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Redefining Medical Care

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REDEFINING “MEDICAL CARE”

*Lauren R. Roth**

President Donald J. Trump has said he will repeal the Affordable Care Act (ACA) and replace it with health savings accounts (HSAs). Conservatives have long preferred individual accounts to meet social welfare needs instead of more traditional entitlement programs. The types of “medical care” that can be reimbursed through an HSA are listed in § 213(d) of the Internal Revenue Code (Code) and include expenses “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”

In spite of the broad language, regulations and court interpretations have narrowed this definition substantially. It does not include the many social factors that determine health outcomes. Though the United States spends over seventeen percent of gross domestic product (GDP) on “healthcare”, the country’s focus on the traditional medicalized model of health results in overall population health that is far beneath the results of other countries that spend significantly less.

Precision medicine is one exceptional way in which American healthcare has focused more on individuals instead of providing broad, one-size-fits-all medical care. The precision medicine movement calls for using the genetic code of individuals to both predict future illness and to target treatments for current illnesses. Yet the definition of “medical care” under the Code remains the same for all.

My proposal for precision healthcare accounts involves two steps—the first of which requires permitting physicians to write prescriptions for a broader range of goods and services. The social determinants of health are as important to health outcomes as are surgical procedures and drugs—or perhaps more so according to many population health studies. The second step requires agencies and courts to interpret what constitutes “medical care” under the Code differently depending on the

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taxpayer's income level. Childhood sports programs and payments for fruits and vegetables may be covered for those in the lower income brackets who could not otherwise afford these items and would not choose to spend scarce resources on them if they could. This all assumes that the government takes funds previously used to subsidize the purchase of health insurance under the ACA (or allocates new funds) and puts the funds in individual accounts so the poor or near poor have money to pay for these expenses.

Section I of this Article will explore the current definition of medical care, which excludes the social determinants of health from "health-care" spending. I then address how precision medicine has changed the types of services and treatments that it makes sense to reimburse for each individual. If efficacy can vary from person to person based on genetic code, then it also can vary depending on environment. There is an opportunity to not only vary the types of "medical care" that can be reimbursed or deducted within the traditional range of services and drugs, but also outside of that range.

Section II addresses the historical shift towards health financing through individual accounts, and specifically through HSAs. If this is the only avenue for health reform in the next few years, I advocate using it to engage in the type of experiments that are typically only possible under the cover of tax expenditures. My proposal for precision healthcare accounts moves the government to experiment with individual social spending that can lead to improved overall health outcomes.

Finally, in Section III, I address two dichotomies that affect any healthcare proposal: (1) entitlement programs v. grants-in-aid, and (2) pooled insurance v. consumer-driven health plans (CDHPs). In the end, I argue that an entitlement method of funding precision HSAs along with pooled insurance subsidized by the government is the most realistic resolution to these dichotomies. Only a broad-based entitlement to funding for all healthcare expenses (medical and social) allows for significant improvements in overall population health.

INTRODUCTION	67
I. MEDICAL CARE	72
A. <i>Current Definition of Medical Care</i>	73
B. <i>Exclusion of Healthcare</i>	77
C. <i>Case Study of Precision Medicine</i>	79
II. HEALTH SAVINGS ACCOUNTS	84
A. <i>History and Regulation of Health Savings Accounts</i> ..	85
B. <i>Political Feasibility of Expanding Medical Care</i>	90
C. <i>A Proposal for Precision Healthcare Accounts</i>	92
III. BRIDGING DICHOTOMIES	96

A. <i>Entitlements v. Grants-in-Aid</i>	97
B. <i>Pooled Insurance v. Consumer-Driven Health Plans</i> .	102
CONCLUSION.....	105

INTRODUCTION

President Donald J. Trump has repeatedly called the Affordable Care Act (ACA or Obamacare) a failure and pressed for it to be repealed and replaced “with a solution that includes Health Savings Accounts (HSAs).”¹ In fact, in his campaign speech at Gettysburg, Trump emphasized the centrality of HSAs to his efforts to repeal the ACA when he stated that he would “[f]ully repeal Obamacare and replace it with health savings accounts.”² Both the American Health Care Act passed by the House of Representatives and the failed Better Care Reconciliation Act Senate bill included a larger role for HSAs through increased contribution limits and flexibility regarding what the money can be used for and when.³ In spite of the failure of recent efforts by congressional Republicans, President Trump’s administration is still focused on repealing the ACA.⁴

Former Secretary of Health and Human Services Tom Price favored revamping Medicaid and Medicare so “both programs would cease to be entitlements that require them to provide coverage to every person who qualifies.”⁵ Entitlement “reform” is on the Trump administration’s agenda in spite of his earlier campaign promises not to cut entitlement

¹ The Transition Team, *Healthcare*, GREAT AGAIN (Dec. 13, 2016), <https://greatagain.gov/healthcare-396f348e51ef#.xxb9yw8iq>. Trump’s plan also includes shifting more power over health insurance to the states. *Id.*

² PBS NewsHour with Jim Lehrer, PBS, Nov. 16, 2016, 2016 WLNR 34567182 (quoting then-Republican candidate for president Donald J. Trump, Contract with the American Voter (Oct. 22, 2016)).

³ H.R. 1628, American Health Care Act of 2017, <https://www.congress.gov/bill/115th-congress/house-bill/1628>; Better Care Reconciliation Act, <https://www.budget.senate.gov/bet-tercare>. The bills proposed nearly doubling contribution limits to \$5,000 for single coverage and \$10,000 for family coverage to coincide with out-of-pocket limits, allowing both spouses to make catch up contributions to one HSA, paying for expenses incurred up to 60 days before HSA-related coverage takes effect, paying for over-the-counter medications (not allowed under the ACA), and reducing the tax penalty when money is used for unqualified expenses to 10% from 20%. *Id.* Congress’ Joint Committee on Taxation estimated the cost of these proposals at \$19 billion through 2026. Tom Anderson, *Senate’s Obamacare replacement bill will likely boost health savings accounts*, CNBC, June 21, 2017, <https://www.cnbc.com/2017/06/21/senates-health-care-bill-will-likely-boost-health-savings-accounts.html>.

⁴ *See, e.g., Trump says he just wants Mitch McConnell “to get repeal and replace done”*, CBS, Aug. 10, 2017, <http://www.cbsnews.com/news/trump-again-pushes-mitch-mcconnell-to-pass-health-care-legislation/>.

⁵ Greg Sargent, Opinion, *Get Ready for a Big, Messy, Explosive Battle over Medicare’s Future*, WASH. POST, Nov. 29, 2016, https://www.washingtonpost.com/blogs/plum-line/wp/2016/11/29/get-ready-for-a-big-messy-explosive-battle-over-medicare-future/?utm_term=.e65618935d93.

programs.⁶ Although Congress has been unable to repeal the ACA to this point, Congress remains closely divided. It is likely that if entitlement reform passes Congress, it will also include a role for individual accounts.

HSAs are individual accounts that must be paired with a high deductible health plan (HDHP). Both employers and employees can contribute to the HSAs up to a specified amount. Regardless of whether those contributions are sufficient to fund basic healthcare needs, the more traditional health insurance coverage does not begin until expenses surpass the deductible—although there is an exception for basic, preventative care, which may be covered before the deductible is reached. Thus, depending on the amount of employer contributions, employees may face thousands of dollars of unreimbursable medical expenses each year.

The types of “medical care” that can be reimbursed through an HSA are listed in § 213(d) of the Internal Revenue Code (Code).⁷ Among other items listed, “medical care” includes expenses “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”⁸ The definition was originally crafted for a tax deduction that applies when individual taxpayers’ medical expenses exceed a set threshold that few taxpayers meet—now ten percent of gross income.⁹ As the use of individual accounts in health financing grew, Congress applied the definition of “medical care” in § 213(d) more broadly to flexible spending accounts, health reimbursement arrangements, medical savings accounts, and HSAs.

The definition of “medical care” under the Code remains the same for all and includes mainly traditional medical treatments. Although research has shown that the social determinants of health play a large role in population health (perhaps larger than those played by physicians, hospitals, and drugs), medical care does not include spending on these social factors that can improve health.

⁶ Richard Rubin & Laura Meckler, *Trump Adviser Says He's Open to Entitlement Program Changes*, WALL ST. J., May 11, 2016, <https://www.wsj.com/articles/trump-adviser-says-hes-open-to-entitlement-program-changes-1462997756> (detailing Trump’s flip flop from saying in his campaign kickoff speech that he planned to “save Medicare, Medicaid and Social Security without cuts” to an apparent willingness to cut spending on Medicare and Social Security if his forecasted budget surpluses do not appear); *see also* Paul Krugman, *Opinion, The Medicare Killers*, N.Y. TIMES, Nov. 18, 2016, https://www.nytimes.com/2016/11/18/opinion/the-medicare-killers.html?smprod=nytcare-iphone&smid=nytcare-iphone-share&_r=0 (“[A]ll indications are that the incoming administration is getting ready to kill Medicare, replacing it with vouchers that can be applied to the purchase of private insurance. Oh, and it’s also likely to raise the age of Medicare eligibility.”).

⁷ 26 U.S.C. § 213(d).

⁸ *Id.* § 213(d)(1)(A).

⁹ *Id.* § 213(a). The threshold prior to January 1, 2013 was 7.5%. *See id.* § 213(f).

Perhaps the funds in your account can be used for an experimental new cancer treatment, or perhaps not. Perhaps they can be used for reconstructive surgery after a mastectomy, or perhaps not. What is clear is that the funds in your account cannot be used to pay for a babysitter to help with your kids while you recover from surgery or an afterschool program for your children.

Recently, the medical profession has focused more on individuals instead of providing broad, one-size-fits-all medical care. The precision medicine movement calls for using the genetic code of individuals to both predict future illness and to target treatments of current illnesses. Although still in its infancy, precision medicine has resulted in Angelina Jolie and many other women undergoing preventive surgery to remove their breasts, ovaries, and fallopian tubes. There are regular reports of new cancer breakthroughs using immunotherapy to target tumors with particular genetic mutations.

If you are not a wealthy individual who can afford to look into your genetic code and act accordingly, however, healthcare spending is not sufficient to meet all of your health needs. The narrow definition of medical care under § 213(d) prevents you from making small improvements that would have a big impact on your health. For example, the funds in your account cannot be used to pay for an afterschool sports program that will help prevent your child from being obese and developing diabetes. Nor can they be used to pay for fresh fruits and vegetables—not to mention the organic apples that those with higher incomes prefer.

Just as medicine is recognizing that health outcomes can be improved by personalizing treatments, the expensive, tax-subsidized system of health financing in this country needs to recognize that health outcomes can be improved by personalized spending. Individual accounts are well-suited for this one purpose, at least. Individuals make decisions about how to spend the money within the bounds of § 213(d). The question then is what a personalized definition of medical care would look like and how it would be implemented. Using resources to fund millionaires’ nanny salaries or vacations does not seem like a wise decision.

Conservatives have long favored using individual accounts to meet social welfare needs instead of more traditional entitlement programs. Entitlements are government funded programs that provide benefits to all who meet the eligibility criteria. Government funded programs that are unconnected to work, such as welfare and the ACA, have been stigmatized as “unearned” benefits while Social Security and unemployment insurance programs are considered a safety net for those who have

worked hard and “earned” their benefits.¹⁰ The American ethos of individual responsibility and small government has resulted in the idea that only the lazy would seek a government “handout”—unless it is indirectly funded through tax expenditures and received through an employer, of course.¹¹

The majority of Americans feel passionately entitled (in the subjective sense) to their Social Security benefits and to their employer-sponsored health insurance¹²—which is heavily subsidized by foregone tax revenue. To many Americans, individual accounts fit with this more socially acceptable form of entitlement. Whether the money is used to fund retirement or health benefits, individuals either contribute or are given by employers a sum of tax-subsidized money—a defined contribution—to use as they wish. Individuals then bear two risks with individual accounts: (1) to the extent that employers do not contribute to the accounts at all or contribute little, employees now pay some or all of the cost of funding health benefits previously covered by traditional health insurance plans; and (2) employees bear the responsibility for rationally deciding what and how much to spend the funds on.¹³ Traditionally, employers had a more paternalistic role of defining and funding the benefits that employees most needed.

My proposal for personalized, or precision HSAs involves first permitting physicians to write prescriptions (a requirement for medical care covered under § 213(d)¹⁴) for a broader range of goods and services. The social determinants of health are as important to health outcomes as are surgical procedures and drugs—few of which have been proven effective through rigorous scientific studies anyway.

