

THE ROLE OF MEDICAL SAVINGS ACCOUNTS IN HEALTH SYSTEM REFORM

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EXECUTIVE SUMMARY

Although medical savings accounts (MSAs) may prove to be one more viable choice for people seeking insurance coverage, they are not likely to have a major impact on solving the larger health system problems we face. They are not a panacea.

The medical savings account concept is an alternative form of health coverage that involves a combination of catastrophic (high-deductible) health insurance with a savings account that is used to pay for non-catastrophic medical expenses. It contrasts with more typical kinds of insurance and managed care coverage that begin to pay at the “front end” even when the level of expenditures is low.

Some modest cost savings could be realized if large numbers of people select the MSA option. People in MSAs would have greater freedom to choose providers and treatments, at least until they reach the deductible limit. The availability of MSAs is not likely to substantially reduce the number of uninsured because MSAs will probably not lower costs enough to make coverage significantly more affordable for many employers and employees. Quality of care is unlikely to be much affected because employers and consumers will continue to want to know what they are getting for the money they spend for health care. MSAs are likely to result in a less even spreading of risk and costs of medical coverage across the population; unhealthy people will be less subsidized by healthy people.

Unless MSAs catch on to a much greater degree than they have to this point, their impact will be quite limited. Thus neither the great expectations of the proponents nor the worst fears of the opponents are likely to be realized.

A switch to MSAs will create winners and losers. If all employees were forced to switch to MSAs, about 73 percent would have lower net costs (considering premiums plus other

payments) after three years. These winners would tend to be younger, healthier people, while the losers would be older, less healthy people.

Initial sales of MSAs were much lower than many expected, even though they were readily available from a variety of insurers. Between January and June 1997, only 22,051 medical savings accounts were opened. It is difficult to tell whether sales will pick up once consumers and insurance agents are more familiar with the product. Employers may be reluctant to push employees into MSAs, especially after many have just channeled them to managed care plans. Consumers may shy away from MSA coverage because they have become risk-averse after long years of enjoying front-end coverage.

To see whether MSAs can produce the benefits its proponents claim for it, Congress authorized the sale of a limited number of medical savings accounts (MSAs) to individuals and to firms with 50 or fewer employees starting in 1997 and to Medicare recipients starting in 1999.

The proponents of MSAs offer a number of arguments for this kind of coverage:

- Typical front-end coverage creates incentives for excess spending on medical services because once people pay the small deductible, they are spending other people's money rather than their own.
- People with MSAs, on the other hand, pay the full costs of coverage with their own money until they reach the high-deductible level of expenditures, so they have strong incentives to economize. Studies show a range of savings, varying from essentially nothing to up to 13 percent of national health spending.
- The availability of MSAs could help correct the problems many people have with the cost constraints of managed care. People with MSA coverage have complete freedom to decide how medical resources should be allocated for their treatment. No one can legitimately complain that they are overspending when they are spending their own money (from their savings account or out of pocket).
- MSAs may reduce insurance administrative costs. A large proportion of people covered by MSAs will not spend enough in a year to be eligible for

reimbursement by their insurance coverage. They will thus not submit claims for insurers to process, so paper work will be reduced.

- Costs may be further reduced because insurers will be getting a profit margin on a lower premium base (since MSA premiums are lower than front-end coverage premiums).

Those who are skeptical of the claims for MSAs offer the following counter arguments:

- The potential savings that would be realized by making people more cost conscious is relatively small. Most medical expenses are incurred by people who are very sick and run up very high medical bills. Even if they are covered by MSAs, these very sick people will spend beyond the high-deductible amount, where they will no longer be “paying their own bill.”
- Thus the kinds of rules and constraints that managed care plans use may also have to be used by those who administer MSAs once people have spent up to the deductible limit.
- There is a danger that people who curtail spending will reduce spending for necessary services and not just wasteful services. Research shows that low-income people are especially likely to forego purchasing beneficial care when they have to pay for the care from their own resources.
- MSAs are likely to encourage risk segmentation, appealing most to relatively healthy people and perhaps to people with higher incomes. If healthy people flock to MSAs, those left in more comprehensive plans will be, on average, sicker. The premiums for these plans could increase a great deal, perhaps by three or four times, as a result of this adverse selection.

