16 Geo. J. L. & Pub. Pol'y 315

Georgetown Journal of Law & Public Policy
Winter, 2018

Note

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MANDATORY HEALTH SAVINGS ACCOUNTS AND THE NEED FOR CONSUMER-DRIVEN HEALTH CARE

ABSTRACT

Yearly health care spending in the United States is now over $3 trillion and represents more than 17% of the country's gross domestic product. These figures are projected to increase substantially over the next decade, but such growth is unsustainable and would hamstring economic progress in the country. The traditional justification for the higher health care costs in the United States is that Americans receive superior care and are healthier. However, data shows that despite higher medical costs and greater public and private spending than in other countries, the United States has inferior population health and access to care. A key cause for these deficiencies is the preferential treatment in the Internal Revenue Code given to employer-sponsored insurance. This results in a distorted market economy that promotes hyper-consumption and gratuitous medical coverage because consumers are unaware of actual health care costs at the point-of-service. A shift to a consumer-driven health system would ameliorate many of these inefficiencies. Health savings accounts, in particular, are the ideal vehicle for such a transition because they preserve the tax benefits employees receive under the current employer-sponsored insurance model while also promoting rational and conscientious use of health care by consumers. Studies have substantiated this position, demonstrating that a shift to a health savings account system would save the United States as much as 400 billion dollars a year in health care spending. In order to begin the process of a sustained reformation of health care, however, health savings accounts must be implemented on a larger scale across the United States. Two legislative changes are required to achieve this: First, the scope of health savings accounts should be expanded and their current statutory restraints removed. Second, health savings accounts should become compulsory for all Americans and lawful residents.

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Health care costs in the United States are increasing at an unsustainable rate. In 2015, yearly health care spending rose 5.8% and accounted for over $3.2 ***317** trillion. [1] These health expenditures have risen to an astronomical $9,990 per capita and now represent 17.8% of the country's gross domestic product (GDP). [2] This upward trend shows no sign of abating over the next decade. From 2016 to 2025, health care spending is projected to increase at an average rate of 5.6% per year, which is estimated to be 1.2% faster than GDP growth over the same period. [3] Accordingly, the percentage of GDP represented by health care is projected to rise from 17.5% in 2014 to 19.9% by 2025. [4]

A. American Health Care in an International Context

The unsustainable growth of health care spending in the United States is more troublesome when compared against spending in other developed nations. In 2013, per capita spending on health care in the United States was $9,086, which was approximately 44% higher than the second highest nation and 148% higher than the median among Organization for Economic Cooperation and Development (OECD) countries. [5] One reason the United States devotes a higher percentage of its GDP to health care spending is that medical procedure costs are substantially inflated. [6] A computerized tomography (CT) scan in the United States, for example, costs approximately $900, while an identical procedure in Canada costs less than $100. [7] A magnetic resonance imaging (MRI) test in the United States generally costs $1,145, whereas the same test in Switzerland costs $138. [8] Also consider bypass surgery: in the United States the surgery costs over $75,000, but the same surgery in the Netherlands costs just under $16,000. [9]

***318** The myth justifying high U.S. health care costs is that higher health care spending and medical costs result in superior care in the United States. [10] Essentially, Americans tend to believe they are healthier and receive better health services. But this is patently untrue. In reality, the United States has among the poorest population health statistics, despite its higher health care spending. [11] For example, the prevalence of chronic diseases in the United States is higher than in other wealthy countries, as 68% of American adults ages 65 and older have at least two chronic conditions compared to figures ranging between 33% to 56% in peer nations. [12] The United States also struggles with life expectancy, with current figures at 78.8 years compared to the OECD median of 81.2 years. [13] The United States is similarly inferior in notable health categories such as adverse birth outcomes, sexually transmitted diseases, obesity, diabetes, lung disease, and heart disease. [14] Sadly, the gap between the United States and other countries continues to widen, with Americans' medical profligacy and poor lifestyle choices resulting in the United States ranking *last* in population health among affluent countries. [15] In the eyes of many researchers, the chief cause of these substandard population health statistics is the subordinate health care system in the United States. [16]

In addition to their inferior population health, United States citizens also have substandard public health care coverage relative to other countries. [17] The key deficiency is that the public health system in the United States does not make

efficient use of each dollar spent. In 2013, for example, public health spending amounted to $4,197 per capita. [18] In that same year, however, public health programs such as Medicare and Medicaid only covered 34% of the country's residents. [19] The National Health Service, by comparison, only spent $2,802 per capita in 2013 and still covered all United Kingdom residents while offering comparable health care services. [20]

