

Health Savings Accounts and High-Deductible Health Insurance Plans: Implications for Those with High Medical Costs, Low Incomes, and the Uninsured

Timely Analysis of Immediate Health Policy Issues

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Summary

Health Savings Accounts (HSAs) and high-deductible health plans (HDHPs) feature prominently in many discussions of health reform.

- In the context of proposals from the Obama administration and Congress, they will be of continuing interest as minimum benefit standards and insurance options under broad-based reform are discussed.
- While supporters hope they will make individuals more prudent purchasers of medical care, the tax structure and incentives built into HSAs make them most attractive to the high-income and the healthy, populations already advantaged by the current system.

Tax Advantages of HSAs

- HSAs provide a generous tax incentive for certain individuals to seek out HDHPs with IRS-defined characteristics. Individuals buying qualified HDHPs either through their employer or in the private nongroup insurance market can make tax-deductible contributions into an HSA.
- Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax free and are not subject to tax or penalty as long as they are withdrawn to cover medical costs.

HSAs in Practice

- HSAs are intended to encourage more cost-conscious spending by placing more of the health care financing burden on out-of-pocket spending by the users of services, as opposed to having services incorporated in the premium component of insurance coverage, which is shared equally across all enrollees regardless of service use.
- Average in-network deductibles for employees enrolled in their employers' HDHP/HSA plans are substantially higher than the IRS minimum for qualifying HDHPs.
- Roughly half of those with HSA-compatible policies do not open HSAs, despite the tax advantages, and two-

thirds of employers report making no contribution to the HSAs of their workers. As a consequence, low-income or high health-care-need workers with these plans are likely to be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy.

What Makes HSAs Attractive?

- The tax subsidy provided for HSA participants is greatest for those in the highest marginal tax bracket and is of little or no value to those who do not owe income tax.
- Those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free.

The Cost Containment Implications of the Health Care Spending Distribution

- A small percentage of the population accounts for a large share of total health care spending, so significantly decreasing health care spending will require substantially lowering the spending associated with high users of medical services. However, the high-deductible/HSA plan approach is not well designed for lowering the spending of the high-cost population in a manner that does not negatively affect their health. To compound the problem, there are no provisions to help these patients choose the services most important to their health.
- The cost-containment potential of HSAs/HDHPs and their implications for health outcomes vary considerably by the income of the enrollee.

Implications of HSAs for the High Medical Need Population

- By providing incentives for healthy individuals and groups to purchase HSA-compatible plans, the average cost of those left in the traditional comprehensive plans may increase so much that maintaining that type of coverage is no longer financially viable. Thus, increasing enrollment in HDHP/HSA plans could actually decrease



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insurance options available and increase the problems associated with underinsurance.

- Without some type of intervention by government or employers to spread health care risk more broadly, the most vulnerable populations (the low-income and the sick) are left bearing a greater burden of their health expenses.

Enforcement of HSA Legal Requirements

- If HSA funds are used for nonmedical purposes, a nonelderly individual would be required to pay taxes on the withdrawal in addition to a 10 percent penalty. However, currently, there is no administrative mechanism in place to verify that spending from HSAs is in fact being used for medical purposes. This lack of verification creates an easy mechanism for evading taxes.

Conclusions

- HSA/HDHPs are a highly tax-advantaged savings vehicle attractive to people with high incomes and those with low expected use of health care services. As such, they are unlikely to decrease significantly the number of uninsured, who often have low incomes and neither benefit significantly from the tax advantages nor have the assets necessary to cover the large deductibles associated with the plans.
- Their ability to reduce system-wide spending is very limited.
- The plans have the potential to increase segmentation of health care risk in private insurance markets, unless employers set premiums to offset the healthier selection into the plans or government subsidizes the higher costs associated with the remaining non-HSA market.