THE ROLE OF MEDICAL SAVINGS ACCOUNTS IN HEALTH SYSTEM REFORM

Introduction

In 1996, as part of the Health Insurance Portability and Accountability Act, Congress authorized an experiment to test the merits of medical savings accounts (MSAs) as an alternative form of health coverage. The Balanced Budget Act of 1997 extended the experiment to allow Medicare recipients to purchase MSA coverage. The MSA concept has strong critics as well as ardent supporters, and the passage of legislation to foster the growth of MSAs has not settled the debate. The soundness of the idea and its viability in practice remain to be determined.

The purpose of this paper is examine what outcomes medical savings accounts might be expected to produce and how they might fit or clash with other efforts to reform the health system. In the process, we outline the present legislation, review the conceptual rationale for MSAs and the concerns of the detractors, look at the research which tries to identify the “winners and losers,” consider the early experience with MSAs, and finally assess how the concept fits within a more comprehensive strategy for health system reform.

The MSA Concept and Present Law

The MSA concept combines catastrophic health insurance with a savings account to pay for non-catastrophic medical expenses. Money is put aside either by the employer or by the individual in a savings account from which the individual can draw to pay for any qualifying medical expenses. Until the high deductible of the catastrophic plan is met, the individual must pay for health care services either out-of-pocket or with money from the savings account.

HIPPA MSAs

The 1996 Health Insurance Portability and Accountability Act (HIPAA) established the rules for MSA plans that would be available to the working population. Contributions made by the employer to the MSA are non-taxable income to the employee, and contributions made by the employee are tax deductible. Thus the contributions have the same tax-preferred treatment as employer-paid insurance premiums. (MSA proponents would generally prefer to eliminate all forms of tax preference for health coverage contributions, but they know that this is probably not politically realistic, so they supported this second-best approach to giving equal tax treatment for MSAs.)

The MSA account must be combined with a high-deductible (catastrophic) insurance policy to cover large losses. Under HIPAA, the individual deductible is set at a minimum of \$1,500 to a maximum of \$2,250, and the out-of-pocket maximum is \$3,000; for families, the deductible must be at least \$3,000 to a maximum of \$4,500, and the out-of-pocket maximum is \$5,500.¹

Under the four-year federal demonstration program for working people, qualified MSA plans eligible for favorable tax treatment could be sold starting January 1, 1997. Only self-employed individuals and small businesses with 50 or fewer employees are eligible to buy this coverage. The number of contracts that can be sold is limited by law, starting at no more than 375,000 by April 30, 1997, and gradually rising to a maximum of 725,000 accounts by the end of the demonstration period.

Medicare MSAs

The Balanced Budget Act of 1997 established an experiment to allow Medicare beneficiaries to choose, as one alternative to traditional Medicare, a combination of a medical savings account and a catastrophic plan with a deductible that can be as high as \$6,000. The services covered are the same as those under standard Medicare, except for hospice care. For people choosing this option, Medicare will pay the premium and put the

¹ U.S. General Accounting Office, *Medical Savings Accounts: Findings From Insurer Survey*, GAO/HEHS-98-57, December 1997, p. 11.

difference between that amount and the normal Medicare capitation amount (AAPCC) in the MSA. The money can be used to pay for medical services, including those not normally covered by Medicare, or long-term care insurance (purchase of insurance to cover the deductible is not allowed). Policies can be sold beginning in 1999, and the experiment is to end by 2002, when no new enrollments can occur. No more than 390,000 people can be enrolled in total.²

The Conceptual Rationale for MSAs

MSAs came into the policy arena because many proponents believe that they could address the problems of cost, quality, and access. The proponents of MSAs think that many of the problems with our current health system can be traced to the forms of health coverage people typically buy. Most people who can afford to do so buy coverage that not only covers a very broad range of services but also severely limits their potential out-of-pocket obligations—what is here called “front-end” coverage, because the health plan begins to pay even when the level of expenditure is low. In practice, this means that the deductibles and out-of-pocket maximum payments are quite low.

This preference for coverage that pays most of the cost for everything from routine check-ups to hospital stays in an intensive care unit is often said to be a consequence of provisions of the tax code which make employer contributions to health premiums a non-taxable form of income for employees. To illustrate, for an employee in the 33 percent marginal income tax bracket, a \$100 employer premium contribution buys coverage worth \$133 in after-tax dollars. The presumed consequence is that people buy more health coverage (and less of other goods and services) than they would if health coverage did not get preferential tax treatment.

² U.S. Congressional Research Service, *Medical Savings Accounts: Legislation in the 105th Congress: CRS Report for Congress*, March 4, 1998.