Second, items which can be considered “medical care” under the Code will depend on your income level. Childhood sports programs and payments for fruits and vegetables may be covered for those in the lower-income brackets who could not otherwise afford these items and would not choose to spend scarce resources on them if they could. Simi-

¹⁰ See generally LINDA GORDON, *PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE 1890-1935* (1998).

¹¹ See generally CHRISTOPHER HOWARD, *THE WELFARE STATE NOBODY KNOWS: DEBUNKING MYTHS ABOUT U.S. SOCIAL POL’Y* (2007).

¹² See generally Lauren R. Roth, *Overvaluing Employer-Sponsored Health Insurance*, 63 U. KAN. L. REV. 633 (2015).

¹³ See generally JACOB S. HACKER, *THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM* (2008) [hereinafter HACKER, *THE GREAT RISK SHIFT*].

¹⁴ Although I believe that the requirement under § 213(d) that physicians write prescriptions for items to be covered by the definition of “medical care”—and the courts’ emphasis on this factor in classifying expenditures—should be changed to also permit nurses and community health workers to write prescriptions to cover items under § 213(d), that topic is beyond the scope of this Article and hopefully the subject of a subsequent project.

larly, the cost of an exterminator to reduce pests in an apartment with a child with asthma and a reticent landlord would also be covered.

This all assumes that the government takes funds previously used to subsidize the purchase of insurance under the ACA (or allocates new funds) and puts the funds in these accounts so the poor or near poor have money to pay for basic expenses. Even if the government simply promotes the expansion of HSAs in the workplace in place of traditional health insurance, however, many of the working poor will find themselves relying on HSAs and HDHPs.

In Section I of this Article, I address how narrow the current definition of “medical care” under the Internal Revenue Code is. Much of our longevity and quality of life is determined by social factors that correlate strongly with income, such as housing and education. Yet § 213(d) follows the traditional medicalized model of “healthcare” and excludes expenditures that are closely correlated with health outcomes. Precision medicine, however, is one example of how medical care has become personalized, resulting in different types of services and treatments that should be reimbursed. If the efficacy of prevention efforts and treatments can vary from person to person based on genetic code, then it also can vary based on environment. There is an opportunity to not only tailor the types of “medical care” that can be reimbursed or deducted within the traditional range of services and drugs, but also outside of that range.

Section II explores the historical movement towards health financing through individual accounts, and specifically through HSAs. While employers have slowly been shifting increasing healthcare costs to employees through co-payments, co-insurance, and deductibles (such as those of the HDHPs), if that is the only avenue for health reform in the next few years, I advocate using it to engage in the type of experiments that are not typically possible except under the cover of tax expenditures. HSAs, if they are funded properly for those with low incomes, can be used to fund improvements in the social factors that affect health outcomes—and while the aim would be to improve overall population health individual by individual, they can be customized to the needs of the account holders.

Finally, in Section III, I will discuss two dichotomies that affect my proposal and most health-related proposals today: entitlements v. grants-in-aid and pooled insurance v. consumer-driven health plans (CDHPs). Entitlements have a stigma that regularly results in calls for “reform.” Americans typically agree that the government should pay some amount for the basic needs of the poor but value choice (including the choices of states) and individual responsibility. In recent decades, federal entitlements have moved towards broad block grants, or grants-in-aid, that allow states to decide how to spend the fixed sum designated for the health

needs of the poor. The ACA's Medicaid expansion changed that, but Republican efforts will likely mean a return to that form of aid to the states—instead of directly to those in need.

Finally, greater reliance on individual accounts calls into question the role of traditional, pooled insurance. While people generally use insurance only for unplanned, catastrophic expenses (which is what HDHPs are designed to cover), health insurance in this country has, up until recently, included a pre-payment for routine, preventive care that is predictable and will not bankrupt the consumer. This is part of the reason that Americans have balked at increasing co-payments, co-insurance, and deductibles. Including routine social expenditures within the definition of medical care for some will only take Americans further from the typical purpose of insurance. Yet a traditional, pooled insurance model also focuses on using the healthy to subsidize the sick. Expanding the definition of medical care only increases the level of expenditures if it is not offset by equivalent cost savings.

I. MEDICAL CARE

In “healthcare” financing, there is widespread disagreement over where to focus spending. The issue does not seem to be the need for additional spending; the U.S. spends 17.6% of gross domestic product (GDP) on “healthcare”, which is roughly double the average for comparable countries.¹⁵ Yet, there seems to be a mismatch between spending and health outcomes. Senator Edward Kennedy wrote just before his death in 2009, “Despite spending more per capita than any other nation in the world, the United States is ranked 37th by the World Health Organization in terms of health outcomes.”¹⁶ More spending on “healthcare” does not necessarily improve health outcomes then.¹⁷

I argue here that the problem is that the United States is spending too much on “medical care” (in spite of its frequent use of the word “healthcare”) and not enough on healthcare—leading to substandard health outcomes. Broadly speaking, medical care is any diagnosis or treatment by a professional, such as a physician or nurse, of a current or

¹⁵ PAUL STARR, *REMEDY AND REACTION: THE PECULIAR AM. STRUGGLE OVER HEALTH CARE REFORM* 1 (2013) (“In 1970, when the uninsured were a considerably smaller fraction of the population, healthcare costs in the United States were much closer to the levels in western Europe and Canada. . . . In the following years, however, as the underlying problems of health coverage and costs became more severe, the attempts to remedy them generated more rancorous partisan divisions.”).

¹⁶ Senator Edward M. Kennedy, *Health Care as a Basic Hum. Right: Moving from Lip Serv. to Reality*, 22 HARV. HUM. RTS. J. 165, 167 (2009).

¹⁷ See Adam Candeub, *Contract, Warranty, and the Patient Protection and Affordable Care Act*, 46 WAKE FOREST L. REV. 45, 93 n.27 (2011) (surveying research that indicates more is not always better in terms of healthcare spending).

future illness or injury. Healthcare, on the other hand, is any attempt to improve the health of a person, including both increasing longevity and enhancing quality of life. While medical care typically takes place in a hospital or physician’s office, healthcare frequently starts at home with a change in lifestyle. Funding to promote small changes in eating habits or exercise, for example, can do more to improve individual and population health than a new drug or medical procedure—particularly for those with low incomes who have shorter lifespans and poor quality of life compared to those with higher incomes.

Yet American spending on medical care far outstrips spending on healthcare—much of which is covered by social welfare programs that provide a basic income level in other countries. One example of this is the definition of “medical care” under Internal Revenue Code § 213(d), which originally allowed individuals to deduct unreimbursed medical expenses above a high threshold (now 10 percent of gross income), but later was incorporated into health reimbursement arrangements (HRAs), flexible spending arrangements (FSAs), medical savings accounts (MSAs), and HSAs.¹⁸ As the statements of President Trump indicate, HSAs are a likely focus of healthcare reform proposals over the next few years. Any growth of HSAs in number or total dollars invested means an increased impact for the Internal Revenue Service’s (IRS’s) definition of medical care since funds in HSAs can only be used without penalty for expenses that qualify as medical care under § 213(d). Without changes to this definition, and to “healthcare” financing broadly, the United States will make little progress towards improving overall population health because spending on medical care is much less efficient than spending on healthcare.

A. *Current Definition of Medical Care*

Under § 213(d)(1): “The term ‘medical care’ means amounts paid— (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, (B) for transportation primarily for and essential to medical care referred to in subparagraph (A)” or certain other long-term care or insurance services. Covered medicines and drugs must be prescribed by a physician.¹⁹ In addition:

¹⁸ Jessica A. Bejerea, Note, *It is Not too Late for the Health Savings Account*, 85 CHI.-KENT L. REV. 721, 733 (2010) (noting that consumer driven health care (CDHC) made § 213(d) “the foundation” of these individual account laws).

¹⁹ See 26 U.S.C. § 213(b) (limiting deduction for medicine and drugs to “prescribed drugs”); *id.* § 213(d)(3) (defining “prescribed drug” as “a drug or biological which requires a prescription of a physician for its use”).

[a]mounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in paragraph (1)(A) shall be treated as amounts paid for medical care if—(A) the medical care referred to in paragraph (1)(A) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and (B) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.²⁰

The regulations clarify that expenses for legal “operations or treatments affecting any portion of the body, including obstetrical expenses and expenses of therapy or X-ray treatments” are “for the purpose of affecting any structure or function of the body.”²¹ Included within medical care are “hospital services, nursing services (including nurses’ board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays, medicine and drugs . . . , artificial teeth or limbs, and ambulance hire.”²² Yet there is a specific exclusion for expenses which are “merely beneficial to the general health of an individual, such as an expenditure for a vacation.”²³

The Code also allows taxpayers to deduct part or all of the cost of residential improvements made for medical reasons. If the improvement increases the value of the residence, then the deduction is reduced by the amount that the value of the residence increases.²⁴ A capital expenditure can qualify as a deductible medical expense where “it has as its primary purpose the medical care” of the taxpayer, her spouse, or her dependent and “is related only to the sick person and is not related to permanent improvement or betterment of property.”²⁵ Examples provided include payments for “eye glasses, a seeing eye dog, artificial teeth and limbs, a wheel chair, crutches, an inclinor or an air conditioner which is detachable from the property and purchased only for the use of a sick person.”²⁶ A “permanent improvement” to the property can also qualify as a medical expense if related to medical care to the extent that the pay-

²⁰ *Id.* § 213(d)(2) (“The amount taken into account under the preceding sentence shall not exceed \$50 for each night for each individual.”).

²¹ 26 C.F.R. § 1.213-1(e)(1)(ii).

²² *Id.*

²³ *Id.*

²⁴ *See id.* § 1.213-1(e)(1)(iii); Rev. Rul. 87-106, 1987-2 C.B. 67; Rev. Rul. 83-33, 1983-1 C.B. 70; Robert K. Lu, Note, *Gross Negl. and the Med. Expense Deduction*, 71 S. CAL. L. REV. 845, 848 (1998) (noting that swimming pools are frequently deductible when built for medical reasons).

²⁵ 26 C.F.R. § 1.213-1(e)(1)(iii).

²⁶ *Id.* (emphasis added).

ment "exceeds the increase in the value of the related property."²⁷ The example provided is a situation where a doctor suggests that the taxpayer "install an elevator in his residence so that the taxpayer's wife who is afflicted with heart disease will not be required to climb stairs."²⁸ To be clear then, the IRS does not want any other family member's health to be improved by access to an air conditioner, but the taxpayer will be fully compensated for installing an elevator by either an increase in property value or a tax deduction, and the entire family can use the elevator.

Transportation expenses are only deductible as medical care if they are "primarily for and essential to the rendition of the medical care," and meals and lodging are not generally deductible when traveling to improve health.²⁹ "For example, if a doctor prescribes that a taxpayer go to a warm climate in order to alleviate a specific chronic ailment," transportation, meals, and lodging are not deductible under § 213(d).³⁰

Finally, institutional care due to a medical condition is deductible, including meals and lodging. Examples include institutionalization of the mentally ill and certain educational expenses.³¹ As the regulations state, "While ordinary education is not medical care, the cost of medical care includes the cost of attending a special school for a mentally or physically handicapped individual, if his condition is such that the resources of the institution for alleviating such mental or physical handicap are a principal reason for his presence there."³² It is clear from these regulations that the IRS does not allow a tax deduction for educational expenses designed to compensate for the social determinants of health that result in poor educational performance, such as poor housing and lack of access to proper nutrition (or even private school tuition).

Courts interpreting § 213's deduction and the corresponding regulations have noted the two basic prongs covering expenses for: (1) the "diagnosis, cure, mitigation, treatment, or prevention of disease" and (2) "the purpose of affecting any structure or function of the body."³³ As explained by the Tax Court in *Jacobs v. Commissioner*,³⁴ the deduction

²⁷ *Id.*

²⁸ *Id.* ("If, however, by reason of this expenditure, it is determined that the value of the residence has not been increased, the entire cost of installing the elevator would qualify as a medical expense.")

²⁹ C.F.R. § 1.213-1(e)(1)(iv).

³⁰ *Id.* (noting that where "travel is undertaken merely for the general improvement of a taxpayer's health," neither transportation nor meals and lodging are deductible).

³¹ 26 C.F.R. § 1.213-1(e)(1)(v)(a).

³² *Id.* § 1.213-1(e)(1)(v)(a) ("Thus, the cost of medical care includes the cost of attending a special school . . . in order to qualify the individual for future normal education or for normal living.")