*319 *B. Misperceptions Regarding Private Health Care Expenditures*

The common riposte to these poor public health care statistics is that the United States health system supplements public health expenses with private spending, as evidenced by annual private health care expenditures of approximately $3,442 per capita. [21] This is indeed a large number, and a 2015 multinational study found this amount to be five times larger than the private health care spending of the second highest nation. [22] But even with this supplemental private spending, the health care system in the United States still lags behind other countries. In particular, the United States falls below the OECD median in key areas such as (1) the number of physicians per capita, (2) the number of patient visits per year, and (3) hospital supply and patient discharge, demonstrating inferior access to medical care in the United States. [23] These deficiencies are partially explained by the fact that millions remain uninsured in the country, which often precludes them from having access to medical care. [24] However, many insured Americans in poor health voluntarily choose not to visit physicians because, based on the co-payment and deductible system in the United States, it can still cost anywhere between $30-$200 for a routine visit. [25] Thus, for many insured Americans, medical costs still remain prohibitive enough to constitute a *de facto* bar to health care access. [26]

This data demonstrates that despite higher public and private health care spending, Americans remain unhealthier and pay more for health services, all while having less access to medical care compared to countries with universal health care systems. [27] A change to the United States health care system is required to reverse these trends, otherwise the country will continue to fall further behind peer nations in terms of population health. Studies have additionally shown that persistently high health care spending will have deleterious consequences for the United States' overall economy, contributing to wage stagnation, personal bankruptcy, and budget deficits. [28] Accordingly, the United States will also trail peer nations economically if the current health crisis remains unresolved, as other countries will reap the benefits of larger and healthier work forces. [29]

*320 II. THE REASONS BEHIND THE INFERIORITY OF THE UNITED STATES HEALTH CARE SYSTEM

Before a plan can be formed to curtail these negative health care trends, it is important to understand the four key causes behind the inefficiencies of the United States health care system.

A. Tax Benefits Favor Employer-Sponsored Insurance

The tax benefits in the Internal Revenue Code (IRC) that favor employer-sponsored insurance (ESI) are a key cause of the suboptimal health system in the United States. The IRC advantages ESI by treating employer-provided health insurance differently than cash wages--whereas employees' cash wages are subject to payroll and income taxes, the amounts employees pay for their ESI health benefits are not subject to those taxes. [30] Thus, payroll deductions from employees' wages for ESI premiums actually lower employees' taxable income and thereby reduce their after-tax cost of health care coverage. [31] Employees therefore receive their ESI health benefits 100% tax-free. [32] This creates a significant incentive for employees to participate in ESI and pay for as much of their health care through employer-sponsored health plans as possible. [33]

The tax system also encourages employers to offer larger and more comprehensive health care packages. Any expenses employers incur by providing health insurance for employees are generally 100% tax-deductible from both federal and state income taxes. [34] In economic terms, this means that $1 in employer-provided health benefits actually costs the employer less than $1 in pay. [35] Employer-sponsored health plans have evolved to maximize this lucrative tax benefit. Accordingly, rather than providing an efficient insurance policy that enables consumers to advantageously select the amount of health coverage they actually need, ESI has become a comprehensive pre-payment plan. [36]

In light of the extensiveness and cost-effectiveness of ESI compared to other forms of insurance, it is unsurprising that most Americans choose ESI. [37] Indeed, even after the passage of the Patient Protection and Affordable Care Act ***321** (Affordable Care Act), ESI remains the leading source of health care coverage for the majority of non-elderly Americans (those under the age of 65). [38] Yet the widespread use of ESI perpetuates a regressive and costly system. Because the exclusion of premiums for ESI reduces taxable income, it is worth more to employees in higher tax brackets than those in lower tax brackets. Thus, the largest tax breaks are given to those who need them the least. [39]

These tax benefits also prove immensely costly to the federal government. Of the roughly $250 billion in yearly federal tax subsidies given to health care, the tax exclusion for ESI represents over $150 billion of that amount. [40] In addition, ESI tax subsidies generate more than $100 billion dollars in economic "efficiency losses" to the federal government each year. [41] And because the ESI tax subsidies are open-ended, there is no cap on the amount this tax distortion could cost the federal government. [42]