Distortion of the Principle of Insurance

MSA proponents see the front-end forms of coverage that result from these circumstances as a distortion of the principles of insurance. The function of insurance is to protect people from large, unpredictable losses. They buy homeowners insurance to pay for losses that might result from a fire or a tornado, for example, because the individual homeowner cannot know whether his or her home will be destroyed by such an event and normally cannot afford to cover the very high cost if it is. But homeowner's coverage does not cover the cost of having to hire a plumber to repair a broken toilet—because the cost is relatively low and thus affordable—or the expense of hiring someone to paint the house exterior—because that is a predictable expense that someone can budget for ahead of time.

The kind of health coverage that protects much of the population is not really insurance. Instead it is a combination of insurance against large “catastrophic” losses and *prepayment*. That is, when people buy coverage with a low deductible and minimal co-payments, they are really prepaying for expenses that are largely predictable or so relatively inexpensive that they could afford to pay for them out of pocket at the time they incur the cost. To use the homeowner's insurance analogy, they are prepaying for plumbing and painter bills. The problem with insuring against these kinds of predictable or relatively low-cost events is that the presence of insurance encourages claims. If people had homeowners insurance of the type described, houses would be painted much more often and plumbers would make many more house calls. And homeowners insurance would cost much more.

The typical generous health insurance policy encourages the same kinds of excesses, the MSA proponents contend. When people have only small deductibles and co-payments, they are in essence spending other people's money, so they have no strong financial incentive to be economical. If a medical service costs \$100 but the patient pays only \$20 out of pocket (20 percent co-payment), the rational person will weigh the marginal cost against the marginal benefit and consume the service so long as he or she thinks the

benefit is worth at least \$20 (if the person is covered by fee-for-service coverage with no external controls on spending). This is wasteful because the value that the person puts on the services is generally far below the \$100 social cost. If, however, insured people had to pay the full \$100 out of pocket, many services now consumed would not be purchased, MSA proponents believe.

Incentives for Cost Containment

The appeal of the MSA approach to coverage is that it restores the insurance principle: people have adequate protection against burdensome financial losses because of the catastrophic coverage, but they still have incentives to be economical in consuming medical services because they bear the full cost of consuming routine and low-cost medical services. MSA proponents believe that this kind of coverage encourages people to be responsible and economical in their purchases of medical services. Up to the point where they reach the catastrophic expenditure level, they are literally spending only their own money: \$100 worth of services costs them \$100 from their medical savings account or from their pockets; so a \$100 service will be purchased only if the purchaser thinks the marginal benefits exceed \$100.³ The supporters of MSAs believe that the result will be to make people weigh costs against benefits, consume fewer (low-benefit) services, and demand better value—thereby helping to produce savings in the health care bill.

Using reasonable but somewhat subjective assumptions, the American Academy of Actuaries estimated the savings that would be realized for an average insured adult if that person were moved from a plan with a \$200 deductible and a \$1,000 maximum out-of-pocket liability to a plan with a \$1,500 deductible and a \$2,500 maximum out-of-pocket

³ This statement is completely accurate only if people can withdraw money from their MSA with no penalty to spend on non-medical goods or services. Otherwise, the opportunity cost of spending \$100 on medical services is less than \$100 spent for other things, assuming the individual puts money in the MSA on a tax-deductible basis. That is, an individual in a 33 percent marginal tax bracket who spends \$100 from his or her medical savings account would be spending only \$67 of after-tax dollars. On the other hand, if the individual had to cover medical expenses out of pocket, as would be the case when the MSA is exhausted but the catastrophic coverage has not kicked in, it would cost \$100 of after-tax dollars to purchase the same medical care. Emmett B. Keeler, Jesse D. Malkin, Diana P. Goldman, and Joan L. Buchanan, "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?," *Journal of the American Medical Association*, June 5, 1996 (Vol. 275, No. 21), p. 1667.

liability (under the assumption that the individual had no choice among plans). According to this estimate, the premium would fall from \$2,699 to \$1,996, while the out-of-pocket costs would rise from \$347 to \$642, so that total health expenditures would fall from \$3,040 to \$2,638. The \$402 savings represents 13 percent of the original \$3,040 base expenditure level and is representative of the reduction in consumption resulting from the increased incentives to economize.⁴