³³ *O'Donnabhain v. Comm'r*, 134 T.C. 34, 49 (2010) (permitting deduction for hormone therapy and gender reassignment surgery to treat gender identity disorder).

³⁴ *Jacobs v. Comm'r*, 62 T.C. 813 (1974).

for medical care is an exception to the general prohibition on deductions for “personal, living, or family expenses” under § 262 of the Code.³⁵ “The two sections must be read in conjunction when determining the deductibility of any given expense.”³⁶

Under the framework used in *Jacobs*, the first step for an expense to fall under the § 213 deduction is to “show the present existence or imminent probability of a disease, defect, or illness.”³⁷ Next, the payment “must be for goods or services directly or proximately related to the diagnosis, cure, mitigation, treatment, or prevention of the disease or illness.”³⁸ The heart of the issue typically relates to expenses which could be considered either medical or personal and is fact intensive.³⁹

Where the expense is not solely a medical one, “many factors, such as the taxpayer’s purpose or motive, the effect of purchased goods or services on the illness, and the origin of the expense, have been considered relevant.”⁴⁰ A doctor’s prescription is not dispositive but is a factor to be considered, as is any “improvement” in health. One key element is a “but for” test where the taxpayer must show that “the expenditures were an essential element of the treatment and that they would not have otherwise been incurred for nonmedical reasons.”⁴¹

Examples of expenses denied because taxpayers could not meet this “but for” test include fees related to a divorce recommended by a psychiatrist and expenses of spending the summer on the water and winter in Arizona after a coronary illness.⁴² Yet in *Urbauer v. Commissioner*,⁴³ the taxpayers were allowed to deduct costs of enrolling their son in a college-preparatory school as a result of drug and behavioral problems, including tuition, room, board, airfare and rental cars to and from the school for therapy sessions, and an allowance account. Because the edu-

³⁵ 26 U.S.C. § 262 (1988); *Jacobs*, 62 T.C. at 817-18 (“The section does not make medical expenses nonpersonal; it merely carves a limited exception out of [§] 262 for those expenses which fall within its terms.”).

³⁶ *Id.* at 818.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Jacobs*, 62 T.C. at 819 (“There would seem to be little doubt that the expense connected with items which are wholly medical in nature and which serve no other legitimate function in everyday life is incurred primarily for the prevention or mitigation of disease. On the other hand, it is obvious that many expenses are so personal in nature that they may only in rare situations lose their identity as ordinary personal expenses and acquire deductibility as amounts claimed primarily for the prevention or alleviation of disease.”).

⁴⁰ *Jacobs*, 62 T.C. at 819.

⁴¹ *Id.* (finding that § 213 should be narrowly construed).

⁴² See Susan L. Megaard, *Scope of the Med. Expense Deduction Clarified and Broadened by New Tax Court Decision*, 112 J. TAX’N 353, 362 (2010).

⁴³ *Urbauer v. Comm’r*, 63 T.C.M. (CCH) 2492 (1992).

cational expenses “are incidental to the special services provided by the school,” they are deductible.⁴⁴

Less is known about the meaning of the second prong relating to expenses affecting the structures or functions of the body, although the IRS has allowed deductions for items such as a vasectomy, an abortion, birth control pills, infertility treatments, and eye surgeries to correct vision.⁴⁵

B. Exclusion of Healthcare

Americans tend to think of health in terms of illness and visits to doctors and hospitals.⁴⁶ Yet research supports the idea that the social determinants of health—the “contexts in which people live, learn, work and play”—have a large impact on health.⁴⁷ Notably, even if the U.S. had a single payor healthcare system with free healthcare for all, social factors would continue to depress population health.⁴⁸

The basic fact drawn from research on the social determinants of health is that those with higher levels of family income live longer.⁴⁹ While research about inequality in the U.S. tends to focus on race, class is a key component of poor health and social outcomes. In a more unequal society, even the richest do not fare as well as the richest in more equal societies—resulting in shorter life spans. “Inequality evidently pulls everyone down.”⁵⁰

While researchers do not fully understand the process through which lower incomes result in poor health outcomes, some speculate that a lack of “basic resources,” particularly during childhood, and the related stress from not meeting essential needs, causes the poor health outcomes.⁵¹

Globally, countries are focused on improving the social determinants of health that result from income inequality as a moral imperative

⁴⁴ *Id.*

⁴⁵ See Megaard, *supra* note 42, at 364 (“*O’Donnabhain* provides partial support for deductibility where a procedure not only treats a disease *but also* promotes a bodily structure or function.”).

⁴⁶ Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Res. Perspective*, 159 U. PA. L. REV. 1649, 1650 (2011) (noting that Americans acknowledge the importance of social influences on health “when primed” (citation omitted)).

⁴⁷ *Id.* at 1649 (quoting Paula A. Braveman et al., *Broadening the Focus: The Need to Address the Soc. Determinants of Health*, 40 AM. J. PREVENTIVE MED. S1, S5 (2011)).

⁴⁸ *Id.* at 1651.

⁴⁹ *Id.* at 1652-53 (noting that social epidemiologists call this correlation “the gradient” or “the tendency of health outcomes to line up on a steady slope from the have-leasts to the have-mosts”).

⁵⁰ *Id.* at 1653 (arguing that Americans have a shorter life span than the Swedes or Japanese because of greater income inequality).

⁵¹ Burris at 1653-54.

and to improve health outcomes.⁵² In 2005, the Director General of the World Health Organization, Dr. J.W. Lee, created the Commission on Social Determinants of Health. As part of its mission, the Commission aimed to “shift global health from a biomedical model to a social model, which includes social and political conditions.”⁵³

The Commission’s recommendations include universal access to healthcare, but they also include reducing the “inequitable distribution of power, money, and resources, which constitute the structural drivers of health.”⁵⁴ The Commission recommended that countries consider the impact of all policy proposals on health equity.⁵⁵ Two commissioners specifically recommended that the U.S. “improve population health, without spending more money on health, by focusing on social determinants of health.”⁵⁶

The law is a key component in establishing social inequality because it (1) “helps structure and perpetuate the social conditions that we describe as ‘social determinants,’” and (2) turns social institutions “into levels and distributions of health.”⁵⁷ As a result, Emily Parento has argued that “coercive legal mechanisms such as direct regulation and taxation are essential to a serious strategy to reduce disparities.”⁵⁸ Health enables individuals and segments of the population to “fully participate in society” by working, socializing, enjoying their families, being politically active, and maintaining a satisfying life.⁵⁹

While not all health inequalities can be fixed, many are susceptible to intervention.⁶⁰ Yet the debate over the place of the law in advancing public health typically focuses on choosing between “paternalism and autonomy—that is, between government’s right or obligation to enact

⁵² Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 *How. L.J.* 887, 905 (2012).

⁵³ *Id.* at 905-06 (noting that the Commission was created as an entity independent of the WHO, and its twenty commissioners promote health equity around the world).

⁵⁴ *Id.* at 906-07.

⁵⁵ *Id.* at 907.

⁵⁶ *Id.* at 908-09 (explaining that a focus on the social determinants of health “would likely be far less costly” than fixing the issues with American healthcare).

⁵⁷ *Id. supra* note 46, at 1655-56.

⁵⁸ Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 *LOY. L. REV.* 655, 659, 662 (2012) (discussing how any argument to use legal coercion to achieve health equity relies on the human right to health, first stated in the 1948 Universal Declaration of Human Rights and restated in the World Health Organization (WHO) Constitution: “[t]he enjoyment of the highest attainable standard of health . . . without distinction of race, religion, political belief, economic or social condition” (alteration in original) (quoting World Health Organization [WHO], *Constitution of the World Health Organization*, at 1 (Oct. 2006), http://www.who.int/governance/eb/who_constitution_en.pdf)).

⁵⁹ *Id.* at 664.

⁶⁰ *See id.* at 667-68 (noting the theory that intervention is necessary where it is possible to have an impact on the disparity in health outcomes).

laws that either circumscribe individual autonomy (e.g., helmet laws) or shift the decision-making paradigm toward more desired choices (e.g., tobacco taxes) versus an individual’s freedom to engage in conduct not immediately and directly harmful to others.”⁶¹ Regardless of philosophical debates over the virtues of freedom over paternalism, a hands-off approach results in greater harm to those with lower incomes.⁶²

In the U.S., any decision for the government to intervene to advance public health also raises the question of which government should intervene—the federal government or states and municipalities. While states have broad police power over the population’s health and welfare and Congress must typically rely on the Commerce Clause, greater federal resources (including a broad tax base) at times mandate federal involvement.⁶³

C. Case Study of Precision Medicine

One component of the movement to improve the social determinants of health is the precision medicine movement (also called personalized medicine). What a focus on social determinants attempts to do for a community or population, precision medicine instead attempts to accomplish for the individual—more personalized care to improve health outcomes. However, where lawmakers and the medical community have been receptive to precision medicine because it fits the medicalized model of healthcare, they have been insufficiently focused on achieving improved health outcomes through the home and through local institutions.

A 2013 report from the Food and Drug Administration (FDA) begins its definition of precision medicine with a quote from Hippocrates: “It’s far more important to know what person the disease has than what disease the person has.”⁶⁴ Although scientists have observed for years the varying responses of different individuals to medical treatments, it was the sequencing of the genome that allowed for the practice of precision medical diagnosis and treatment.⁶⁵

⁶¹ *Id.* at 677.

⁶² *Id.* (“Law is an essential tool in reducing health inequity because it is axiomatic that a laissez-faire system disadvantages those individuals with less education, fewer resources, and less political power.”).

⁶³ *Id.* at 679.

⁶⁴ FDA, PAVING THE WAY FOR PERSONALIZED MEDICINE: FDA’S ROLE IN A NEW ERA OF MEDICAL PRODUCT DEVELOPMENT 5 (Oct. 2013) [hereinafter *Paving the Way*], <http://www.fda.gov/downloads/ScienceResearch/SpecialTopics/PrecisionMedicine/UCM372421.pdf> (last visited Feb. 6, 2017). Precision medicine is also called “personalized medicine,” “stratified medicine,” “targeted medicine,” and “pharmacogenomics.” *Id.* at 6.

⁶⁵ *Id.* at 5.

As the FDA tells it, “The goal of personalized medicine is to streamline clinical decision-making by distinguishing in advance those patients most likely to benefit from a given treatment from those who will incur cost and suffer side effects without gaining benefit.”⁶⁶ This contrasts with the current “trial-and-error” method of determining the best treatment for an individual.⁶⁷

Although much of the focus on precision medicine is devoted to genetic diagnostic tests and genetic tests that guide treatment decisions, precision medicine includes the use of particular treatments based on: “patient anatomy (*e.g.*, size), physiology (*e.g.*, nervous and cardiovascular systems, metabolism, reproduction) and environment of use (*e.g.*, intensive care unit, home use).”⁶⁸ New technology also allows for individual monitoring at home or work that impacts treatment and patient satisfaction.⁶⁹

Scientists, scholars, and administrators promote the shift taking place in medical care from the “‘one size fits all’ approach of the past to personalized medicine in which a new generation of molecular diagnostics will be used to target treatments to an individual’s unique genetic profile,”⁷⁰ family history, and environmental exposures.⁷¹ Although physicians may see an increased likelihood of a person developing certain diseases based on his or her genetic code, or prescribe treatments that work better for people with certain genetic sequences, they are largely using the statistical correlation data without understanding why these things are true. This “black box” may lead to many unintended consequences before the science advances further.⁷² Yet physicians are permitted the leeway to experiment and try different treatments targeted to an individual’s unique needs.

⁶⁶ *Id.* at 6 (describing precision medicine as “providing ‘the right patient with the right drug at the right dose at the right time’” or “tailoring of medical treatment to the individual characteristics, needs and preferences of a patient during all stages of care” (quoting Wolfgang Sadeé & Zunyan Dai, *Pharmacogenetics/Genomics and Personalized Medicine*, 14 *HUM. MOLECULAR GENETICS* R207, R207 (Oct. 15, 2005))).

⁶⁷ *Id.*

⁶⁸ PAVING THE WAY, *supra* note 64, at 8 (noting the use of 3D printing to customize medical devices).

⁶⁹ *Id.* at 9.

⁷⁰ Gary E. Marchant, *Foreword: Law and the New Era of Personalized Med.*, 48 *JURIMETRICS J.* 131, 131 (2008).

⁷¹ Shubha Ghosh, *Decentering the Consuming Self: Personalized Med., Sci., and the Market for Lemons*, 5 *WAKE FOREST J.L. & POL’Y* 299, 299-300 (2015) (“Diagnosis and treatment can be even more precise and scientific, and consumers of health services will be better off.”).