Introduction

Health savings accounts (HSAs) and the high-deductible health plans associated with them continue to garner interest in both the public and private sectors for their purported potential to rein in health care spending. Fifty-four bills in the 110th Congress related to HSAs, Senator John McCain proposed expanding HSAs during the 2008 presidential campaign, and some public health insurance programs have now introduced high-deductible/HSA plans for elderly and very low income people. High-deductible/HSA-like plans for Medicare enrollees, called “Medicare Medical Savings Account” plans, are now available to nearly all Medicare-eligible individuals.¹ “Health Opportunity Account” plans, authorized under the federal Deficit Reduction Act (DRA) of 2005, are high-deductible/HSA plans currently being evaluated as an option for low-income individuals and families enrolled in some state Medicaid programs.² However, HSAs first arose in the private sector, which is still the primary marketplace for these products and the focus of most HSA-related policy proposals. As the Obama administration and Congress discuss minimum benefit

standards and insurance options during the coming years, the role of HSAs is certain to be of continuing interest.

Background

Between 2000 and 2006, employer-based health insurance premiums grew by 86 percent, compared with 20 percent for workers’ earnings and 18 percent for overall inflation.³ By 2006, the number of uninsured had increased to 18 percent of the total nonelderly population in the United States, and a third of the nonelderly population with incomes below 200 percent of the federal poverty level were uninsured.⁴ Health savings accounts have been one approach some policymakers have embraced to address these dual and growing problems of escalating costs of medical care and the number of uninsured.

While high-deductible plans have been available in the nongroup market for many years, the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provided a generous tax incentive for certain individuals to seek out high-deductible health insurance policies with particular characteristics. In 2008, the minimum

annual in-network deductibles for these policies were \$1,100 for single and \$2,200 for family policies (table 1). Annual out-of-pocket maximums for these plans were capped at \$5,600 for single policies and \$11,200 for family policies, with the limits applying only to the services covered in the plan. As the table shows, however, the average deductibles in HSA-compatible plans in the employer-sponsored insurance market were almost twice as high as the minimums.

Tax Advantages of HSAs. Individuals (and families) buying HSA-qualified, high-deductible policies either through their employer or independently in the private nongroup insurance market can make tax-deductible contributions into an HSA. Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax free and are not subject to tax or penalty as long as they are withdrawn to cover medical costs. Funds withdrawn for nonmedical purposes prior to age 65 are subject to income tax and a 10 percent penalty. Contributions can be made by employers, individuals, or both. In 2006, Congress removed the requirement that

annual deposits into HSAs be capped at the level of the plan's deductible, and instead provided a fixed statutory limit for annual contributions. In 2008, these limits were \$2,900 for single policies and \$5,800 for family policies. The Joint Committee on Taxation projected that the tax cost associated with HSAs would amount to approximately \$600 million in 2008 and would grow over time, amounting to \$4.6 billion over the 2007–2011 period.⁵

HSAs in Practice. HSAs are intended to encourage more cost-conscious spending by placing more of the health care financing burden on out-of-pocket spending by the users of services, as opposed to having services incorporated in the premium component of insurance coverage, which is shared equally across all enrollees regardless of service use. In the employer-sponsored health insurance market (ESI), average in-network deductibles for employees enrolled in high-deductible/HSA plans are substantially higher than the IRS minimum for HSA-qualifying high-deductible health plans (HDHPs). Average deductibles in high-deductible/HSA ESI plans in 2007 (inflated to 2008 dollars) were \$2,040 for single policies and \$4,120 for family policies. Maximum annual out-of-pocket liability for the average high-deductible/HSA ESI plans were about three-fifths of the maximums set by IRS statute for single and family policies.

Roughly half of those with HSA-compatible, high-deductible policies

do not open HSAs, despite the tax advantages of doing so.⁶ Two-thirds of employers offering single coverage through high-deductible/HSA combinations report making no contribution to the HSAs of their workers.⁷ As a consequence, low-income or high health-care-need workers with no choice of coverage but a high-deductible/HSA plan are likely to be exposed to much larger out-of-pocket financial burdens than they would be under a comprehensive policy, since employers are not, by and large, offsetting these higher deductibles with cash contributions to HSAs.