A 1996 simulation study estimated the savings that would be realized if everyone in the country were to switch from HMOs and fee-for-service plans to MSA plans. The savings would vary depending upon the features of the MSA plan; there might be no savings, or they could be as high as 13 percent. Of course, in a system in which people have choice, not everyone will opt for MSA coverage. Based on the assumption that people could choose from several typical types of plans, the simulation suggests that introduction of options to MSAs would produce less savings (because the people most likely to use services would tend to choose the plans with greater financial protection). Under these circumstances, national health spending could fall by up to 2 percent or rise by as much as 1 percent.⁵

Another simulation study concluded that if *all* people in employer-sponsored health plans moved to an MSA plan with catastrophic coverage, the reduction in national health spending would be in the range of 4 percent to 6 percent.⁶

A fourth study estimated that if the portion of the population that switched to a MSA plan represented a cross section of the population, the switchers would reduce their spending by between 2 percent and 8 percent.⁷

⁴ American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995, pp. 8-9.

⁵ Keeler et al, p. 1670.

⁶ Len M. Nichols, Marilyn Moon, and Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans," Urban Institute, April 1996,

⁷ L. Ozanne, "How will Medical Savings Accounts Affect Medical Spending?" *Inquiry*, Fall 1996 (Vol33, No. 3), pp. 225-36.

A Viable Alternative to Managed Care

Creating a situation in which consumers are paying the full costs of what they consume has another important benefit, in the eyes of many MSA supporters. It allows *consumers* to decide how medical resources should be allocated, thereby creating a viable alternative to managed care. Managed care became popular because it was seen a way to control the rapid cost escalation that had plagued a system based on indemnity insurance with front-end coverage and fee-for-service payment of providers. That combination gave none of the decision-makers any incentive to control costs because neither consumers nor providers bore the cost of consuming more care. Managed care puts health plans—and, frequently providers—at risk for the cost of care, thereby creating incentives for them to economize in providing care. The health plan managers and providers determine how medical resources will be allocated.

But managed care cost control has its own problems, many believe, especially when physicians are rewarded for minimizing costs. It is seen as interfering with the role of the physician as an advocate for the patient, creating a conflict of interest. It creates incentives for health plans to cut costs by rationing care, which sometimes leads to providing too little care so that patients' well-being is jeopardized.

MSAs can make the cost controls of managed care unnecessary, MSA supporters contend. When people decide to consume care and fully pay for it *with their own money*, no one can complain that they are overspending. It is a long-held principle that people should be permitted to judge for themselves whether a purchase meets their needs as long as they are paying the full cost. MSAs assure that this condition is met. Thus providing the MSA option lets people choose health coverage that leaves more of the medical purchasing decisions in their hands, to be made in consultation with their physicians, rather than giving that decision to a managed care utilization reviewer or forcing patients and doctors to adhere to rules that must inevitably be somewhat arbitrary and inflexible.

MSAs may also cut administrative costs. Since most people do not have large medical expenses in any year, most people who have MSAs will not make any insurance claims.

(The American Academy of Actuaries estimates that in 1995 about 17 percent of the adult population had essentially zero medical expenses and 78 percent had expenses below \$2,000.⁸) Their costs will be fully covered by withdrawals from their medical savings accounts or out of pocket, and the insurance carrier need not be involved at all. The insurer thus avoids the costs that would be incurred in processing and paying claims for expenses that are above the normal deductible of comprehensive coverage plans but below the level at which MSA catastrophic coverage begins. The savings could be significant because the administrative costs are a relatively high percentage of the claim payment for these low-cost claims.⁹ Moreover, administrative costs are further reduced—for insurers and providers—because these services do not have to pass through the utilization review process.

The American Academy of Actuaries estimates that the administrative costs related to the savings account portion of protection should be only a bit higher than 2 percent, compared to about 15 percent for premiums for typical comprehensive coverage insurance. (The administrative costs for MSA catastrophic premium are also estimated to be about 15 percent, but, of course, the total administrative cost is less because the premium is lower.)¹⁰

The costs of MSA insurance might be somewhat lower for another reason. If insurers price their products so that profit margins are a more-or-less fixed percentage of the premium, the amount that consumers pay toward profits should be somewhat lower, since the premium base is lower because MSA insurance does not provide front-end coverage.

⁸ American Academy of Actuaries, May 1995, pp. 6-7.

⁹ American Academy of Actuaries, May 1995, p. (after Figure II-2).