B. Consumer Culture of Over-Utilization Disregards Actual Health Care Costs

The extensive use of ESI has shifted control over health care away from the consumers and to third parties such as employers and insurance companies. [43] This paradigm shift has largely eliminated customer choice regarding health care providers and reduced competition among insurance companies, creating a distorted health care market that promotes hyper-consumption at a high cost. [44] Comparing the inflated costs in the American health care marketplace with that of peer nations once again demonstrates the magnitude of this distortion. For example, pharmaceutical spending per capita in the United States is almost 100% more than the OECD median. [45] Institutional spending is even higher, as the costs per patient discharged from the hospital are 200% more than the OECD median. [46]

The crux of the issue is that the insurance plans offered are generally broader and more expensive than healthy individuals actually need, since insurance ***322** companies and employers both benefit from higher ESI spending. [47] Accordingly, younger and healthier employees are prompted to choose "high-cost, first dollar" coverage while remaining unaware that they would be better served by advantageously selecting "low-cost, high deductible" coverage because of their lesser need for medical care. [48] And while employees receive this high-cost health care in the form of a tax benefit, opting into more health care coverage than needed still bears opportunity cost in terms of non-health expenditures or savings that could have benefitted the employees. [49]

The shift to third-party insurance also creates "moral hazard" problems in the health care system because consumers are not using their own money for medical costs at the point-of-service. [50] Indeed, of the $3.2 trillion spent on health care each year, only 11% represents consumers' out-of-pocket spending. [51] Individuals are therefore encouraged to consume more medical care than they otherwise would because third-party coverage under ESI insulates patients from the actual costs of care. [52] This distorts the normal supply-and-demand structure of capital markets, as actual health care costs rise without much of the "demand" component of the marketplace noticing or seeking alternative suppliers. [53]

The bottom line is that because individuals are not held directly responsible for their health care spending and utilization at the point-of-service, they have no incentive to curtail their over-consumption. [54] This has led to a steep increase in the costs of medical care and a creeping rise in health insurance premiums in the public and private sectors, both of which show no sign of abating. [55]

C. Current Health Insurance Lacks Portability

The deficiencies in the United States health care system are further exacerbated by the fact that individuals currently lack portability with their health insurance. Persons insured through ESI do not have actual ownership of their health care coverage, meaning that most Americans lose their health insurance ***323** when they leave employers. [56] This creates a socioeconomic dilemma. On the one hand, employees may feel obliged to stay in undesirable jobs to try and foster longstanding relationships with health care providers. Indeed, these established relationships are often considered prerequisites for quality care. [57] On the other hand, a static labor market undermines economic growth, since a mobile labor force is a necessary component for a dynamic and competitive economy. [58] Either result is suboptimal and undermines the general welfare of the United States.

D. Americans Choose Exceedingly Unhealthy Lifestyles

The final contributor to the inferiority of the United States health care system is that Americans lead exceedingly unhealthy lives. These unhealthy lifestyles, in turn, cause or exacerbate chronic illnesses that require additional health care spending and further deplete health resources. [59] The statistics themselves are disconcerting, as a 2016 study demonstrated that merely 2.7% of Americans live a "healthy lifestyle." [60] A "healthy lifestyle" was defined as a lifestyle that met four qualifications: (1) moderate or vigorous exercise for at least 150 minutes a week, (2) a diet score in the top 40% of the Healthy Eating Index, (3) a body fat percentage under 20% for men or under 30% for women, and (4) no smoking. [61] But Americans are more than just unhealthy--their health is deplorable. [62] As a prime example, the United States consistently ranks among the fattest countries in the world, with 36.2% of the population suffering from obesity. [63]

Health care spending in the United States will continue to rise if the population continues its descent into poor health. The unhealthy lifestyles of Americans increase their risk of developing chronic health conditions, meaning that poor health is certainly causing much of the widespread heart and lung diseases that are inflating medical costs. [64] Without comprehensive lifestyle changes among the American population, any health care reform will be unable to curtail the growing health expenses in the country.

III. THE NEED FOR CONSUMER-DRIVEN HEALTH CARE

A key undercurrent in the United States health system is that consumers are too detached from their own health care and require a sociological shift away ***324** from consumerism and to conscientiousness. [65]

A. Increased Consumer Involvement Will Lead to Greater Conscientiousness

Conscientiousness can be best achieved by forcing consumers to have greater "skin in the health care game," [66] as the only alternative would be invasive and expensive third party oversight by public and private health care providers. [67] This increased consumer involvement comports with the fundamental psychological tendencies of humans, who are most

willing to alter their behavior when directly affected by the consequences of their decisions. [68] It therefore seems logical that much of the current imprudence concerning health care decisions in the United States would be remedied by shifting to a more consumer-driven health system. While such a paradigm shift would not be a final, comprehensive solution to the myriad of health care issues in the United States, it would certainly remediate several pervasive problems with the current health care system and catalyze needed reform in the country.