Variable HSA Contributions by Employers. Regulations enacted under the Tax Relief and Health Care Act of 2006 allow employers to voluntarily make larger HSA contributions for their lower-income workers than for their higher-income workers, and in 2007, the Bush administration proposed allowing larger employer contributions to HSAs of employees who are chronically ill or who have a spouse or dependent who is chronically ill.⁸ However, presented with the option of making varying contributions to HSAs as a function of worker income or health status, employers are highly unlikely to do so. If, as economists recognize, workers accept lower wages in return for compensation in the form of health care benefits, the minimum wage will limit the extent to which an employer can pass back larger HSA contribution amounts to lower-wage workers. And, if an employer does not

or cannot pass back the costs of higher HSA contributions to their workers, making such additional contributions would be equivalent to increasing compensation for low-wage workers relative to high-wage workers. Shifting compensation from higher- to lower-income workers would not be desirable from an employer's perspective unless the workers' relative productivity had changed as well. Lower-wage workers are presumably contributing less value to the firm's production (otherwise they would be paid more) and they also tend to have less firm-specific human capital, making turnover among these workers less costly to the firm.

As to the proposals to allow higher employer contributions for those with chronic conditions, it is doubtful that an employer would offer a benefit specifically tailored to attract workers with higher medical expenditures. Such workers will tend to be less productive, due to absenteeism and other limitations, than will healthier workers, and their medical costs would drive up aggregate compensation costs for the firm.⁹

What Makes HSAs Attractive?

As a consequence of the structure of the tax subsidy and the shift of health care spending to out-of-pocket costs, these accounts are most attractive to high-income people and those with low expected health care expenses. As income and marginal tax rates

Table 1. IRS Statute for High-Deductible/HSA Plans and HDHP/HSA Plan Averages in the ESI Market, 2008

	In-network deductible		Maximum annual out-of-pocket liability		Maximum annual HSA contributions	
	Single	Family	Single	Family	Single	Family
IRS Statute for High-deductible/HSA plans, 2008	> \$1,100	> \$2,200	< \$5,600	< \$11,200	\$2,900	\$5,800
HDHP/HSA Plan Averages in the ESI Market, Inflated to 2008 Dollars	\$2,040	\$4,120	\$3,279	\$6,902	n/a	n/a

Sources: Department of the Treasury, "Health Savings Accounts," 2007; Kaiser Family Foundation/Health Research and Education Trust, Survey of Employer-Sponsored Health Benefits, 2007.

n/a = not applicable

increase, the value of the tax exemption associated with contributions to HSAs and the interest, dividends, and capital gains earned on HSA balances grows as well. So the tax subsidy provided for HSA participants is greatest for those in the highest marginal tax bracket and is of little or no value to those who do not owe income tax.

While HSAs thus have some financial advantages for the high-income, the uninsured tend to be low income and are therefore unlikely to accrue such benefits. Clemans-Cope¹⁰ demonstrates that 70 percent of the nonelderly uninsured have family incomes below 200 percent of the federal poverty level, and that only 16 percent of uninsured adults fall into the 20 percent or greater marginal tax bracket. A \$5,800 HSA contribution, the maximum permitted under the law, would generate a tax reduction of \$2,030 to a household in the top income tax bracket. The value of the tax benefit would be less than half as much for a moderate-income family. And it would be worth much less if the family could not afford to contribute very much into the account. For those whose incomes are so low that they have no income tax liability, the subsidy is worth nothing. However, HSA contributions made by an employer, as opposed to by an individual, will decrease even a low-income worker's payroll tax liability, resulting in a modest tax savings.

Higher-income individuals are also better able to cover the costs of a high deductible, should significant medical expenses be incurred. Jacobs and Claxton showed that uninsured households have substantially lower assets than do the insured.¹¹ As a consequence, high-deductible policies are unlikely to provide the uninsured with sufficient financial access to medical care in the event of illness or injury.

Additionally, those who do not expect to have much in the way of health expenses will be attracted to HSAs by the ability to accrue funds tax free

that they can use for a broad array of health-related expenses that are not reimbursable by insurance (e.g., non-prescription medications, eyeglasses, some cosmetic surgery). Those without substantial health care needs may also be attracted to HSAs because they can be effectively used as an additional IRA. For those who have already made the annual maximum tax-advantaged contributions to their IRAs or other pension plans, HSAs provide an additional tax-advantaged savings vehicle; HSAs' accrued balances can be withdrawn with no penalty after age 65, even if the funds are spent for non-health-related purposes.¹² Young, healthy individuals may even choose to use employer contributions to their HSAs for current non-health-related expenses, after paying a 10 percent penalty and income taxes on the funds—a perk unavailable to those enrolled in traditional comprehensive insurance plans.