¹⁰ American Academy of Actuaries, *Medical Savings Accounts: An Analysis of the Family Medical Savings and Investment Act of 1995*, October 1995, p. ***.

Concerns of the Critics

Limited Cost Containment Incentive

The people who are skeptical about the ability of MSAs to improve the performance of the health system believe that the claims for beneficial effects are overdrawn. In particular, they doubt that MSAs will do much to contain costs. The fact that people are using their own money to pay for expenses below the deductible limit will probably discourage some wasteful spending, but such expenses do not represent a very high proportion of the nation's total medical bill. The 78 percent of adults in 1995 that are estimated to have incurred medical claims below \$2,000 (comparable to MSA catastrophic trigger point of between \$1,500 and \$2,250) account for only 13 percent of charges. A very large portion of the nation's medical expenses go to pay for services of the seriously ill: the 10 percent of the adult population that incurred charges in excess of \$6,000 in 1995 are estimated to have accounted for 84 percent of total medical expenses.¹¹ This means, of course, that most expenses incurred by people with medical savings accounts will not be paid out of the pockets or the savings accounts of the insured person but by the insurer providing the catastrophic coverage. Once that coverage begins to pay, the person insured with an MSA has no more (nor less) incentive to economize than does the person covered by a plan that has front-end coverage.

Thus various kinds of care management practices and rules may still be necessary to limit costs for the expensive medical treatment that accounts for a very large part of the nation's health care bill.

Any reduction in national spending might also prove to be just a one-time reduction, lowering the base but not affecting the subsequent rate of growth. The fundamental factors that influence the rate of growth, particularly technological change and increasing

¹¹ American Academy of Actuaries, May 1998, pp. 6-7.

affluence, will probably not be affected by the incentives that MSAs create for consumers.¹²

What Care Will Be Curtailed?

The MSA critics also question whether the people who curtail their spending will eliminate just unnecessary and low-benefit services. The research shows that cost-sharing provisions tend to discourage necessary as well as unnecessary care in roughly the same proportion. And *low-income* people who have to pay significant amounts out-of-pocket are especially likely to forego purchasing beneficial care.¹³ The consequence for patients' health and perhaps ultimately for costs of treating these people could be significantly negative. People at the lower end of the income scale who have MSA coverage might not get care they need, especially preventive services, and the ultimate effect on costs might be an increase rather than a decrease if they later have to be treated for more serious problems. Of course, the fact that people would typically be using money already set aside in their MSA, rather than having to come up with new dollars, might moderate this adverse effect.

Critics also question the premise that people will be wiser and more frugal consumers if they are spending their own money. Because of the technical nature of modern medicine, most people are not equipped to decide whether a medical service recommended by their physician is appropriate or necessary. They frequently do not have the level of information or the experience to weigh costs against expected benefits. They rely on physicians to make those decisions. That is one reason why it is generally agreed that under fee-for-service payment some physicians were able to "induce demand" for services of questionable necessity or value. The mere introduction of MSAs into the equation does not necessarily equip the consumer to judge whether the physician's advice is correct. The fact that the patient is paying for the service from his or her own funds

¹² Marilyn Moon, Len M. Nichols, and Susan Wall, "Medical Savings Accounts: A Policy Analysis," Urban Institute, March 1996, Website: www.urban.org.

¹³ Deborah Chollet, "Why the Pauly/Goodman Proposal Won't Work," *Health Affairs*, Summer 1995, p. 273.

might make physicians more careful to avoid ordering marginally necessary services; but in many, perhaps most, cases, providers will not know whether the patient is covered by an MSA plan or a front-end plan. And most physicians would be offended by the suggestion that their decisions about what care to prescribe should be influenced by who is paying the bill.

Increased Risk Segmentation

Perhaps the strongest objection of MSA critics is that these plans will have a serious unintended negative consequence. They fear increased risk segmentation—that is, less spreading of risk and costs of care among the healthy and the unhealthy. When people have options, they choose the health plan that they think will protect them adequately at the lowest cost. People who are relatively unhealthy, and therefore anticipate that they will incur substantial medical expenses, are not likely to find an MSA plan financially attractive. They will generally prefer a comprehensive plan that provides front-end coverage, because if they had a medical savings account, they could normally expect to exhaust the amount in it and still have to pay out-of-pocket until they reached the catastrophic level. The reason is that, although the employer realizes saving by paying the lower premium for catastrophic coverage rather than conventional coverage, the savings will not be sufficient to permit the employer to fully make up the difference between the large deductible of the catastrophic plan and the small deductible of the conventional plan. So unless the employer is willing to pay more in total for the MSA coverage than for conventional coverage, the amount in the MSA account will not be sufficient to cover the high deductible (at least, not until the amount has been built up over several years).¹⁴