⁷² *Id.* at 300 (“[M]edical professionals have a sense of what works and use their judgment as a guide in identifying and treating disease.”).

Precision medicine upholds the "ideal of the autonomous individual" with "more meaningful choice over health care decisions."⁷³ The focus is on the rational individual, controlling clinical care decisions. The issue of course is how to make sure that consumers are given accurate information and not misled or misdiagnosed as well as ensuring that customized treatments are the best option for that individual.⁷⁴

Areas where precision medicine is currently in use include chemotherapy drugs that target tumors with particular genetic mutations, blood thinner doses determined based on genetics, and predictions of future illness or health conditions based on genetic information.⁷⁵ A brief look at two controversies that received a significant amount of attention recently is illustrative of legal issues that arise.

In 2013, the U.S. Patent and Trademark Office published a patent application by Myriad, Inc., a company seeking to patent its method for determining whether women with Ashkenazi-Jewish heritage have a BRCA gene deficiency that dramatically increases the likelihood that they will develop breast and/or ovarian cancer.⁷⁶ In *Association for Molecular Pathology v. Myriad Genetics, Inc.*,⁷⁷ the Supreme Court agreed with the Association of Medical Pathologists's claim that the breast cancer gene could not be patented. According to the Court, portions of DNA are not patentable, although synthetic DNA is patentable.⁷⁸ Another company, Nitromed, described its patent for the pharmaceutical BiDil as reducing deaths from heart failure or improving the quality of life in black patients.⁷⁹ Each of these companies relied on previous patents but then customized them to specific populations. The question of whether this creates an issue for the patent system is beyond the scope of this Article,⁸⁰ but it illustrates how medicine is taking existing tests and treatments and customizing them to groups of similarly situated individuals to improve medical care.

Rachel Sachs examines how new regulations of diagnostic testing brought about by the movement for precision medicine are decreasing

⁷³ *Id.* at 301.

⁷⁴ *Id.* at 301-03 ("Information can be revealed, but it cannot be verified in the same way that it can with a car or with the creditworthiness of a borrower. With medical treatment, the patient cannot know whether the diagnosis or treatment is correct until the disease either does not arise or there is full recovery.").

⁷⁵ Rachel E. Sachs, *Innovation Law and Pol'y: Preserving the Future of Personalized Med.*, 49 U.C. DAVIS L. REV. 1881, 1883-84 (2016) (noting President Obama's January 2015 announcement of a \$215 million Precision Medicine Initiative during his State of the Union speech).

⁷⁶ Ghosh, *supra* note 71, at 304-06.

⁷⁷ 133 S. Ct. 2107 (2013).

⁷⁸ *Id.* at 2119.

⁷⁹ Ghosh, *supra* note 71, at 306-07.

⁸⁰ *See id.* at 309-11.

incentives for innovation, however. While Myriad's genetic test for BRCA mutations has analytic validity—can accurately determine the presence or absence of the relevant genetic mutations—it lacks clinical validity since the extent to which particular mutations result in an increased risk for breast or ovarian cancer is not provided and there may be untested mutations that result in increased risks.⁸¹

The case of the company 23andMe, Inc., which marketed genetic testing broadly to individuals interested in learning more about their genetic code, is similar. In November 2013, a complaint was filed with the FDA against 23andMe, followed shortly by a class action lawsuit.⁸² The FDA found that the genetic tests did not support the company's claim that it provided information that could be used to diagnose consumers or make predictions about their future health outcomes. In addition, 23andMe was building a database of consumers' genetic information to market information to other groups, creating issues related to information privacy. The company now provides only ancestry and raw genetic information.⁸³

Just as the lack of data demonstrating the validity of new precision medicine testing results in government restriction and a lack of innovation, the lack of studies demonstrating that a particular social intervention will improve an individual or a population's health will be an obstacle towards funding to decrease social inequality in an effort to improve health outcomes. The main difference is that precision medicine is couched in the mystique of the medicalized model of healthcare and less subject to scrutiny. The result is that doctors and scientists have been given more leeway to experiment with tailoring their new brand of medicine.

The exclusive focus on the advance of healthcare through precision medicine is misguided if the goal is improved population health. Just as increased healthcare spending has not resulted in improved health outcomes in the U.S. overall, increased spending on precision medicine alone is not sufficient because it fails to address the social determinants of health. As public health scholars have pleaded, “[W]e worry that an unstinting focus on precision medicine by trusted spokespeople for

⁸¹ Sachs, *supra* note 75, at 1891-94 (noting that regulation by Centers for Medicare & Medicaid Services (CMS) under the Clinical Laboratory Improvement Amendments of 1988, or CLIA, helps ensure analytical validity).

⁸² Ghosh, *supra* note 71, at 320-21.

⁸³ *Id.* at 321 (“As with the other examples of personalized medicine related companies, the story of 23andMe demonstrates the differences in information between companies and consumers and the controversies over the underlying science supporting the services being advertised and provided.”). When combined with decreased reimbursement rates under Medicare for diagnostic tests and cases restricting the ability of companies to patent personalized diagnostic tests, the effect of these additional regulations is to hinder innovation in this area of precision medicine. Sachs, *supra* note 75, at 1923.

health is a mistake—and a distraction from the goal of producing a healthier population.”⁸⁴

Genetic links have less impact on health outcomes than “behavioral and social factors.”⁸⁵ In fact, research shows that even when individuals are aware of risk factors for disease that suggest they should modify their behavior in some way, they fail to make those behavioral changes.⁸⁶ Only by addressing “the foundational causes of ill health such as poverty, obesity, and education,” can substantial health gains be made.⁸⁷ There is ample evidence that improving clinical care, while helpful at the individual level, cannot improve the disparity in health outcomes among different subpopulations.⁸⁸ Spending on preventive public health programs typically improves health more than clinical treatment of illness and injuries.⁸⁹ Genetic risk factors are responsible far less for diseases like asthma, diabetes, cancer, and cardiovascular disease than “environmental and behavioral factors.”⁹⁰ Yet funding for research related to population health or public health has declined over the last decade while genetic research funding has increased dramatically.⁹¹

There are ways to apply precision medicine for the benefit of the population, however. Dividing populations into risk groups and adjusting medical strategies to each group can help and might reduce the cost of care by focusing on those with the greatest need.⁹² Research must focus on both genetic and social determinants of health. “For example,

⁸⁴ Ronald Bayer & Sandro Galea, *Public Health in the Precision-Med. Era*, 373 *NEW ENG. J. MED.* 499, 501 (2015).

⁸⁵ Muin J. Khoury & Sandro Galea, *Will Precision Medicine Improve Population Health?*, 316 *JAMA* 1357, 1357 (2016) (“The solution to these challenges is probably not an increased focus on the individual, but rather involves focusing on the social, economic, and structural drivers of population health that are ubiquitous and inevitably linked to health achievement as a country.”).

⁸⁶ *Id.*

⁸⁷ *Id.*; Bayer & Galea, *supra* note 84, at 501 (“Unfortunately, all the evidence suggests that we, as a country, are far from recognizing that our collective health is shaped by factors well beyond clinical care or our genes.”).

⁸⁸ Bayer & Galea, *supra* note 84, at 500 (citing British studies showing that even a strong national, single payer system does not alleviate the differential in health outcomes between those with different income levels); Chris Carlsten et al., *Genes, the Env't and Personalized Med.*, 15 *EUR. MOLECULAR BIOLOGY ORG. REP.* 736, 736 (2014) (“[P]ersonalized medicine could theoretically reduce healthcare costs, as an individual’s genetic or other biological information could be used to make better or earlier diagnoses of disease, apply cheaper, preventive measures to decrease risk, and make more efficient use of therapeutic opinions. However, there remains a considerable gap between theory and reality, and we think that the prevailing focus on an individual’s genes and biology insufficiently incorporates the important role of environmental factors in disease etiology and health.”).

⁸⁹ Carlsten et al., *supra* note 88, at 736.

⁹⁰ *Id.* at 737 (“[T]he ‘elephant in the room’ of personalized medicine is the fact that genetic effects in isolation are insufficient to identify the risk in the most prevalent diseases.”).

⁹¹ Khoury & Galea, *supra* note 85, at 1357.

⁹² *Id.* at 1357-58.

biological knowledge of genetic susceptibility to environmental and occupational exposures could lead to population-wide policy protection based on thresholds determined by the most susceptible individuals in the population rather than individual genetic testing with exposure avoidance only in susceptible individuals.”⁹³ Focusing on health concerns at the individual level, on the other hand, has the “potential for widening the divide between the haves and have-nots.”⁹⁴

II. HEALTH SAVINGS ACCOUNTS

The best way to reduce social inequality is through a basic income that allows families to meet essential needs and therefore improves health outcomes. Given the current political climate, however, a basic income is unlikely to be implemented in the U.S. for the next several years (at a minimum). With the Republican focus on HSAs, they are instead a realistic avenue for reform.

Jacob Hacker asserted in 2008 that HSAs are a “near-theological aspiration of the Right” but are “poised to make the increasingly risky world of private health insurance even more fragmented and frightening.”⁹⁵ His concern was that only the healthy and those who could afford to bear a significant level of medical expenses before high-deductible insurance kicks in would voluntarily enroll in HSAs. The accounts would therefore skim the cheapest workers to cover from traditional health insurance plans and leave behind less healthy workers. This would cause premiums to increase in traditional plans, the healthiest of those remaining to leave for HSAs, and the process to continue in the “death spiral of adverse selection.”⁹⁶

Yet today, many employees have HDHPs, and the ones who have HSAs at all are lucky. HSAs and the HDHPs that they are paired with are a large and growing portion of the health insurance landscape. Among firms that offer health benefits, twenty-four percent offered an HSA-qualified HDHP in 2016.⁹⁷ Large firms are more likely to offer an HDHP with a savings account than smaller firms.⁹⁸ Twenty-nine percent

⁹³ *Id.* at 1358.

⁹⁴ *Id.*

⁹⁵ HACKER, *THE GREAT RISK SHIFT*, *supra* note 13, at 153-54.

⁹⁶ *Id.* (“The Right once embraced private insurance precisely because it pooled risk without government intrusion; but as private insurance has grown less capable of pooling risk across America’s working population—both because of the sharp decline in its reach and because of the dramatic change in employer and insurance practices—conservatives have not tried to save what they once championed.”).

⁹⁷ Kaiser Family Found.: THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, *Employer Health Benefits 2016 Annual Survey* 154, 158 ex. 8.1 (Sep. 14, 2016), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey> (last visited Feb. 7, 2017).

⁹⁸ *Id.* at 154, 158-59 exs. 8.2-8.3.

of all employees covered by employment-based health insurance are enrolled in an HDHP with a savings account (HRA or HSA); nineteen percent are enrolled in an HDHP with an HSA.⁹⁹ Employees have slowly gotten used to this method of health financing—and to paying more for their health expenses.

Employees enrolled in HDHPs pay more for their healthcare than employees enrolled in traditional health insurance plans. The average annual deductible for HDHPs/HSAs is \$2,295 for single coverage and \$4,364 for family coverage—with a wide variation among plans.¹⁰⁰ The average annual out-of-pocket maximum for single coverage is \$4,083.¹⁰¹ Employees receive an average annual employer contribution to their HSA of \$686 for single coverage and \$1,208 for family coverage, but this obscures the fact that twenty-five percent of employees enrolled in an HDHP/HSA option do not receive any employer contributions in their accounts.¹⁰² After factoring in employer contributions, the average annual deductible for those with single coverage is \$1,701 at small firms and \$1,326 at large firms.¹⁰³

Many employees cannot afford to pay these deductibles and must therefore sacrifice medical care to pay for other essential items like housing and childcare. Yet this appears to be the direction that Republicans will take health reform if given the chance. Perhaps they will be expanded to cover more Americans with contributions to the accounts coming from the government instead of only from employers and employees. Regardless, they can only be spent on items defined in § 213(d). Here, I discuss the rise of individual accounts in health financing and specifically the laws and regulations relevant to HSAs. I argue that HSAs can be tailored to help reduce social inequalities in health.

A. *History and Regulation of Health Savings Accounts*

HSAs were established effective January 1, 2004. A few weeks later, President George W. Bush stated that “[t]hey will help restrain the health care costs that are affecting us all.”¹⁰⁴ He used the word “em-

⁹⁹ *Id.* at 154, 160-61 exs. 8.4-8.6.

¹⁰⁰ *Id.* at 154-55, 161-62 exs. 8.7-8.8.

¹⁰¹ THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST., at 155, 161-62 exs. 8.7-8.8.