These expectations have been borne out in the enrollment experience of HSAs.¹³ The GAO analysis found that the average adjusted gross income of HSA participants was about \$139,000 in 2005, compared with \$57,000 for all other tax filers. They also found that average contributions to HSAs were more than double the average withdrawals, suggesting that HSA participants were not high users of medical services or they used these accounts as savings vehicles—or both.

Because most of the uninsured have low incomes and get little or no value from tax exemptions, the subsidies are very poorly targeted for expanding coverage to the population most in need of affordable health insurance—the low-income and those with above average medical needs. In addition, the “one size fits all” high-deductible policy under the HSA legislation is flawed since, for example, a \$2,200 deductible could have almost no cost-containment impact for a high-income family, while the same deductible could be financially ruinous for a low-income family.

The Cost-Containment Implications of the Health Care Spending Distribution

The distribution of health care spending is highly skewed, meaning a small percentage of the population accounts for a large share of total health care spending. The top 10 percent of health care spenders spend 64 percent of health care dollars, while the bottom 50 percent of spenders account for only 3 percent of those dollars.¹⁴ As a consequence, significantly decreasing health care spending will require substantially lowering the spending associated with high users of medical services, ideally, while not decreasing quality of care. However, the high-deductible/HSA plan approach is not well designed for lowering the spending of the high-cost population in a manner that does not negatively affect their health.

Effective price increases in the cost of care can reduce utilization in two ways: a decline in the amount of *services per episode of care* and a decline in the *number of episodes of care*. In other words, providers could guide patients to more cost-efficient treatment options, or the patient could reduce the number of contacts with a provider that he or she chooses to have. The impact of these changes in utilization should be considered for three populations:

- Individuals who use relatively low levels of care today; those whose total spending is currently below the levels of the high deductibles associated with HSA-qualified policies (group 1);
- Individuals who use higher levels of care; those whose total spending is currently above the levels of the high deductibles, but for whom these policies may decrease their utilization significantly, possibly to levels below the new deductibles (group 2);
- Individuals who are very high users of care; those whose total spending is currently well above the levels of the high deductibles, and for whom

health spending would continue to exceed the levels of the new deductibles (group 3).

Cost Saving Potential among the Healthy. For those in the first group who are generally healthy and do not have annual spending that exceeds the high deductibles associated with HSA-compatible plans, the increased out-of-pocket price of medical care could affect their use.¹⁵ Incentives to curtail unnecessary services are strongest for these individuals, since all of their health spending is under the deductible and therefore subject to the full force of cost-sharing. However, our analysis of the Medical Expenditure Panel Survey – Household Component showed that only 3 percent of total health care spending is attributable to those who spend below the minimum required deductibles.¹⁶ Consequently, there is little room for system-wide cost savings among this population since their spending accounts for so little of the overall expenditures.

Implications of Cost Savings for the Less Healthy. For those in the second and third groups who are unhealthy and who, with comprehensive insurance coverage, would spend above these higher deductibles, a number of scenarios are possible. Some individuals will face higher out-of-pocket maximums than they do today, and some, likely those from group 2, could reduce their health care use as a consequence. However, research has demonstrated that the reductions in their spending would occur as a result of reducing the number of episodes of their care, as opposed to reducing the cost of an episode once initiated.¹⁷ As noted above, this suggests that patients are making independent decisions to limit health service use without provider guidance. Such independent decisions based on financial considerations may have potentially serious consequences for their health and for the long-term costs of their care. Two studies have found that HSA participants were more likely to report missed or delayed health services and not filling prescriptions due to cost.

These problems were greater for those with lower incomes or worse health.¹⁸

For the third group of individuals, significant savings are unlikely to materialize. Ninety-seven percent of total health care spending is attributable to those who spend more than the minimum HSA-compatible deductibles. Plus, the lion's share (80 percent) of health care spending for those high-cost users is incurred once those higher deductible levels are surpassed.¹⁹ Since any cost-saving potential of HSAs/high-deductible plans occurs as a result of reducing spending below the deductible, they cannot be expected to have significant effects on the largest portion of total health care spending.