¹⁴ To illustrate why this is so, assume we are looking at the difference between a plan that has a \$100 deductible and one that has an \$1,800 deductible (a \$1,700 difference), assuming the same population is being insured. The additional premium for the comprehensive coverage will be substantially less than an additional \$1,700 because most of the people insured under the front-end comprehensive plan will incur substantially less than an \$1,700 of expenses, and the “excess” premium collected from them can be used to pay expenses of those who do incur expenses closer to or equal to \$1,800. This means that people buying MSA coverage will not realize a premium saving as high as \$1,700. So to provide the same protection they would get from front-end coverage, they or their employer will have to put in some of “their own” money in the MSA or be exposed to having to pay out-of-pocket when their MSA is exhausted and their catastrophic coverage has not yet kicked in.

In contrast, MSAs are likely to appeal to healthy people who expect that their medical expenses are likely to be very low in most years, well below the level at which the catastrophic coverage begins to pay the bills. They are better off financially by buying the less expensive MSA coverage and putting money aside on a tax-free basis in the medical savings account, knowing that in most years they will use little of that money but will still be protected against high expenses. Over the years, they might build up a substantial amount in the account.

Because contributions made by individuals to the MSA are tax deductible, the MSA is also likely to have greater appeal to higher-income people, who pay high marginal tax rates: they can protect more of their income by contributing to the account.¹⁵ (If a person's employer contributes to the MSA, the present federal law does not permit the employee to contribute also.) And, of course, having to pay either out of pocket or from the MSA is not likely to be the deterrent to getting care for the wealthy that it might represent for lower-income people.¹⁶ So the possibility that they might have to bear costs below the catastrophic level is not so likely to discourage higher-income people from buying MSA coverage.

The concern is, then, that sales of MSAs will be made especially to the healthy and wealthy. If MSAs attracted low-risk people and employers with relatively healthy employees, the premiums will be lower for people in MSAs and will, in consequence, rise for people covered by more comprehensive plans, as the low-risk people leave the comprehensive plan insurance pools. The comprehensive plans will suffer "adverse selection," getting a disproportionate share of less healthy people and being forced to raise premiums. If this happens, there will be less spreading of risk among the sick and the healthy and among the wealthy and not-so-wealthy.¹⁷ Many proponents of MSAs,

¹⁵ The extent to which an MSA plan is attractive to the healthy and unattractive to those not-so-healthy depends, in part, on the point where the catastrophic coverage begins. If the level is relatively low (as the minimum level is in the federal legislation), the premium difference between the comprehensive plan and the MSA plan will not be very great, and thus the tax savings for the healthy people will not be very high either.

¹⁶ Moon, Nichols, and Wall, March 1996.

¹⁷ If, however, the premium difference between MSA coverage and comprehensive became extreme, some less healthy employee groups would probably move to MSAs to realize the savings. If states put some

including some insurers, do not see this as a bad outcome. They think that people should, within some limits, pay premiums that reflect their relative risk.¹⁸

The same kind of risk segmentation could incur within a single employer's workforce, causing rates to diverge between comprehensive coverage and MSA coverage. But MSA supporters believe that individual employers can offset such redistribution effects by manipulating the employee's contribution amount to make the MSA relatively more attractive to the not-so-healthy and less attractive to the healthy.¹⁹

To get some perspective on the magnitude of risk-segmentation effects, it is useful to review estimates made by the American Academy of Actuaries. Using reasonable assumptions, they compared the premiums for a low-deductible (\$200) plan and a high-deductible (\$1,500) plan with and without the effects of risk segmentation (the latter under the assumption that people could freely choose either type of plan). For the low-deductible plan, the risk segmentation effect would raise the premium from \$2,699 to \$4,343 (a 61 percent increase), whereas the high-deductible premium would fall from \$1,996 to \$1,430 (a 28 percent decrease).²⁰

The Urban Institute also estimated the effects of risk segmentation on premiums, using a variety of assumptions about the proportion of healthy people switching to MSA plans when people have a choice of either an MSA catastrophic plan or a typical comprehensive plan. If half of the people who would be financially better off (in any year) by switching to an MSA did so, the premium for the comprehensive plan would more than double (going from \$1,701 to \$3,444).²¹

limitations on the ability of insurers to set premiums using health status or past claims experience for individual small employers, as many do, this migration process would moderate the premium differences. (Federal law prohibits insurers from turning down small employers on the basis of health status or any other individual characteristic of their employees, so MSA insurers could not refuse coverage to some small employers while offering it to others.)