¹⁰² *Id.* at 156-57, 161-62 exs. 8.7-8.8.

¹⁰³ *Id.* at 164 exs. 8.12.

¹⁰⁴ Press Release, Off. of the Press Sec’y, President Bush Discusses Quality, Affordable Health Care (Jan. 28, 2004), <https://georgewbush-whitehouse.archives.gov/news/releases/2004/01/20040128-2.html> (“When consumers don’t have the incentive to get better prices, costs go up.”).

power” repeatedly.¹⁰⁵ Individuals would be empowered by saving for and paying their own routine medical expenses while maintaining insurance coverage for catastrophic health events. President Bush also said that the “incentive” for individuals to better take care of their health would prevent illness.

Among President Bush’s claims was that employers and individuals would save on the cost of health insurance premiums through the use of HDHPs. The accounts would help cover the uninsured by allowing individuals to deduct premiums for HDHPs regardless of whether they itemize.¹⁰⁶

The overall message from President Bush and other supporters of HSAs, though, was that these are accounts that “the employee controls” and “families can keep their savings in an account that belongs to them, not to their employer or to an insurance company.”¹⁰⁷ Representative Michael C. Burgess added, “The most important thing, though, Mr. Speaker, is this is money that patients own and they control. It is their accounts, not the government’s.”¹⁰⁸

A health savings account is a “trust created . . . exclusively for the purpose of paying the qualified medical expenses of the account beneficiary.”¹⁰⁹ Both the employer and employee may contribute to the HSA.¹¹⁰ For 2017, the limit on contributions to an HSA is \$3,400 for an account holder with individual insurance coverage and \$6,750 for an ac-

¹⁰⁵ *Id.* (“The best way to empower citizens is to let them save and spend their health care dollars as they see fit. In other words, start to empower people to make the right decisions with their health care dollars.”).

¹⁰⁶ Press Release, Off. of the Press Sec’y, Fact Sheet: Expanding Access and Increasing the Affordability of Health Insurance Through Health Savings Accounts (Aug. 9, 2004), <https://georgewbush-whitehouse.archives.gov/news/releases/2004/08/20040809-14.html>.

¹⁰⁷ *Id.*

¹⁰⁸ 150 CONG. REC. H3405-06, H3406 (daily ed. May 20, 2004) (statement of Rep. Burgess).

¹⁰⁹ 26 U.S.C. § 223(d)(1). Where employer involvement is limited, HSAs are not subject to ERISA. U.S. DEP’T OF LABOR, EMP. BENEFITS SEC. ADMIN., FIELD ASSISTANCE BULL. NO. 2004-01, HEALTH SAVINGS ACCOUNTS (2004) [hereinafter FIELD BULL. HSAs], <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2004-01#Footnotes> (last visited Feb. 7, 2016) (HSAs do not typically meet the definition of “employee welfare benefit plans” under Title I of ERISA even if an employer contributes to the accounts because participation by employees is voluntary and “the beneficiaries of the account have sole control and are exclusively responsible for expending the funds in compliance with the requirements of the Code.”); see also U.S. DEP’T OF LABOR, EMP. BENEFITS SEC. ADMIN., FIELD ASSISTANCE BULL. NO. 2006-02, HEALTH SAVINGS ACCOUNTS—ERISA Q&As (2006), <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2006-02> (last visited Feb. 7, 2017); IRS Notice 2004-2, 2004-1 C.B. 269, Q&A-29 (HSA trustees or custodians need not determine that account holders are spending the funds properly, and the account holders must maintain paperwork to prove that the funds are used for qualified medical expenses.). The shift of responsibility to individuals with HSAs and the movement away from ERISA protection is troubling.

¹¹⁰ IRS Notice 2004-2, *supra* note 109, at Q&A-11.

count holder with family coverage.¹¹¹ Those age 55 or older can contribute an additional \$1,000 per year.¹¹² Employers making their own contributions to employee HSAs must contribute similarly for all eligible employees during the same time period.¹¹³

Only individuals who are participants in an HDHP¹¹⁴ are eligible to deduct amounts contributed to an HSA from their income.¹¹⁵ For 2017, an HDHP is defined as a plan "with an annual deductible that is not less than \$1,300 for self-only coverage or \$2,600 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed \$6,550 for self-only coverage or \$13,100 for family coverage."¹¹⁶ Account holders may not have other health insurance coverage in addition to the HDHP¹¹⁷ with a few exceptions.¹¹⁸ An exception permits insurance plans that do not charge a deductible for preventive care only to be treated as HDHPs,¹¹⁹ although it is not required that HDHPs offer coverage for preventive care.¹²⁰

¹¹¹ Rev. Proc. 2016-28, 2016-20 I.R.B. 852.

¹¹² 26 U.S.C. § 223(b)(3).

¹¹³ FIELD BULL. HSAs, *supra* note 112.

¹¹⁴ 26 U.S.C. § 223(c)(2) ("The term 'high deductible health plan' means a health plan—(i) which has an annual deductible which is not less than—(I) \$1,000 for self-only coverage, and (II) twice the dollar amount in subclause (I) for family coverage, and (ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—(I) \$5,000 for self-only coverage, and (II) twice the dollar amount in subclause (I) for family coverage.").

¹¹⁵ *Id.* § 223(a) ("In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual."); *id.* § 223(c)(1)(A) ("The term 'eligible individual' means, with respect to any month, any individual if—(i) such individual is covered under a high deductible health plan as of the 1st day of such month . . .").

¹¹⁶ Rev. Proc. 2016-28, 2016-20 I.R.B. 852. *But see* IRS Notice 2004-50, 2004-2 C.B. 196, Q&A-16 ("Restricting benefits to UCR [usual, customary and reasonable amounts] is a reasonable restriction on benefits. Thus, amounts paid by covered individuals in excess of UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.").

¹¹⁷ 26 U.S.C. § 223(c)(1)(A) ("The term 'eligible individual' means, with respect to any month, any individual if— . . . (ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—(I) which is not a high deductible health plan, and (II) which provides coverage for any benefit which is covered under the high deductible health plan.").

¹¹⁸ *See id.* § 223(c)(1)(B), (c)(3). *But see* Rev. Rul. 2004-38, 2004-1 C.B. 717 ("This ruling provides that if an individual is covered by both a high deductible health plan (HDHP) that does not cover prescription drugs and by a separate drug plan (or rider) that provides benefits before the minimum annual deductible of the HDHP has been satisfied, that individual is not an eligible individual under [§] 223(c)(1)(A) of the Code and may not make contributions to a Health Savings Account.").

¹¹⁹ 26 U.S.C. § 223(c)(2)(C) ("Safe harbor for absence of preventive care deductible.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).").

¹²⁰ IRS Notice 2004-23, 2004-1 C.B. 725.

The IRS has provided a significant amount of guidance on what fits within the preventive care exception to the requirement that HSA account holders use them with only HDHPs. Preventive care includes, but is not limited to:

“Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.

- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight-loss programs.
- Screening services”¹²¹

Screening services include everything from routine newborn care to specific cancer and heart disease screenings.¹²²

Preventive care includes medications taken to control the risk for a disease “that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent reoccurrence of a disease.”¹²³ The safe harbor also covers “any treatment that is incidental or ancillary to a preventing care service or screening” such as the removal of polyps during a colonoscopy because it is “unreasonable or impractical” to repeat the procedure to treat the ancillary condition.¹²⁴

Section 1001 of the ACA added section 2713 to the Public Health Service Act, which requires those offering group and individual health insurance to provide certain preventive healthcare without cost-sharing requirements such as deductibles, co-payments, and co-insurance.¹²⁵ Therefore, a health plan will not fail to qualify as an HDHP simply because it offers these preventive care services without a deductible.¹²⁶

Outside of preventive care, the individual must pay for medical expenses under the HDHP deductible threshold using HSA funds (or outside funds if the HSA account balance is insufficient). HSA funds may only be used for “qualified medical expenses,” which are “amounts paid by such beneficiary for medical care (as defined in [§] 213(d)[I])” for

¹²¹ *Id.*

¹²² *Id.* at app.

¹²³ IRS Notice 2004-50, 2004-2 C.B. 196, Q&A-27 (providing the examples of cholesterol lowering drugs such as Statins and weight-loss programs while noting that the safe harbor “does not include any service or benefit intended to treat an existing illness, injury, or condition”).

¹²⁴ *Id.* at Q&A-26.

¹²⁵ 42 U.S.C. § 300gg-13; *see* IRS Notice 2013-57, 2013-40 I.R.B. 293 (noting that the ACA also incorporated section 2713 into ERISA and the Code).

¹²⁶ IRS Notice 2013-57, 2013-40 I.R.B. 293.

the account holder and her family “but only to the extent such amounts are not compensated for by insurance or otherwise.”¹²⁷

Payments from the account for qualified medical expenses are excluded from the account holder’s income.¹²⁸ Any medical expenses defined by § 213(d) that are paid for from the HSA may not also be deducted to the extent they constitute ten percent or more of income.¹²⁹ Payments not used for qualified medical expenses are subject to a twenty percent penalty tax,¹³⁰ although there are exceptions for payments made after the account holder becomes eligible for Medicare or is disabled and after the holder’s death.¹³¹ Unlike with FSAs, the account holder does not forfeit unused balances in the account.¹³²

Today, there is evidence that HSA account holders with lower incomes engage in fewer non-preventive outpatient office visits, particularly specialist visits, than low income workers enrolled in a preferred provider organization (PPO) plan.¹³³ Although there is a decline in such visits for higher income employees as well, it is twice as large for the low income group.¹³⁴ Low income employees enrolled in an HSA also reduce their use of preventive services, such as flu vaccinations, more than higher income employees.¹³⁵ Finally, low income HSA account holders have higher rates of emergency room (ER) visits and hospital admissions compared to those in the PPO plan.¹³⁶ The effect appears however, to be only a short-term increase in hospital visits. Inexperienced HSA users may shift towards preventive and outpatient care once

¹²⁷ 26 U.S.C. § 223(d)(2)(A).

¹²⁸ *Id.* § 223(f)(1).

¹²⁹ *Id.* § 223(f)(6) (“For purposes of determining the amount of the deduction under [§] 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.”).

¹³⁰ *Id.* § 223(f)(4)(A) (“The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 20 percent of the amount which is so includible.”).

¹³¹ 26 U.S.C. § 223(f)(4)(B) (“Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of [§] 72(m)(7) or dies.”); *id.* § 223(f)(4)(C) (“Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.”).

¹³² *Id.* § 223(d)(1)(E) (“The interest of an individual in the balance in his account is nonforfeitable.”).

¹³³ 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, at 1, 12-14 (Aug. 2016).

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.* at 1, 14, 17 (“Perhaps the biggest surprise among the findings is that emergency department visits and inpatient hospital admissions increased among lower-income individuals who enrolled in the HSA-eligible health plan.”).

they see the costs associated with hospital visits,¹³⁷ which emphasizes the need for education of individuals on how to minimize expenses when using an HSA and HDHP.

B. *Political Feasibility of Expanding Medical Care*

The definition of “medical care” covered by health insurance and individual accounts has already been expanded over the years to include the pre-payment of regular, predictable expenses associated with preventive care. Americans have become used to health insurance that covers catastrophic medical expenses that would otherwise result in great financial harm to the individual in addition to the pre-payment of regular medical care. It is this latter category that seems most akin to the funding of basic social needs that result in poor health outcomes.

Many Republican proposals to replace the ACA would increase the cost of medical care by allowing healthy individuals to opt out of the insurance market. Any increases to direct government expenditures will be politically unpalatable, though. Christopher Howard has, however, brought scholarly attention to the American use of indirect spending, tax expenditures in particular, to finance a welfare state that is much bigger than is commonly perceived.¹³⁸ “The hidden welfare state is roughly one-third to one-half the size of the visible welfare state of direct spending.”¹³⁹

Tax expenditures are tax deductions, credits, deferrals, exclusions, or reduced tax rates targeted to “a particular industry, activity, or class of persons.”¹⁴⁰ Foregone tax revenues are the equivalent of direct spending appropriations.¹⁴¹ In healthcare, for example, the largest federal tax expenditure is the exclusion for private employer-sponsored health insurance.¹⁴² “Most housing programs are administered through the tax code rather than appropriations; the U.S. government spends twice as much on housing tax expenditures as on traditional housing programs.”¹⁴³ Middle and upper class Americans are typically the beneficiaries of tax expenditures,¹⁴⁴ although as my proposal below shows, that need not be the case.