That is, unless the increased cost sharing is so much higher as to strongly dissuade the unhealthy from seeking much of the services that they would use if they had more comprehensive coverage. To compound the problem, there are no provisions to help these patients choose the services most important to their health. The health consequences for sick patients who forgo medical treatment could be extraordinarily grave, and the long-term cost consequences of allowing conditions to worsen substantially before care is sought may offset the cost saving from decreasing their early care. In addition, the cost-containment potential of HSAs/HDHPs and their consequent implications for health outcomes will vary considerably by the income of the enrollee. While a high deductible may have a considerable impact on the decision of a moderate-income patient to seek care, the same deductible may lead to no cost containment affect for a high-income patient.

Some researchers suggest modest one-time savings of 2 to 7 percent might be anticipated from conversion to high-deductible/HSA plans (presumably by reducing spending among the group 2 population described above). They do not imply that such a change would have a significant impact on the rate of growth of medical spending²⁰ because

medical spending growth is driven largely by the increased use of, and intensity of, technologies and services for people with high health care needs.²¹ So while increased cost sharing can lower the frequency of health care provider visits, it does not lower the costs per episode once an episode of care occurs.

Promising Cost-Containment Strategies. Other, more promising avenues exist for saving costs in our health care system. These include

- using coordinated approaches to evaluation of cost-effectiveness, such as using new and existing technologies, procedures, and medications with new regulatory and pricing strategies to target resources to the most cost-effective options;
- increasing the use of cost-effective preventive care;
- developing cost-effective chronic-care or high-cost case management strategies;
- reforming payment methods and developing purchasing strategies that promote the consistent delivery of care in the most efficient and appropriate setting;
- developing administrative cost-saving strategies, including effective information technology infrastructure.

While many of these avenues require significant upfront investment in infrastructure, research, analysis, or experimentation, they are substantially more likely to yield system-wide savings without compromising access to and quality of care for the high-need population.

Implications of HSAs for the High Medical Need Population

The most significant premium savings accruing to high-deductible/HSA plan enrollees likely occurs by altering the mix of individuals who purchase coverage of different types.

By providing incentives for healthy individuals and groups to purchase HSA-compatible plans, insurance risk pools can be further segmented by health status. The average medical costs of those purchasing the HSA plans will be substantially lower if the high-risk population is left in more traditional comprehensive plans. As the average cost of those in comprehensive plans increases, so does the premium associated with the coverage. In the extreme, premiums for comprehensive coverage may increase so much that maintaining that type of coverage is no longer financially viable. Thus, increasing enrollment in high-deductible/HSA plans could decrease insurance options available and increase the problems associated with underinsurance.

Such a circumstance can be avoided in the employment context if both high-deductible and comprehensive options are offered and employers set premiums for each plan independent of the health care risk of those enrolling in a particular plan. In other words, premiums for the high-deductible/HSA plan could be set such that they are lower than the comprehensive plan, but only due to the difference in actuarial value across the plans, not due to the differential health care risk of those enrolling in each plan. In essence, each plan's premium would be set as if all employees were enrolled in each plan. Then, a portion of premium collections for the high-deductible/HSA plan could be transferred to the comprehensive plan to subsidize premiums for that higher-cost group. In the nongroup market context, however, the transfer of financial support from the healthy to the less healthy will only occur through regulation or through direct government subsidization.

Without some type of intervention by government or employers to spread health care risk more broadly, the practical effect of high-deductible/HSA plans is that the most vulnerable populations (the low-income and the sick) are left bearing a greater burden of their health expenses. The extent

to which this is a preferred societal outcome should be explicitly debated, as it is the primary impact of a move toward high-deductible/HSA plans.

The Ability of Patients to Be Good Value Shoppers

Theoretically, placing a greater share of the health care financing burden on the individual users of health care should create incentives for greater price/quality comparisons and more cost-effective medical decisions. However, the ability of the patients to engage in such comparison shopping is extremely limited in the current private insurance context. As Ginsburg describes, effective comparison of services on price occur only in the context of non-emergency care, services that are not complex, and services that have consistent quality across providers.²² Also, when providers do not bundle the same services together for pricing purposes, it is difficult for patients to compare prices. Moreover, effective comparison shopping can only be done after an appropriate diagnosis has been made. Situations that meet such criteria eliminate a great deal of the medical care within the system. In addition, confidentiality agreements between providers and insurers often prevent the providers from being able to give patients actual prices, as opposed to ranges that are generally not useful for comparison purposes. Traditionally, patients have relied upon their insurers to guide their provider decisions by choosing an efficient provider network on their behalf.