A transition to a consumer-driven health care model would entail shifting a large share of health payments away from third parties and to the actual consumers. [69] Several studies demonstrate the positive effects of such a change, finding that a consumer-driven system would reduce health care spending by tens of billions of dollars a year. [70] This is because a consumer-driven system promotes rational decision-making among health care consumers. [71] In particular, consumers will be more prudent with their selection of health insurance plans and their health care consumption when forced to directly bear the costs of excessive coverage and over-consumption. [72]

Consumer cognizance of the actual medical costs at the point-of-service will also correct many of the current distortions in the health care marketplace, since consumers will seek alternate suppliers if health care costs rise too significantly. ***325** [73] This will force insurers to diversify their insurance plan offerings to remain competitive, which will enable consumers to select health plans that more accurately reflect their personalized medical needs. [74]

B. Beneficial Socioeconomic Consequences

A consumer-driven system will also ameliorate the portability issues under the ESI model. Consumers will personally select and buy into their health plans, meaning that changing jobs will no longer result in a loss of health insurance. Such a change would provide a two-fold solution to the current socioeconomic dilemma: a consumer-driven system would allow individuals to build important longstanding relationships with health care providers and would cultivate a dynamic and mobile work force. [75]

Shifting control back to the individual will further resolve a longstanding disconnect between the economic reality of health care and the legal responsibilities placed on health care consumers. Courts have increasingly held that consumers are responsible for being informed of their medical needs and for their health care decision-making. [76] Yet this responsibility is at odds with the substantial control third parties wield over consumers in the ESI model, which often deprives consumers of medical information and the autonomy needed for decision-making. [77] If the legal system is going to judge consumers as being informed about and in control of their own health care, then the economics of the health care system should be reconfigured to actually give them this information and control.

A shift to consumer-driven health care will also catalyze necessary lifestyle adjustments among the American population. A consumer-driven health system implements the necessary "nudges" to shift individual values towards more conscientious decision-making, which is necessary to stem the excessive medical consumption and poor population health in the United States. [78] Consumer-centric models work because, sociologically, humans respond more strongly to "loss" than any other consequence. [79] The prospect of unnecessarily losing their own money by over-consuming medical services or enrolling in excessive ***326** health care coverage will therefore motivate individuals to advantageously select the appropriate amount of medical care. [80]

This motivation will encourage individuals to become healthier, as doing so will prevent their health care expenses from increasing. [81] Data supports this notion, as families that switch from traditional ESI health plans to consumer-driven plans spend an average of 21% less on health care and require less medical assistance. [82] Studies also confirm that the

most common way a population avoids unnecessary medical costs is by making productive lifestyle choices and becoming healthier. [83] Thus, a transition to a consumer-driven health system will cultivate a change in ethos among the American population--a shift away from hyper-consumerism and towards informed decision-making, economic rationalism, and health care mindfulness. [84]

IV. HEALTH SAVINGS ACCOUNTS: A CONSUMER-DRIVEN SYSTEM WITH TAX BENEFITS

A common counterargument against shifting to a consumer-driven health care model is that many employees will lose the tax benefits they currently receive under the ESI model. Fortunately, the government has already created a vehicle for consumer-driven health care that preserves these tax benefits--the health savings account (HSA).

A. Health Savings Accounts: An Overview

HSAs are tax-advantaged medical savings accounts created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. [85] Similar to an individual retirement account (IRA), yearly contributions can be made to HSAs, and each account is portable and owned by the individual. [86] Contributions into an account are made by the individual or by his or her employer. [87] For 2018, the yearly contribution limits for HSAs are $3,450 for self-only coverage and $6,900 for family coverage. [88] Money is withdrawn from HSAs to pay for ***327** qualified medical costs not covered by health insurance, such as deductibles and copayments, but funds cannot be used to pay most health insurance premiums. [89] Account holders can also use family HSAs to pay for the qualified medical expenses of their spouses and dependents. [90] Alternatively, the money in the HSA can be invested, and unused funds roll over from year-to-year. [91]