¹³⁷ *Id.*

¹³⁸ Christopher Howard, *The Hidden Side of the Am. Welfare State*, 108 POL. SCI. Q. 403 (1993).

¹³⁹ *Id.* at 405.

¹⁴⁰ *Id.* at 407.

¹⁴¹ *Id.*

¹⁴² SEAN LOWRY, CONG. RESEARCH SERV., CONG. RESEARCH SERV., R44333, HEALTH-RELATED TAX EXPENDITURES: OVERVIEW AND ANALYSIS AT SUMMARY AND 7 (Jan. 8, 2016). <https://fas.org/sgp/crs/misc/R44333.pdf>.

¹⁴³ Howard, *supra* note 138, at 416.

¹⁴⁴ *Id.* at 416-17.

Howard’s research challenges the idea of a two-track social welfare system because the benefits employees receive through tax expenditures are not truly earned. “[M]ost tax expenditures are structured as open-ended entitlements; their receipt does not depend on the judgment of caseworkers and does not entail social stigma. . . . [B]enefits are tied more to income than employment. Recipients do not have to earn their tax benefits.”¹⁴⁵

Tax expenditures have been enacted regularly, even during times known for resistance to new social welfare programs. Unlike direct social spending, which largely came in a few “big bangs” such as the New Deal and the Great Society, important tax expenditures have at times done what “the government could not or would not do directly.”¹⁴⁶ Tax expenditures have also been passed during Republican control of the White House and Congress.¹⁴⁷ In fact, “the actors who keep surfacing as the builders of the hidden welfare state are moderate and conservative members of Congress.”¹⁴⁸

Although the debate over tax expenditures has become more public over time, conflict over these provisions still pales in comparison to major direct spending bills in social welfare. As Howard says of past enactments, “Hardly anyone at the time trumpeted their passage or predicted that dire consequences would result. Hardly anyone noticed at all.”¹⁴⁹

Another reason that tax expenditures are easier to pass in political climates hostile to new social welfare spending is “ambiguity of purpose.”¹⁵⁰ Tax expenditures can be touted as “social welfare programs” or as “tax relief”—or both.¹⁵¹ Although Congress has become less receptive to new tax expenditures,¹⁵² I imagine that the extreme rhetoric against the ACA will make healthcare reform feasible only through indirect tax expenditures enacted as part of the repeal of key provisions of the ACA.

¹⁴⁵ *Id.* at 418.

¹⁴⁶ *Id.* at 421-22.

¹⁴⁷ *Id.* at 423 (“Tax expenditures for corporate pensions and corporate health benefits, two of the three largest programs currently, were enacted under unified Republican control for the White House and Congress. The Work Incentive (WIN) tax credit and Earned Income Tax Credit were enacted when Republicans controlled the White House and Democrats controlled Congress.”).

¹⁴⁸ *Id.* at 425.

¹⁴⁹ *Id.* at 426-31 (explaining also the credit claiming opportunities for members of the revenue committees in Congress passing tax expenditures).

¹⁵⁰ *Id.* at 431.

¹⁵¹ *Id.* (noting that this allows for broader political coalitions to be built around the proposals).

¹⁵² *Id.* at 433 (explaining how Congress attaches a tax expenditure budget to its annual budget and how congressmen supporting new expenditures need to detail how they will pay for the programs).

Although conservatives frequently discuss limiting the high costs of entitlement programs, the use of tax expenditures as an alternate strategy does not decrease costs. While entitlement programs that must provide benefits to all who meet the eligibility criteria are criticized because costs—which are clear and measureable—can increase far beyond forecasts, the same is not true of tax subsidized private social welfare programs.¹⁵³ As Jacob Hacker says about tax-funded, private programs:

Tax subsidies for private benefits are actually identical to entitlement programs in structure. Once the tax treatment of a benefit is decided upon, qualification is automatic, and no additional legislative action or budgetary appropriation is required, regardless of eventual costs. Unlike most entitlements, however, the effects of privatized approaches emerge from the interplay of public policies and a multitude of private decisions by individuals and organizations, making their ultimate outcomes even more unpredictable and unstable.¹⁵⁴

Thus, the main advantage of indirect tax expenditures instead of direct government funding for broad-based social welfare programs is political cover. They have provided the government with a tool to enact programs to fill unmet needs—even where the public does not recognize the need. They have enabled the millions who receive welfare benefits through tax expenditures to feel positive about their benefits, although they have also set up the view of other groups who do not receive such benefits as unworthy of them.

C. *A Proposal for Precision Healthcare Accounts*

I argue here that the time has come to experiment with personalizing health financing through individualized tax expenditures that rely on a taxpayer's genetic code, personal characteristics, and environment to determine what can appropriately be considered "medical care" under § 213 of the Code. Too much focus in precision medicine is on genetics and too little on the social determinants of health. Targeted spending on housing and education, for example, can improve health outcomes more than genetic testing ever will. Precision healthcare accounts can help.

Assuming that healthcare reform will proceed through individual accounts tied to the definition of medical care under § 213, I propose that: (1) the government provide subsidies for low-income taxpayers in

¹⁵³ JACOB S. HACKER, *THE DIVIDED WELFARE STATE: THE BATTLE OVER PUB. AND PRIVATE SOC. BENEFITS IN THE U.S.* 48 (2002) [hereinafter HACKER, *THE DIVIDED WELFARE STATE*] ("Yet compared with many privatized social policy approaches, public entitlement programs seem exceedingly well mannered and responsive.").

¹⁵⁴ *Id.*

the form of contributions to the HSA, and (2) the definition of “medical care” under § 213 be interpreted to apply to expenses such as food, housing, and educational costs that could prevent diseases like asthma, diabetes, obesity, and cardiovascular disease among those with low incomes. I do not believe this requires a statutory amendment but instead only a change in the interpretation of current law—a recognition that the social determinants of health play a far bigger role in the “treatment” and “prevention of disease” than clinical care and certainly affect the “structure or function of the body.”

Those with lower incomes need more spending on food, housing, and education to prevent poor health than on genomics. If the IRS is concerned with ensuring that those who install elevators in their houses for health reasons are fully compensated, then why not pay for a low-income person with the same health issues to move from an apartment in a non-elevator building to a building with an elevator? Why prohibit the deduction of the air conditioner simply because it benefits the health of the rest of the family?

Personalized default rules are instructive here. Courts or administrative agencies could apply different default tax rules for individuals in different income brackets. Those with higher incomes could deduct as “medical care” or spend HSA funds on experimental genetic testing and targeted immunotherapy cancer treatments but not on ordinary food, housing, and educational expenses that the person is likely to and can afford to pay for regardless of whether they are tax-subsidized. Those with lower incomes, whose health is affected by these ordinary expenditures that they cannot afford to make, could deduct or use HSA funds for healthcare that is both ordinary and essential. While they can engage in the same use of precision medicine as those in higher income brackets, they are likely to use the funds to meet more basic needs.

Although a doctor’s prescription for mold remediation, pest control, or a personal trainer might not be definitive to show that this is allowable medical care under the Code, it would be one factor in showing that these services are necessary to prevent or treat illness or disease. Given the emphasis on individual control over the funds in HSAs and rational decision making in healthcare use, the decision of what to spend this limited source of funds on should be between the individual and her doctor—with the IRS simply issuing guidelines on allowable medical care that are different for people with different income levels.

Farther into the future, I believe it will be possible to customize tax deductions based on an individual’s genetic code and risks. The use of big data in commerce will someday be mirrored in healthcare. Yet there is a need to fix the mismatch between improved genetic diagnosis of health risks and medical care that deals appropriately with those newly

discovered risks. The solution is not always more clinical spending. This is why the U.S. spends nearly eighteen percent of its GDP on healthcare but produces population health inferior to its peer countries.

Instead, a database will hopefully someday show the most efficient social spending to prevent asthma in young children at high risk for the disease, even if it means subsidizing a move to a different location under § 213. Research in precision medicine at the individual level can be brought to bear on problems “beyond the individual for population- or community-level interventions.”¹⁵⁵ Individuals can be sent a list of items that will be tax-subsidized this year based on their characteristics and genetic risk factors. That list could change every year or remain stable for a designated time period to allow for long-term planning.

The increasing use of big data in medicine—and in commerce—has made personalization possible. While data mining raises ethical questions, it presents opportunities and will likely reshape our legal system in the coming decades.

Ariel Porat and Lior Jacob Strahievitz make the argument that “law should become more personalized.”¹⁵⁶ An example they give is having different default rules in intestacy for men and women since men are more likely to leave all their property or a larger share of their property to their spouse in a will. Porat and Strahievitz give the reason that women are less trusting that their husbands will not later remarry and divert money from the couple’s children.¹⁵⁷ They also advance an argument for allowing courts to “determine how an intestate’s estate should be allocated based on an analysis of his consumer behavior during his lifetime.”¹⁵⁸ With big data, courts can investigate the choices of “guinea pigs” with similar behavior and characteristics to use as a “template” for identifying choices that the intestate would have made in a will.¹⁵⁹

¹⁵⁵ Carlsten et al., *supra* note 88, at 737 (providing the example of a group of students with a higher genetic risk for asthma and parents who lobby the city to build a school outside a high traffic area as a result, benefiting the whole community and not just those at high risk).

¹⁵⁶ Ariel Porat & Lior Jacob Strahievitz, *Personalizing Default Rules and Disclosure with Big Data*, 112 MICH. L. REV. 1417, 1418 (2014) (arguing for personalized default rules and disclosures instead of a tradition where the “state generally does not tailor the contents of the law to people’s characteristics and traits”).

¹⁵⁷ *Id.* at 1419.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* at 1419-20 (noting that this would better fit the desires of the majority of individuals who do not draft wills and might result in increased efficiency if others determine that they no longer need to pay for the drafting of wills with more tailored default rules); see Ian Ayres, *Preliminary Thoughts on Optimal Tailoring of Contractual Rules*, 3 S. CAL. INTERDISC. L.J. 1 (1993); George S. Geis, *An Experiment in the Optimal Precision of Contract Default Rules*, 80 TUL. L. REV. 1109 (2006); Cass R. Sunstein, *Deciding by Default*, 162 U. PA. L. REV. 1 (2013).

Contract law is also thought of as an area where default rules can save parties money by implicit incorporation into contracts.¹⁶⁰ Yet if the default rules are not sufficiently personalized to the parties' preferences, then default rules can increase transaction costs by forcing parties to opt out or preventing an agreement where opting out is too costly.¹⁶¹

Porat and Strahilevitz address how to implement a legal system with different default rules for different people. Because of institutional competence concerns, they focus less on the option for courts to *ex post* fill in the default terms where a contract or will is silent using the characteristics of the parties at the time they entered into the contract or will. Instead, they suggest that: (1) companies provide their customers with personalized default contracts, which customers can view before execution, or (2) government agencies like the Consumer Financial Protection Bureau develop default contracts tailored to types of customers and require companies to offer the terms to customers fitting the profile, which customers can view before execution.¹⁶² The first solution strikes me as unlikely to succeed because companies lack the incentive to carefully research what default provisions make sense for particular consumers. But the second permits a government agency to develop more granular default rules based on the data available, and this is a solution that could apply in the context of medical care deductions and the social determinants of health.

Among the examples used by Porat and Strahilevitz of areas where personalized default rules might be helpful are organ donation and medical malpractice. In organ donation, the U.S. faces constant shortages because we have an opt in system instead of an opt out system as some other countries use.¹⁶³ They recommend personalizing a default rule that varies depending on a predictive model of organ donation preferences.¹⁶⁴ In the area of medical malpractice, the personalized default framework allows for more accuracy in establishing what a reasonable physician or patient would do in a given set of circumstances.¹⁶⁵

These two examples are informative. If the U.S. can incentivize individual spending in areas that are key to population health and do so by utilizing data on what a reasonable HSA account holder with similar

¹⁶⁰ Porat & Strahilevitz, *supra* note 156, at 1422-23.

¹⁶¹ *Id.* at 1423 ("Default rules governing specific types of transactions should be tailored until finer tailoring is not cost justified, i.e., when additional tailoring will increase transaction costs.").

¹⁶² *Id.* at 1440-41.

¹⁶³ *Id.* at 1442.

¹⁶⁴ *Id.* at 1442-44.

¹⁶⁵ *Id.* at 1444-46 (explaining that figuring out what a reasonable physician or patient would have done at the time of the medical decision or action in question is easier under this model because it moves away from "hindsight bias").

characteristics would do in a similar situation, then it can target its spending—through tax subsidies—to the areas that are needed to improve overall health. This targeted spending would hopefully reduce the blunt instrument of overall healthcare spending as preventive care resulted in cost savings.