Enforcement of HSA Legal Requirements

As noted earlier, spending by those under 65 years of age out of HSA accounts is tax advantaged only if that spending is for medical purposes. If HSA funds are used for nonmedical purposes, a nonelderly individual would be required to pay taxes on the withdrawal in addition to a 10 percent penalty. However, currently, there is no administrative mechanism in place to verify that spending from HSAs is in

fact being used for medical purposes. Unless an individual HSA participant is subjected to an IRS audit, there are no checks on the type of spending being done. Given that any individual's likelihood of an audit is very low, this lack of verification creates an easy mechanism for evading taxes. This problem is amplified by the increase in allowable annual contributions to HSAs and the fact that such contributions can now exceed the associated insurance plan's annual deductible.

Flexible spending accounts (FSAs) are employment-related accounts that allow users to deposit pretax dollars into accounts that can then be drawn down during the year to pay for medical expenses. The permissible medical expenses are defined broadly, including out-of-pocket costs for care that is or is not part of the account holder's insurance policy, just like HSAs. There are a number of differences between FSAs and HSAs (e.g., unused FSA balances are forfeited at the end of the year, they do not earn income, and they do not require health insurance plan participation), but the only relevant difference for this discussion is that account administrators verify that withdrawals from FSAs are medical-related expenses that comply with the FSA law. This is precisely the type of verification that could be required of HSA withdrawals, and would be under the "Taxpayer Assistance and Simplification Act of 2008" (H.R. 5719).²³

The insurance industry complains that imposing such verification on HSAs would eliminate their cost-saving potential by imposing new and onerous administrative costs. However, the administrative costs of FSAs, which would be directly comparable with that of HSAs for this purpose, are actually very low. In fact, overall FSA administrative costs, which include payment of claims (a function that HSAs already perform and is included in their current administrative costs) as well as verification of the appropriateness of claims, are about \$5.25 per member per month (\$63 per member per year).²⁴ However, much of the administrative

tasks associated with FSAs are not applicable to HSAs, and the cost of adding adjudication of claims to the HSAs would be about \$2 per member per month, according to the third-party administrator of such plans that we contacted. If an additional cost of \$24 per member would substantially reduce or eliminate the cost savings associated with HSAs, as some contend, then that is clear evidence that there is currently little to no cost savings associated with participating in those plans today.

Such an increment to administrative costs associated with these plans is clearly a very small price to pay to ensure that the law is being complied with and individuals are not using HSAs merely as a personal tax dodge.

Conclusion

HSA/HDHPs are a highly tax-advantaged savings vehicle that is attractive to people with high incomes and those with low expected use of health care services. As such, they are unlikely to decrease significantly the number of uninsured, who often have low incomes and neither benefit significantly from the tax advantages nor have the assets necessary to cover the large deductibles associated with the plans. Their ability to reduce system-wide spending is also very limited. The plans have the potential to increase segmentation of health care risk in private insurance markets, unless employers set premiums to offset the healthier selection into the plans or the government subsidizes

the higher costs associated with the remaining non-HSA market.

To date, HSAs have been less popular than their advocates envisioned, making up only about 2 percent of the health insurance market.²⁵ Thus, their potentially negative ramifications on populations with high medical needs have probably been limited. However, efforts to expand enrollment in these plans through further tax incentives, for example, could place growing financial burdens on those least able to absorb them, leading to more barriers to medical care for the low-income and the sick and fewer insurance options.

Endnotes

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- ²³ Legislation requiring substantiation of qualified HSA withdrawals was proposed by the House Committee on Ways and Means on April 9, 2008, under H.R. 5719. 110th Congress (2008) Taxpayer Assistance and Simplification Act of 2008. <http://www.govtrack.us/congress/bill.xpd?bill=h110-5719>.
- ²⁴ From personal communication with third-party administrators providing administrative services for FSAs and consumer-directed health plans.
- ²⁵ U.S. GAO, "Health Savings Accounts: Participation Increased and Was More Common among Individuals with Higher Incomes," GAO-08-474R, 2008.

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