of companies willing to provide new malpractice insurance plummeted from 14 to one in Mississippi and dropped from 17 to four in Texas. Premiums have increased for obstetrics in many cases over the last decade from $10,000 to $100,000, resulting in a dearth of physicians willing to deliver babies in some states. Awards for medical malpractice need to be capped and the tort system needs to be reigned in.

2. Make High Deductible Health Plans deductible for everyone and prohibit deductions for low-deductible plans. Some groups in a Rand study lowered spending by as much as 30% when faced with higher deductibles and co-payments, seeking better value in their medical choices, without adversely affecting their health. In addition, because people love deductions, the number of uninsured people would likely drop by millions.

3. Out-of-state purchases of health insurance should be allowed. Because of mandates for all sorts of additional coverage required in New Jersey, the cost of insurance there is five times greater than in Connecticut.

4. There are more than 100,000 pages of Medicare regulations with which doctors, clinics and hospitals must comply. Medicare, which currently consumes 4% of Gross Domestic Product (GDP) will, if allowed to grow at forecast rates, swallow up 10% of GDP by 2040. The Medicare payroll tax, which began as a nominal .7% tax on wages up to $6,600 in 1966, has ballooned to a 2.9% tax on all wages, while average Medicare spending per enrollee has skyrocketed from $233 in 1967 to over $7,000 in 2004 (in constant dollars). Workers per Medicare recipient are projected to drop form just under four to less than two and a half in just the next twenty years. The long-term actuarial shortfall in taxes vs. spending on Social Security at some $10 trillion pales in comparison with that of the Medicare system, which is estimated to have a $72 trillion deficit using conservative growth-in-spending models. We need to deregulate and allow market forces to work for seniors before the system implodes. Create market incentives by requiring HDHPs and allowing HSAs for seniors, increasing deductibles and co-payments from the ridiculously low $100 now provided for Medicare recipients. Allow seniors to choose from competing private plans, subsidized by the Medicare tax to the extent politically necessary, but creating incentives up and down the income ladder.

5. While the new prescription drug benefit was considered a huge expansion of Medicare, it may turn out to be the opposite. A Columbia University study found that every additional $1 spent on pharmaceuticals reduced hospital costs by $3.65. The expected ten-year $550 billion increase in government spending, which even the "let's spend other people's money" Democrats lambasted, may turn into a dramatic decrease in spending, because it's smarter spending. However, it needs to be put on the same footing as other medical expenses by integrating it with "senior" HDHPs, which should allow first dollar coverage for "preventive" care along with other HDHPs.

6. Allow insurers to charge more for those with certain controllable conditions that are out of control, such as smoking, obesity and alcohol or other drug addiction. As The Economist magazine puts it, "If people want to eat their way to…an early grave, let them," but at their own cost.

I'm not ready to properly lay out and support a series of proposals for dealing with the interrelated problems of emergency room admissions and alcohol/other drug addiction. However, such recommendations will take into account several observations, from which you may be able to piece together some recommendations of your own. (1) 50% to 90% of ER admissions are directly or indirectly a result of alcohol or other drug addiction. (2) Roughly 350 secondary diseases and disorders are caused or aggravated by alcoholism. (3)

Although alcohol and other drug addicts represent only 10% of the population, because of the first two observations they are responsible for 25% to 50% of overall medical expenditures. Therefore, without adjusting for the severity of the disorders and medical interventions required, every percentage decrease in the number of practicing addicts may result in a savings of two and a half to five times that amount. Reducing the rate of addiction, then, may reap enormous leverage in reigning in skyrocketing medical costs. And the most important observation, (4) addicts generally enter rehab or AA only if coerced into doing so via credible threats of logical consequences.

Plan for Income Changes in November

For years, we have included a bright "please note" sticker on the cover letter sent with every tax return urging you to contact us if any major changes occur during the current year. Now is the time to add us to your calendar. Make a note now to contact us on the first Monday in November if there are any major changes in your situation. By doing so, you will eventually save a heap in taxes.

Some ask why we don't call you to ask if there are changes that could affect your tax and financial lives. Nineteen out of twenty would respond there are none, resulting in wasted time on our part and unnecessary return phone calls on yours. The vast majority of you experience relatively stable situations in most years. It's that oddball fifth, tenth or twentieth year that requires attention. Effective planning is best done during the year, not January 2nd of the following one.

We detail many instances of change for which we should be contacted on our "please note" sticker, as well as in newsletters. The obvious ones include large increases in income, proposed sales of property, impending marriage or divorce. The less obvious include large drops in income and, believe it or not, imminent death. At least two clients experienced a drop in income during 2004 that made conversions from traditional to Roth IRAs immensely profitable. Another two clients with large IRA balances and beneficiaries in high tax brackets opted to withdraw far more from their IRAs than they would have had death not been near. We'll soon learn who should have called in 2004, but didn't.

Retirement Plan Annual Limits

	2004	2005
IRAs and Roth IRAs	$3,000	$4,000
Over 49 years of age "catch-up" contributions — IRAs	$500	$500
401(k), 403(b), 457 plan employee deferral	$13,000	$14,000
Over 49 years of age "catch-up" contributions — 401Ks, etc.	$3,000	$4,000
SIMPLE plan employee deferral	$9,000	$10,000
Over 49 years of age "catch-up" contributions — SIMPLE's	$1,500	$2,000
SEPPs	$41,000	$42,000
Over 49 years of age "catch up" provisions — SEPPs	$3,000	$4,000

Remember to File 1099s

1099s must be filed on all non-corporate entities to which you paid over $600 in the course of operating your business or rental property during the year. We need name of recipient, address, taxpayer identification number (usually Social Security number) and amount paid in order to file these forms. While they are due January 31, you are far better off filing late than never. Also, if a California business or rental, the Franchise Tax Board must be notified within 20 days of entering into a contract to pay someone over $600. This must be done during the year and is required independently of the year end filing.

Tax Amnesty for Those Owing California Taxes

California is offering an amnesty to those who currently owe the state taxes, including income tax, sales tax, use tax and other taxes. In order to qualify, strict rules must be adhered to. Penalties for all sorts of infractions, including paying late, underreporting income, overstating deductions and failing to timely file returns increase dramatically after the amnesty period, which ends March 31. California is far more likely to seek criminal sanctions against errant taxpayers who do not participate in the amnesty. While our own clients are extremely unlikely to have anything to come clean about, you may know someone who does. If so, tell them that now is the time.