Drawbacks to this personalized deduction framework include cross subsidization—two healthcare consumers buy the same good or service for the same price but different tax rules govern the transaction, strategic behavior—behaving differently to receive a different default rule from the database, inappropriate data use by the government, and uncertainty about consumer behavior that decreases the effectiveness of the law or increases adjudication costs.¹⁶⁶ Concerns also include creating negative stereotypes about a group based on data¹⁶⁷ and information privacy issues and laws that may prevent efficient mining of big data for the purpose of tailoring default tax rules.¹⁶⁸

Yet the very idea of precision medicine mandates that different individuals receive different medical care. The next step is to realize that this care need not be clinical. Individualized medicine should give way to individualized tax rules related to healthcare. This framework is appropriate not only because much of our welfare state is financed through tax expenditures, but also because even a single payer system does not remediate the social determinants of health. Personalized tax expenditures could therefore be combined with other methods of healthcare financing.

III. BRIDGING DICHOTOMIES

My proposal to personalize tax expenditures requires reconciling two dichotomies that pervade health policy discussions: (1) entitlements v. grants-in-aid and (2) pooled insurance v. consumer-driven health plans (CDHPs, also called consumer-directed health plans). Health financing for the poor in this country has fluctuated between an entitlement model—in which all who meet the eligibility criteria have a right to health insurance—and grants-in-aid—where a specific amount of money is designated to states to provide money to its needy population regardless of the number or demographics of those who fall below a specific income level.

While precision healthcare accounts could be funded either as a traditional entitlement program where all participants are entitled to certain balances in their accounts depending on their income level or as a

¹⁶⁶ Porat & Strahilevitz, *supra* note 156 at 1453-59.

¹⁶⁷ *Id.* at 1461-63.

¹⁶⁸ *Id.* at 1467-69.

grant-in-aid where states are given a set amount of money to put in accounts for their populations, if Medicare moves to an individual account form, the likelihood of entitlement funding for these accounts increases because of its broad base of support.

Similarly, putting more power in the hands of individuals to decide how their healthcare funds are spent calls into question the tradition of pooled insurance in favor of the recent push towards CDHPs. It is difficult for insurance companies to calculate risk if they do not know precisely what expenses they will incur for different populations. Increasing expenses for those already at the highest risk for costly medical problems (those with lower incomes) makes them undesirable as insurance customers. Yet if science can show direct cost savings that result from using healthcare funding to address the social determinants of health, then insurance companies may be more willing to move into this uncharted territory. Individual choice over how to spend money allocated for social and medical causes may even be unnecessary if parties are required to choose among items with demonstrated efficacy that improve health outcomes and decrease costs.

In the end, I argue that an entitlement method of funding precision HSAs along with pooled insurance subsidized by the government for those able to spend funds on social causes of poor health is the most realistic resolution of these dichotomies. Only a broad-based entitlement to funding for all healthcare expenses (medical and social) allows for significant improvements in overall population health. Since allowing individuals to spend their account balances on items such as housing and food will increase overall expenses and result in insurance companies paying more of their medical expenses, the government must subsidize traditional insurance costs for individuals who receive this type of funding for social expenses or demonstrate that the additional expenses result in equivalent long-term savings from improved health outcomes.

A. *Entitlements v. Grants-in-Aid*

After the passage of the ACA, states such as Indiana received waivers to implement a unique version of the Medicaid expansion. In Indiana, when Vice-President Mike Pence was Governor, that included payments made by those enrolled in Medicaid into individual accounts that are used for insurance premiums (not co-pays, which must be paid for separately).¹⁶⁹ This means that participants were required to pay for

¹⁶⁹ Indiana Family and Social Services Administration, *Healthy Indiana Plan*, IN.GOV, <http://www.in.gov/fssa/hip/index.htm> (last visited Feb. 7, 2017); see Alana Semuels, *Indiana's Medicaid Experiment May Reveal Obamacare's Future*, THE ATLANTIC, (Dec. 21, 2016), <https://www.theatlantic.com/business/archive/2016/12/medicaid-and-mike-pence/511262/> (last visited Feb. 7, 2017).

a portion of their Medicaid health insurance premiums, and the government paid the remainder. While a brief history of the hostility towards entitlement programs will demonstrate why those on Medicaid typically receive an unfavorable reception, Indiana's plan (and Kentucky's desire to follow it¹⁷⁰) illustrates some of the benefits and drawbacks of using individual accounts to finance healthcare.

Although the American welfare state has been considered anemic in comparison to those of western Europe, that impression changes when private programs, subsidized by foregone tax revenue, are included. Public social welfare programs have come in big waves, during the New Deal in the 1930s, the Great Society in the 1960s, and more recently with the passage of the Affordable Care Act. As a backlash developed against public benefits that were not "earned" like those associated with employment such as Society Security and private healthcare, the advance of the welfare state continued through supposedly private programs that are still funded by government tax expenditures.¹⁷¹ "The politics of private social benefits . . . is 'subterranean' politics—far less visible to the broad public, far more favorable to the privileged, far less constrained by the features of American politics that routinely stymie major social reforms, and far more dominated by conservative political actors than the making of public social programs."¹⁷² A significant amount of policymaking takes place under the cover of private social welfare benefits.

Although lawyers frequently speak of an entitlement as a "legally enforceable right," this in fact says little about how a person will recognize an entitlement—public or private—when she sees it.¹⁷³ In laying out the steps for an argument that there is a "constitutional right to minimum entitlements," Erwin Chemerinsky included among those entitlements the right to food, shelter, and medical care.¹⁷⁴

¹⁷⁰ See *Kentucky's Medicaid Expansion Under ACA Could Soon Change*, PBS NEWSHOUR, Jan. 7, 2017, <http://www.pbs.org/newshour/bb/kentuckys-medicaid-expansion-aca-soon-change/> (last visited Feb. 7, 2017).

¹⁷¹ STARR, *supra* note 15, at 129-30 ("To most Americans, 'welfare' meant aid to the idle poor, particularly the program of cash assistance to single-parent families. . . . But the many who disapproved of 'welfare' in the narrow sense did not necessarily think of Medicare or even Medicaid as belonging in the same category.").

¹⁷² HACKER, *THE DIVIDED WELFARE STATE*, *supra* note 153, at xiii.

¹⁷³ David A. Super, *The Pol. Econ. of Entitlement*, 104 COLUM. L. REV. 633, 640-58 (2004) (providing a "taxonomy of entitlements" that includes: (1) subjective entitlement, (2) unconditional entitlement, (3) positive entitlement, (4) budgetary entitlement, (5) responsive entitlement, and (6) functional entitlement, and arguing in favor of clear eligibility criteria and purpose of the funds provided instead of arbitrary caps on benefits provided or limitations of beneficiaries).

¹⁷⁴ Erwin Chemerinsky, *Making the Right Case for a Const. Right to Minimum Entitlements*, 44 MERCER L. REV. 525, 536-39 (1993) (advancing the possibility of using the privileges or immunities clause, the due process clause, or international norms to locate this constitutional right to minimum entitlements).

In 1993, President Bill Clinton tried to frame healthcare as an “earned entitlement”, saying that he wanted to “giv[e] every American health security—health care that’s always there, health care that can never be taken away.”¹⁷⁵ Yet Americans showed themselves to be “deeply ambivalent about bestowing ‘entitlement’ status to health care” in spite of acknowledging the need for additional government involvement in healthcare.¹⁷⁶ This ambivalence was carried over to the implementation of the ACA by the Obama administration.

Part of the problem is that Americans—including those who sit on the Supreme Court—have made different judgments about what social welfare benefits are most important. In addition, the lack of data showing the efficacy of particular medical services or drugs—at all or for people of different ages, genders, and ethnicities—makes it difficult to agree upon priorities for public spending on healthcare within entitlement programs related to medical care. With this disagreement among policymakers, judges, and the scientific community about health priorities, the door is open to shift prioritization to the judgment of individuals in need of “medical care.”

Although the Social Security Act passed programs to help those in need with cash payments through the Old-Age, Survivors, and Disability Insurance (OASDI) and the Aid to Families with Dependent Children (AFDC) programs, President Roosevelt’s desire to pass national healthcare legislation never took shape. Many scholars blame the opposition of employers, the unions, or the doctors, but the main reason that healthcare reform failed then and may be repealed now is that the public has never defined national, compulsory healthcare as a need.¹⁷⁷ As Paul Starr wrote in one of his historical accounts of health reform, “Americans are still at odds over the most basic question about health care: whether it is a requirement for a free life that the community has an obligation to provide or a good that needs to be earned (and if you can’t earn it, too bad for you).”¹⁷⁸

The caveat here is that these valuable benefits that Americans “earn” through employment are subsidized by vast amounts of foregone tax revenue, as discussed above. Employers’ deduction of health insur-

¹⁷⁵ Sandra R. Levitsky, “What Rights?” *The Construction of Pol. Claims to Am. Health Care Entitlements*, 42 *LAW & SOC’Y REV.* 551, 551 (2008) (quoting *SOLVING AMERICA’S HEALTH-CARE CRISIS* 301-14 (Erik Eckholm ed., 1993)).

¹⁷⁶ *Id.* at 552-53 (“Claims involving the duties and obligations of care—including care for young children, the sick, and the elderly—are rarely advanced in this country by relying on the discourse of rights.”).

¹⁷⁷ DANIEL S. HIRSHFIELD, *THE LOST REFORM: THE CAMPAIGN FOR COMPULSORY HEALTH INS. IN THE U.S. FROM 1932-1943* 43, 66-70 (1970) (“The more fundamental cause was the lack of any broadly based public feeling that medical care needed a reform as drastic as compulsory health insurance seemed to be.”).

¹⁷⁸ STARR, *supra* note 15, at 24.

ance premiums paid is a tax expenditure. Employees' use of pretax funds for a 401(k) or flexible spending account is also a tax expenditure. Yet this false dichotomy of benefits that workers earn and public entitlements that the government provides persists. I will here discuss the two-track social welfare system and the challenge it poses for healthcare reform to demonstrate the difficulty in defining American healthcare priorities and acting accordingly to fulfill those needs.

The two-track social welfare system that came from the New Deal is still with us today. Social insurance policies (such as Social Security or Medicare) are national benefits "earned" through work, and "public assistance policies" (including AFDC or its successor "welfare" program, Temporary Assistance for Needy Families, TANF) are controlled locally and subject African-Americans to discrimination.¹⁷⁹ In 1976, Ronald Reagan brought the idea of the welfare queen to the forefront in the national debate over entitlement programs, saying in a campaign speech, "She used 80 names, 30 addresses, 15 telephone numbers to collect food stamps, Social Security, veterans' benefits for four nonexistent deceased veteran husbands, as well as welfare. Her tax-free cash income alone has been running \$150,000 a year."¹⁸⁰

Most Americans support the general idea that the government has an important role to play in helping those in need, but "[i]n large measure, Americans hate welfare because they view it as a program that rewards the undeserving poor."¹⁸¹ Today, "welfare" typically refers to state need-based programs and the federal and state run TANF. Americans wrongly believe that most people on welfare are African-American and that African-Americans are poor because they do not work hard enough.¹⁸²

The public falsely believes that African-Americans constitute a larger percentage of the poor and welfare recipients than they do.¹⁸³ Poverty became "racialized" in the 1960s after African-Americans mi-

¹⁷⁹ ROBERT C. LIEBERMAN, RACE AND THE LIMITS OF SOLIDARITY: AM. WELFARE STATE DEVELOPMENT IN COMPARATIVE PERSPECTIVE 23-46 (Sanford F. Schram et al., eds., 2003) ("While regular workers gained nationally protected social rights through an expanding social insurance regime, African Americans were disproportionately relegated to weaker, partial, and fragmented links with the welfare state through public assistance. Thus entering the post-World War II era, the United States had a two-track welfare state with a strong racial valence essentially built into its institutional structure, the legacy of the configuration of racial rule that structured social politics in the 1930s.").

¹⁸⁰ Rachel Black & Aleta Sprague, *The "Welfare Queen" is a Lie*, THE ATLANTIC, Sept. 28, 2016, <https://www.theatlantic.com/business/archive/2016/09/welfare-queen-myth/501470/> (last visited Feb. 7, 2017) (discussing how welfare policy has since been defined by the myth of the welfare queen and resulted in a wasteful focus on a problem that doesn't exist).

¹⁸¹ MARTIN GILENS, WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTIPOVERTY POL'Y 3 (1999).

¹⁸² *Id.* at 3, 61-67.