An individual must satisfy four federal requirements to be eligible for an HSA. First, the individual must be covered under a qualified high-deductible health plan (HDHP). [92] To be considered a qualified HDHP for 2018, the insurance plan must (1) have a minimum deductible of $1,3500 for self-only coverage or $2,700 for family coverage, and (2) have a maximum out-of-pocket limit of $6,650 for self-only coverage or $13,300 for family coverage. [93] The second requirement is that an individual cannot be covered under any non-HDHP insurance plan. [94] The third element requires the person be under the age of 65. [95] Fourth, and finally, another tax payer may not claim the individual as a dependent. [96]

B. The Tax Benefits of Health Savings Accounts

HSAs provide several important tax advantages that offset the benefits lost when shifting away from an ESI model. Foremost, the contributions an individual makes to his HSA are tax-deductible, and employer contributions are excluded from the employee's taxable income. [97] Employers also receive federal and state tax deductions for any contribution made to their employees' HSAs, which reduce employers' gross payroll amounts. [98] In sum, the HSA model provides tax benefits comparable to those already received by employers and employees under the ESI model.

HSAs also provide new fiscal benefits. For instance, HSA funds can be invested in the same fashion as IRA assets and grow tax-free without limitation. ***328** [99] But unlike IRAs, the funds in HSAs can be withdrawn at any time, without a tax penalty, to pay for qualified medical costs. [100] Additionally, an HSA account holder can designate a beneficiary to receive ownership of the account upon his or her death. [101] If the beneficiary is the account holder's spouse, then the HSA funds are transferred without tax implications. [102] The HSA model therefore provides account holders with additional tax benefits and new methods for retirement and estate planning. [103]

C. Health Savings Accounts Can Significantly Reduce Health Care Spending

HSAs are also shown to considerably reduce health care spending, and many employers successfully lowered their health expenditures by shifting to an HSA-centric health care model. [104] The Employee Benefit Research Institute's 2013 analysis of a large employer that replaced its traditional ESI with an HSA system found that the HSA system substantially reduced total health care spending over a four-year period, with the first-year alone seeing a reduction of 25% in health spending and $527 per person in the aggregate. [105]

A recent study by the Health Care Cost Institute is even more optimistic, demonstrating that HSA models both reduce health care spending *and* improve employees' health. [106] The research also examined the effect shifting to an HSA model would have on health care spending and use by comparing a subset of individuals who shifted to the HSA model against a population group that remained on traditional insurance models. [107] The findings over the five year period from 2010 to 2014 showed that the HSA subset (1) reduced their health care spending and usage over the timeframe, (2) received more timely care and thus did not require as many emergency room visits, and (3) was healthier and therefore required less medical care. [108]

The Health Care Cost Institute study suggests that a shift to an HSA model would result in a healthier United States while achieving sustained reductions in total health ***329** care spending. In fact, studies project that an aggregate shift to an HSA model would reduce health care spending by 12.5% in the United States. [109] Considering that annual spending in this industry exceeds $3.2 trillion, achieving sustained reductions would amount to more than $400 billion in savings per year.

V. EXPANSIVE AND COMPULSORY HEALTH SAVINGS ACCOUNTS: THE KEYSTONE FOR REFORM

Despite the myriad benefits of shifting to an HSA health care model, federal law limits potential gains by imposing artificial constraints on HSAs. These constraints not only stifle the reformative capabilities of HSAs, but they also contravene the mission and characteristics of an ideal health care system.

A. Characteristics of an Ideal Health Care System

A common misconception is that medical care solely defines the quality of a medical system. Yet many other elements warrant consideration, including the efficiency of health care delivery, the accessibility and affordability of medical care, and the total economic costs of the health care system. [110] There are also secondary considerations, such as deterring "moral hazards" of health care over-utilization and eliminating "free rider" problems whereby the uninsured have their medical costs passed on to other consumers. [111]

In light of these considerations, an ideal health care system consists of the following: affordable and quality medical care to all of society in a manner that is cost-effective, eliminates unnecessary consumption, and ensures that all citizens are participants. At its core, an ideal health care system is centered around consumers who are incentivized and empowered to make prudent medical and fiscal choices. [112]

Upon examining the previously mentioned attributes of an ideal health care system, the current HSA model is rife with artificial constraints that limit its reformative capabilities. [113] The low contribution limits and recent reductions to the number of qualified medical expenses are particularly damaging, as they diminish participation in HSAs, therefore limiting HSAs potential utility. [114] HSAs have also been confined by new restrictions promulgated by the Affordable Care Act, such as the removal of over-the-counter medications from the list of medical costs that qualify for tax-free HSA

coverage. [115] Without universal and large-scale implementation, HSAs will be unable to positively impact the ***330** health care crises in the United States. [116] In order for HSAs to effectuate sustained health care reform in the country, two legislative changes are necessary. First, the statutory constraints on HSAs must be removed and the scope of HSAs must be expanded. Second, HSAs must be compulsory for all citizens and lawful residents.