¹⁸ Moon, Nichols, and Wall, March 1996.

¹⁹ Mark V. Pauly and John Goodman, "Medical Savings Accounts: The Authors Respond," *Health Affairs*, Summer 1995, p. 278.

²⁰ American Academy of Actuaries, May 1997, p. 9.

²¹ Nichols, Moon, and Wall, April 1996.

If *all* those who would gain by switching to MSAs did so, the premium for the comprehensive plan would rise to 4.4 times its original level (to \$7,396), according to the Urban Institute researchers. In this last instance, even if employers reduced their contribution to the MSA account to zero and diverted the funds to subsidize the premium for those staying in the comprehensive plan, the employees in the comprehensive plan would have to contribute \$5,031 to pay for coverage, compared to only \$340 when everybody was covered by comprehensive coverage. This depicts a situation in which none of the “good risks” are in the comprehensive plan insurance pool. It represents a theoretical extreme, since not everyone could accurately predict before choosing a health plan whether they would be a “winner” or a “loser” by buying MSA coverage rather than comprehensive coverage. But the researchers concluded that between 81 percent and 97 percent of workers could accurately predict their winner or loser status. “Thus, the likelihood of favorable selection into MSA/catastrophic arrangements vs. comprehensive arrangements appears to be very high, and would likely increase over time. . . .”²² Under such circumstances, employers would probably decide to discontinue comprehensive coverage.

Plan Switching and Cost Shifting

A concern closely related to risk segmentation between the healthy and unhealthy is that people will move back and forth from the high-deductible MSA plan to comprehensive coverage plans depending upon their expectations about their need for medical services. People normally covered by MSA plans have strong incentives to switch to comprehensive coverage if they anticipate needing medical care that would exhaust the funds in their MSA—for example, because the family is planning a baby or will need expensive non-emergency surgery. Once the expense is incurred and paid by the comprehensive plan, the individual or family could switch back to MSA coverage at the next open enrollment period. This kind of switching not only creates strong adverse selection against comprehensive plans, critics charge; it is also grossly unfair. Over time,

²² Nichols, Moon, and Wall, April 1996.

switchers in the aggregate may pay substantially less than their full share of the care they receive, by shifting the costs to people who stay insured under the comprehensive plans (including HMOs, PPOs, and so forth).²³

Coexistence Between MSAs and Managed Care

One of the questions that the introduction of MSAs raises is whether they are compatible with managed care. One concern is related to the risk segmentation issue. Because they provide comprehensive coverage with low cost-sharing, HMOs might be subject to adverse selection.

If this were to begin to occur, could managed care plans compete? HMOs could not respond by offering a high-deductible plan because federal and state laws and regulations prohibit that. Apart from the legal constraint, the concept of high cost-sharing is anathema to the fundamental principles of HMOs. They are built on the notion of encouraging prevention and health maintenance and on the assumption that providers, given proper incentives, are in the best position, because of their expertise, to manage care in an economical and appropriate way. The MSA approach puts health *maintenance* organizations in the paradoxical position of not being able to encourage the use of preventive services—in fact, the incentives discourage patients from consuming such care. HMOs cannot influence the use of medical services below the catastrophic level, but they then have the responsibility to manage care once the illness becomes a “catastrophe,” perhaps because the previous medical resource allocation decisions were poorly made.

Of course, if MSAs began to account for a large share of health coverage, laws would probably be changed to permit HMOs to enter the market for high-deductible plans. But HMOs might find many difficulties in offering both their traditional comprehensive plans and this fundamentally different form of coverage at the same time.

²³ Elliot K. Wicks and Rick Curtis, “Making Medical Savings Accounts Work in conjunction with Insurance Market Reform,” unpublished paper prepared for the American College of Physicians by the Institute for Health Policy Solutions.

PPOs would experience difficulties too. PPOs encourage enrollees to use network providers by imposing higher copayments when enrollees choose to go to non-network providers. If PPOs were to offer a high-deductible plan, the copayment would be 100 percent until the deductible is reached, regardless of whether enrollees choose network or non-network providers. So until that point, people have no incentive to use network rather than non-network providers.