¹⁸³ *Id.* at 102.

grated in large numbers from the south to northern cities and as they made up an increasing percentage of welfare recipients after years of exclusion from and disparate treatment by these programs. The civil rights movement's focus on economic equality also connected race and poverty.¹⁸⁴ Finally, the association of poverty with race is a result of the "news media's tendency to use pictures of poor blacks in unsympathetic poverty stories and pictures of poor whites in sympathetic stories."¹⁸⁵

The American picture of need is therefore clouded by a view that the connection to work is what justifies protection from the hazards of life. Issues of race and class are of course bound up in this assessment. It has prevented support for universal healthcare or a health insurance mandate from reaching a level sufficient to sustain and grow a new program like the ACA.

When asked how much responsibility the government has for providing medical care, only three percent of Americans said that the government has no responsibility. Yet, Americans were much less likely than Germans, Italians, and the British to say that this is an essential responsibility of government.¹⁸⁶ Although there were about 50 million uninsured Americans in 2010 when the ACA was passed,¹⁸⁷ most Americans with employment-based health insurance like that insurance.¹⁸⁸ They like that insurance because it feels like a reward for hard work instead of a government handout, and they do not see why others should receive government funding for healthcare when they instead work hard and pay for it themselves.

Under the Healthy Indiana Plan (HIP), members use a Personal Wellness and Responsibility (POWER) account to pay the first \$2,500 of covered medical expenses during the year. The debit card associated with the account does not apply to co-payments. "Members must make copayments out of pocket."¹⁸⁹ When costs exceed \$2,500, HIP Basic members are still responsible for co-payments, while members in the HIP Plus program no longer need to pay co-payments. The money taken from the account to pay for qualified medical expenses is largely paid for by the State, except that members are required to contribute (or have their employers or a non-profit contribute for them).

¹⁸⁴ *Id.* at 104–11.

¹⁸⁵ *See id.* at 111–32.

¹⁸⁶ *Id.* at 26, tbl.1.1. The pattern holds true for adequate housing, where only five percent of Americans said the government has no responsibility, but Americans were much less likely to say that it is an essential responsibility.

¹⁸⁷ STARR, *supra* note 15, at 1.

¹⁸⁸ Roth, *supra* note 12.

¹⁸⁹ Indiana Family and Social Services Administration, *Healthy Indiana Plan FAQs*, IN.GOV, <http://www.in.gov/fssa/hip/2452.htm> (last visited Feb. 7, 2017).

Members' contributions to their POWER accounts in Indiana are determined by income and family size but are "approximately 2 percent of annual family income."¹⁹⁰ Members with incomes above the poverty level who fail to make required payments to their accounts will be removed from the health insurance program and subject to a six month lock-out period.¹⁹¹ Those with incomes below the poverty line will be switched to the HIP Basic plan, without vision or dental coverage, where they will be required to make co-payments when visiting the doctor or hospital.¹⁹²

One study showed that one-third of those eligible for Indiana's HIP 2.0 Plan, which encompasses both the HIP Plus and HIP Basic plans, who apply do not enroll because they fail to make a premium payment. Approximately 30,000 people eligible for a sixty day period did not enroll at all. In fact, "[eighty-four] percent of people who were bumped from HIP Plus to HIP Basic for nonpayment said they had been confused about the payment process and the program in general."¹⁹³

Recognizing that any Republican replacement for or modification of the ACA is likely to involve individual accounts, I think the focus needs to be on using the funds for items other than premium payments for those who qualify for Medicaid. This focus on individual responsibility fails to take into account all of the other items that the poor or near poor need to spend money on outside of premiums. Health-related expenses for the poor include not only co-payments but healthy food and physical activities that prevent illness.

B. Pooled Insurance v. Consumer-Driven Health Plans

Employees have seen a shift in recent years to defined contribution individual accounts, including in health financing. I describe this movement in my article *Overvaluing Employer-Sponsored Health Insurance* while advocating for the use by employees of the tax-subsidized funds that employers contribute to these accounts to purchase health insurance on the ACA exchanges. Employees would have plenty of choice if the government reduced attachment to employer-sponsored health insurance and encouraged purchases on the exchanges, increasing the number of consumers on the exchanges dramatically and varying their risk pro-

¹⁹⁰ *Id.*

¹⁹¹ *Id.* ("Members with incomes above the poverty level, for example \$12,060 a year for an individual, \$16,240 for a couple or \$24,600 for a family of four in 2017, that choose not to make their POWER account contributions will be removed from the program and not be allowed to re-enroll for six months. This enrollment lockout will not apply if the member is medically frail or residing in a domestic violence shelter or in a state-declared disaster area.").

¹⁹² *Id.*

¹⁹³ Semuels, *supra* note 169.

file.¹⁹⁴ A brief description here will suffice to place HSAs in their proper context within the broader movement towards individual accounts, one that Republicans have wholeheartedly embraced. Then, I will focus on the tension between this focus on individual accounts and the tradition of pooled insurance.

Individual accounts, whether used to fund retirement benefits or health benefits, are popular because they "fit with the American narrative of individual choice and ownership."¹⁹⁵ Employees with accounts have more choice about how to spend the employer's healthcare contributions, for example, and can stretch their dollars by spending carefully and rationing their healthcare.¹⁹⁶ Through high deductibles, co-payments, and co-insurance, however, employers have slowly been shifting healthcare costs to employees without the additional contributions to individual accounts required to fund these new expenses. Regardless of the wisdom of using indirect tax spending to address healthcare needs in this country, one thing is clear: "Americans have increasingly been exposed to tax-favored individual accounts that allow them to own and control their social welfare benefits."¹⁹⁷

In the 1980s, Congress developed "cafeteria plans" through Internal Revenue Code section 125, allowing employees to choose whether to receive taxable income or purchase benefits using pre-tax funds. Employees used FSAs to defray the cost of co-payments, deductibles, and co-insurance from their health insurance plans, although the funds were forfeitable if not used by the end of the year.¹⁹⁸

¹⁹⁴ Roth, *supra* note 12, at 667-76.

¹⁹⁵ *Id.* at 668 (citing EDWARD A. ZELINSKY, THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AM. 5-30 (2007)) (discussing why individual accounts are popular in spite of the shift of risk that the money will fall short of employees' needs to the employees from the employers); Amy B. Monahan, *The Promise and Peril of Ownership Soc'y Health Care Pol'y*, 80 TUL. L. REV. 777, 778 (2006) ("The ownership society generally refers to a society in which individual ownership of assets is encouraged and where individuals are 'in control of their own lives and destinies' and not dependent on handouts." (citation omitted)).

¹⁹⁶ *But see* Wendy K. Mariner, *Can Consumer Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Ins. Contracts*, 69 BROOK. L. REV. 485, 499-500 (2004) (arguing that individual accounts force employees to decide how much and what type of healthcare to spend their funds on and to bear the consequences of poor decisions or bad luck); *see also* BEATRIX HOFFMAN, HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE U.S. SINCE 1930 195 (2012) (describing how President Bush sought to have consumers curtail medical spending through high deductible health plans).

¹⁹⁷ *See* Roth, *supra* note 12, at 670 ("[H]ealth insurance coverage and the tax system have been deeply entangled for more than half a century. This co-dependence has been expanded substantially during the past several decades with an exponential growth in complexity." (quoting Fred T. Goldberg, Jr. & Susannah Camic, *Tax Credits for Health Insurance*, 37 J.L. MED. & ETHICS 73, 75 (2009))).

¹⁹⁸ ZELINSKY, *supra* note 195, at 159; Daniel C. Schaffer & Daniel M. Fox, *Tax Law as Health Pol'y: A History of Cafeteria Plans 1978-1985*, 8 AM. J. TAX POL'Y 1 (1989).

The Health Insurance Portability and Accountability Act of 1996 created the medical savings account (MSA), based on the individual retirement account (IRA), which allowed a self-employed individual or employees of small employers with fifty or less employees to make tax-deductible contributions to the accounts and use the funds to purchase “high deductible” health insurance. As the HSA/HDHP combination took over, no new MSAs could be established after December 31, 2007.¹⁹⁹

Insurance companies built on the MSA to lobby for a new vehicle called a health reimbursement arrangement (HRA) in 2001, which is another employer-funded method of reimbursing employees’ health costs. An HRA can reimburse regular expenses until they reach a certain threshold and then a health insurance plan kicks in. An employer who self-insures can cover all health expenses through the HRA, but this is not typical.²⁰⁰

Individual accounts, or defined contribution plans, such as those discussed above, are also known as CDHPs. Although individuals like the idea of managing their own health expenses, some scholars have questioned whether employees can or will make reasoned choices about how to use these accounts.²⁰¹ My previous work addresses how rationality with respect to health insurance purchases is bounded by tax subsidies and path dependence from the historical dominance of the employer-sponsored health insurance model, but these concerns are muted if we take the growth of individual accounts and HSAs specifically as a baseline and look for ways to address concerns using these tax-favored vehicles.

Similarly, one main critique of individual accounts is that employees using them pay more for their healthcare than employees using other insurance arrangements. Employers have been able to shift some of the risk of rising medical costs to employees using these accounts.²⁰² However, if we take the use of these accounts as the major component of healthcare reform in the Trump administration to be a given, then we

¹⁹⁹ See ZELINSKY, *supra* note 195, at 60-61; Roth, *supra* note 12, at 680 n.175.

²⁰⁰ See Roth, *supra* note 12, at 673-74 nn.177-82.

²⁰¹ See Mary Crossley, *Discrimination Against the Unhealthy in Health Ins.*, 54 U. KAN. L. REV. 73, 129-31 (2005) (discussing concerns that consumers are not fully informed about medical decisions, place too much weight on physician recommendations, and will be making important decisions during medical crises when indicating that poor decision-making will do great harm).

²⁰² See *id.* at 119-20 (“While promising consumers a broader choice of providers and greater control over their medical decisions, consumer-driven plans promise employers cost savings flowing from the combination of greater efficiency in the purchasing decisions of cost-conscious consumers and a shifting of health-care costs to employees.”); Amy B. Monahan, *Employers as Risks*, 89 CHI.-KENT L. REV. 751, 756 (2014).

must focus on how these vehicles can be improved to address important social concerns.

One key purpose of the movement for personal responsibility in healthcare spending is to educate individual consumers of medical care, which is especially important if we are concerned both with their decisions regarding what and how much healthcare to “buy” and their satisfaction with outcomes. Patients might demand unnecessary care far less often if they were educated on its lack of efficacy or even negative impact on health.²⁰³ Wendy Mariner argued in 1994 that “it will be important to avoid coercing the patient into choosing the least expensive form of care when that would not be appropriate for the patient.”²⁰⁴ Yet reliance on individual accounts shows that this country, or some portion of it at least, is now comfortable with forcing patients to make medical decisions based on their account balances—as long as catastrophic expenses are covered. I think it is safe to assume that those making healthcare policy over the next few years will not worry about forcing patients to choose the least expensive care.

The problem with the movement towards CDHPs is that those with expensive medical conditions are no longer subsidized by the healthy—as they are through traditional insurance plans. Without forcing the healthy to have health insurance, such as through the individual and employer mandates in the ACA, the cost of health insurance premiums increases and more healthy individuals leave as the death spiral continues. The Republicans have so far not found a way to reconcile their goal of freedom over the decision of whether or not to have health insurance and how to spend funds allocated for that purpose with this need to subsidize risky and expensive healthcare consumers. My proposal is to first focus CDHPs and spending for the social determinants of health on expenses below the HDHP threshold for HSAs. If there is no health insurance mandate, then the government will face higher costs for those whose insurance it subsidizes as the healthy exit the market. Yet any of the new administration’s proposals are likely to increase costs because of a failure to impose a mandate. My proposal is one experiment that could result in significant cost savings and economic expansion.

CONCLUSION

Individual accounts such as HSAs are seen as the solution to the stigma of entitlements—which are viewed by many Americans as unearned government handouts that are also unlimited in scope since all

²⁰³ Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J.L. & MED. 37, 43-44 (1994).

²⁰⁴ *Id.* at 45 (adding that incentives for physicians to limit the cost of care complicate this analysis).

who qualify can receive them. Forcing individuals to make rational decisions about how to spend the money in the accounts to best improve their lives can be a good thing, as long as the government provides money to those with empty accounts and the money can be used for items outside of the traditional range of clinical care. In the future, the amounts provided could increase for all or be increased substantially for those with lower incomes. Regardless, this would be a health spending tool that by targeting individual needs would substantially improve population health because of its reliance on addressing the social determinants of health.