B. Expanding Health Savings Accounts and Removing Artificial Constraints

The primary goal of HSA expansion is to return decision-making control back to consumers, which results in a more choice-oriented and competitive health care marketplace. [117] The first adjustment should therefore be an enlargement of contribution limits so that nearly all individuals could use HSA funds for 100% of their medical needs. [118] With yearly medical expenditures at approximately $10,000 per person, [119] raising the annual contribution limits to $10,000 per individual and $20,000 per family brings HSAs closer to enabling consumers to financially control all their medical care. [120]

The enlargement should also apply to qualified medical expenses so that HSA account holders are permitted to use their funds for *all* medical expenses, including insurance premiums. [121] This would allow consumers to advantageously select the amount of risk they are willing to assume regarding their own health and would likely result in many uninsured individuals enrolling into affordable HDHPs because their premiums could be paid out of the HSA. [122] Increasing individuals' contact with the insurance marketplace would likely improve the population's health, as a lack of health insurance is a perceived link to poor personal health in the United States. [123] Increased contact would also ensure that consumers have the option of *fully* preserving the tax benefits they currently receive under the ESI model.

Employers should not be limited in the amount of tax-deductible contributions they choose to make to their employees' HSAs. Specifically, employers' contributions into employees' HSAs should no longer count against the contribution limits for employees, and employers should have no cap on the amount they can contribute into their employees' accounts. These changes would better conserve the tax benefits employers currently receive under the ESI system and ***331** thereby mitigate the chief concern about transitioning to a consumer-driven health care model. Removing these current HSA limits would also promote a competitive health care marketplace, as employers would compete against each other to procure high-potential employees by offering better contribution plans as part of their compensation packages. [124] This increased customization of compensation packages also benefits employees in their ability to individually negotiate contribution plans. [125]

To further ensure individuals have full ownership and control over their health care dollars, Congress should also eliminate the current eligibility requirements for HSAs. [126] Most importantly, the requirement for individuals to have an HDHP in order to open an HSA should be eliminated, as this current prerequisite provides no discernible health care benefit. [127] Removing this requirement would ensure that true competition returns to the health care market, because consumers would no longer have a mandate to enroll in specific insurance plans in order to maintain an HSA. [128] The elimination of this mandate would vastly expand consumers' health care choices--the health insurance marketplace would need to diversify so that more competitive health plans were offered to meet the health needs of specific subsets of the population. [129] This competition would incentivize insurance providers to reduce costs, supply more information to consumers, and provide higher quality service to remain commercially attractive, thereby ensuring that individuals would receive more value from their health plans. [130]

Finally, there should be no tax implications for any beneficiary the HSA account holder selects. The ability to bequeath account funds without subjecting beneficiaries to standard inheritance and estate taxes would incentivize greater use of

HSAs. [131] This would also encourage account holders to contribute more to their HSAs because their beneficiaries are not subjected to estate taxes. Furthermore, since the beneficiary would become the new account holder of the HSA, he or she would still be required to use the account funds for medical purposes or else incur tax penalties. [132] Because the HSA would be earmarked, beneficiaries will most likely choose to avoid incurring punitive "losses" and would therefore be less likely to use the funds for expenses ***332** unrelated to healthcare. [133]

C. Compulsory Health Savings Accounts

The second necessary legislative change is to make HSAs compulsory for all American citizens and lawful residents. [134] To implement this change, a minimum flat-rate percentage of individuals' monthly wages and salary would be automatically deducted and contributed to their HSAs. An aggregate cap on deductions could be instituted when the account balance reaches $34,000, which is the near equivalent of deduction caps in other countries with a comparable system. [135] As with 401(k) retirement accounts, employees could also select additional amounts to deposit into their accounts each year. [136]

A compulsory HSA model would amplify and sustain the aforementioned benefits of the HSA model, such as reducing aggregate health care spending and increasing informed and conscientious health care utilization among consumers. [137] Moreover, the compulsory model would also provide new benefits. First, compulsory HSAs would expand health care coverage by covering working individuals who remain uninsured either because they were not offered ESI or because they have been unable to afford their share of the insurance premiums. This represents a sizeable group, as approximately fourteen million Americans fall within this category. [138] Considering recent estimates that nearly 28 million non-elderly adults in the United States still lack health insurance, a compulsory HSA model would be a more efficient and dependable method for reducing the number of uninsured Americans than the individual mandate of the Affordable Care Act, as the "enrollment" of these working individuals into health care coverage would be *both* compulsory *and* automatic. [139]

Another benefit of the compulsory HSA system is that it would ensure the benefits and costs of health care were spread more evenly across society. The compulsory HSA model better captures the economic actuality that health care reforms should affect as many individuals as possible (regardless of their earned income) because a person who earns $50,000 a year can incur equal medical expenses as a person who earns $1 million a year. [140] For this reason, the ***333** socioeconomic interests compelling health reform are largely independent from income levels. [141] A compulsory HSA system would more accurately reflect this economic reality because it mandates that individuals set aside sums to pay for their medical costs or to enroll in insurance plans. [142]

A compulsory HSA model would also mitigate the free rider problem pervading the United States health care system. Presently, free riders can elect not to enroll in health insurance and spend their money elsewhere with the assurance that the community will bankroll their medical expenses if they cannot afford to pay for them. [143] This practice persists despite the tax penalties imposed by the individual mandate of the Affordable Care Act, because individuals often conclude that any health care costs they may incur will eclipse the monetary limits of the punishment. [144] Essentially, free riding currently works because of an implied social agreement that no one will go without health care. [145] The Emergency Medical Treatment and Active Labor Act bolsters this social contract because it requires Medicare-participating hospitals to treat and stabilize any patient that is in an emergency condition, regardless of that patient's citizenship, legal residency or ability to pay. [146] Under a compulsory HSA system, however, working individuals would no longer be able to opt out of paying for any of their medical costs and therefore would be unable to exploit the larger population by free riding. This change would essentially eliminate the previous social contract and replace it with new expectations for health care consumers.

Making HSAs compulsory would similarly eliminate a key psychological pitfall among many heath care consumers. Consumers presently decide how much they will contribute to their HSAs while in generally good physical and mental health. [147] This leads to a self-enhancement bias where individuals underestimate the likelihood of their future medical needs and therefore underfund their HSAs. [148] A compulsory HSA model removes this cognitive fallacy. Because consumers in the working population would be forced to contribute a minimum amount to their accounts each month, their unrealistic medical projections could not override the base funding they are obligated to provide. Moreover, because these HSAs would be permitted to pay for insurance premiums, these individuals would also have resources set aside to enroll in an HDHP or other catastrophic health insurance to cover extraordinary medical expenses.

*334 *D. Singapore: An International Case Study*

Singapore's Medisave program, a system of mandatory medical savings, provides a model for the effective implementation of expansive and compulsory HSAs.

Medisave was instituted in 1984 to reflect the new national philosophy that each individual should be responsible and pay for his own health care, which was a marked shift away from the previous system of universal health care. [149] At its core, Medisave is a compulsory savings program whereby a percentage of an individual's monthly salary is automatically deducted and deposited into a Medisave account owned by that person. [150] The Medisave account acts as self-insurance, and funds can be withdrawn to pay for hospitalization and outpatient expenses for the account owner and his immediate family. [151] When a Medisave account balance reaches the equivalent of approximately US $34,000, surplus funds are carried over into another account that can be used for non-health care purposes. [152] When the Medisave account holder dies, all remaining balances are allocated to beneficiaries in accordance with the deceased's will. [153]

Medisave covers approximately 85% of the Singaporean population, and the average account balance is approximately US $18,000. [154] The remaining 15% of the population is covered by two programs. The first, Medishield, is a national risk-pooling health insurance plan into which all Singaporeans and permanent residents are automatically enrolled and for which the premiums are paid out of Medisave accounts. The second, Medifund, is a government endowment fund that assists indigents and other citizens and permanent residents with the payment of their medical bills. [155] Through these programs, the Singapore health care model effectively reshaped the primary role of the government into ensuring that individuals save for unexpected medical expenses. [156]

The diminished government role immediately cut the Singaporean government's share of total health care expenditures from 50% to 20%. [157] Spending reductions have been maintained over time, as the government's health expenditures now account for only 2.1% of GDP--a 50% reduction from pre-Medisave ***335** levels. [158] Aggregate spending on health care is now only 4.9% of GDP, [159] or US $2,752 per capita, and is nearly 360% less than per capita spending in the United States. [160] The reduced spending bolsters the Singaporean economy and enables the government to maintain regular budget surpluses and low tax rates. [161] For example, the top personal income tax rate in Singapore is currently 22%, [162] nearly half the rate of the highest income tax bracket in the United States. [163] Equally as important, these fiscal advantages have not come at a cost to the health of Singaporeans. [164]

Despite spending considerably less on health care, Singaporeans are significantly healthier than Americans. [165] In fact, the Singaporean health system has gained international recognition for its cost-effectiveness and excellent quality of care. The World Health Organization ranks Singapore as the sixth best system among 191 countries, [166] and the Economist

Intelligence Unit ranks the country second in terms of health outcomes. [167] In the 2016 Bloomberg Rankings, which evaluate countries according to data from the United Nations, World Bank, and World Health Organization, Singapore was rated the healthiest country in the world, due largely to the fact that it is was also the second-highest ranked health care system in terms of efficiency. [168]

The principal reason the Singaporean health care system works so well is that it places responsibility for individual health-care decisions and spending on consumers. [169] Because Singaporeans directly bear the costs of their health care consumption, they have been incentivized, or "nudged," to make rational medical decisions and healthier lifestyle choices. [170] If the United States could replicate a fraction of the reduced government spending and improved population ***336** health seen in Singapore, the decrease in health care costs would be astronomical.

E. A Final Cautionary Note on the Limits of Compulsory Health Savings Accounts

This Note argues the merits of shifting to a compulsory HSA health care system in the United States. However, the compulsory HSA model alone is not a sufficient method for resolving *all* the current health care deficiencies in the United States. Other changes to the health care system are still necessary to provide for the medical needs of those who are unemployed or destitute, or whose wages are insufficient to cover their expensive health care.

A logical solution to these shortcomings would be to mirror the Singaporean approach, whereby the United States government would (1) provide an automatic, risk-pooling national insurance plan to protect people from catastrophic medical expenses, and (2) create an endowment fund to assist individuals who are impoverished, unemployed, or otherwise cannot pay their medical expenses. [171] This model reflects the practical reality that, despite the consumer-driven health system removing the government as a primary provider of health care, the government should not remain a passive bystander within the United States health system. Indeed, a consumer-centric model with ancillary government assistance would better ensure that all Americans and lawful residents have adequate health care access and coverage. [172]

A compulsory HSA system would successfully begin the journey toward comprehensive and sustained health care reform, which the United States sorely needs. Further, a compulsory HSA model would be an incremental shift towards an ideal health care system. The realization of such a system would catalyze a sociological and economic transformation across the country.

VI. CONCLUSION

In its current state, the United States health care system is substandard, unsustainable, and will hamstring future economic development in the country. Despite higher public and private spending than peer nations, the United States still has inferior population health and inferior access to care. [173] The principal cause of this deficiency is that consumers are too detached from their own health care. Shifting to a consumer-driven health care system would ameliorate this problem, and the HSA is an ideal vehicle for doing so. Data shows that a greater emphasis on HSAs would reduce health care spending in the United States by as much as $400 billion a year. Consumers are also more likely to make healthier lifestyle choices and rational medical decisions once they become ***337** responsible for health care payments at the point of service, leading to a healthier American population.

The possibilities for reduced spending are even greater under a more expansive and compulsory HSA system. The benefits of the HSA model would be amplified without its current and unnecessary statutory constraints, and a compulsory system would ensure that a larger percentage of Americans cover the costs of their own medical needs. Producing a more fiscally responsible and rational consumer base would also reestablish a traditional supply-and-demand model in the health care marketplace. This would force insurers to provide more diversified and cost-effective health insurance, guaranteeing that

consumers could advantageously select high-quality health plans that are better tailored to meet their actual health care needs. The end result would be a more cost-effective health care system and a healthier American population.

Footnotes

a1 J.D., University of Virginia School of Law, 2017, Tnm3jg @virginia.edu. I would like to thank Darren Skyles for his advice and commentary and Pamela Lim for her tireless support, without which this Note would not be possible.

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44 *Id.*

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46 *Id.* at 6.

47 Cannon, *supra* note 42, at 1-2.

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49 *Id.*

50 Keehan et al., *supra* note 4, at 1522-31; Cannon, *supra* note 30, at 2; Hall & Havighurst, *supra* note 36, at 1491-1500.

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