In addition, if the total out-of-pocket maximum is not too much higher than the deductible (as is true in the federal law), then consumers would have little incentive to choose network providers most of the time—specifically, only within the corridor when they had passed the deductible maximum but not yet reached the out-of-pocket maximum. The cost-saving potential of PPOs would be reduced, and their leverage in bargaining with providers to join the network would diminish.²⁴

Winners and Losers

As noted earlier, if MSAs were to catch on, they would appeal to some people and not others, depending on the financial advantages and disadvantages of various forms of coverage. Some individuals would be better off under MSAs than under current comprehensive coverage (the “winners”), and some would be worse off if some people switched to MSAs (the “losers”). The winners would tend to be people who, because of the tax subsidy to employer-sponsored insurance, now purchase an “excess” amount, that is, more than they would want to purchase if the dollars spent for health care did not have extra value because of their tax-preferred status. If these people had the option to buy less coverage (a catastrophic plan) and still get the tax advantage by putting the difference in an MSA, some would do so. In general, the people who fall into this category are those with relatively low risks of needing substantial health care services—that is, healthy people. Because only a small proportion of people are ill enough to incur substantial medical costs in any year, the healthy people in a comprehensive plan heavily subsidize the seriously and moderately ill. Under catastrophic coverage, the healthy people would

²⁴ American Academy of Actuaries, October 1995, pp. 2-3.

subsidize the unhealthy to a lesser extent and would recoup the savings. The unhealthy would consequently have to pay substantially more out of pocket to compensate for the fact that the insurer is collecting substantially less in premiums from everybody.

Based on a simulation, the Urban Institute identified the winners and losers if *all* employees were forced to switch to catastrophic coverage. About 80 percent would be financially better off after one year and 73 percent would be better off after three years. (This is a consequence of the fact that most people in any year have very low medical expenses.) And over that three-year period, the winners would gain more (\$1,323) than the losers lose (\$962). As expected, the winners would tend to be younger and healthier than the losers.²⁵

It is, of course, highly unlikely that everyone would be forced into MSA plans in the near future. As noted earlier, if people had options, some people would choose to buy comprehensive coverage, and they would experience very high premiums; they would be big losers.

The Current Situation

To this point, the actual experience with MSAs is very limited for all populations. Since no one is yet enrolled in the Medicare program, there is no experience to draw on to indicate how MSAs might work for this specialized population. There is still a good deal of uncertainty about how the Medicare MSA program will be implemented. Some people are concerned about the extent of favorable selection that the MSA plans might enjoy, since that would raise costs either to the recipients in other plans or for the government for covering the rest of the population. Risk segmentation seems especially likely with the Medicare population since elderly people experience dramatically different levels of health.

The MSA program for the employed population began in January 1997. Although MSA plans were readily available at the starting date, the number of MSAs policies that were

²⁵ Nichols, Moon, and Wall, April 1996.

sold in the early months was fewer than many people expected. Between January and June of 1997, only 22,051 medical savings accounts had been opened (when the cap was 525,000). About 78 percent of insurers reported that sales were lower than they anticipated. Almost 60 insurers and health plans offered the new kind of plans by the summer of 1997, including a significant number of Blue Cross and Blue Shield plans. MSA plans were available in every state. But few HMOs (only three) offered MSAs, and most of the very large commercial carriers did not offer them.²⁶

The number of people buying MSA plans has certainly increased since the last official information was reported for the period prior to June 1997. But the official tally compiled by the Internal Revenue Service is based on data reported by insurers to the IRS in August of each year; so recent official data is not yet available. Based on conversations with a number of insurers offering MSAs, one researcher estimates that the number of medical savings accounts is approximately 125,000 in mid-1998.²⁷ Given the relatively slow start, it seems virtually certain that the enrollment caps will not be a constraint on the number of plans sold, at least for the foreseeable future.

What accounts for the slow growth of MSA sales? Insurers cited a number of factors:

- The product is new and seems somewhat complex and confusing to consumers.
- Insurance agents, who greatly influence purchases in the individual and small-employer market, are not very familiar with the product, and the commission structure may not provide much incentive to promote the product.
- Some insurers did not offer the product because they did not expect MSAs to account for a large market share.
- The structure of the benefits, particularly the low out-of-pocket maximums, may make the product unattractive to PPOs; people who have met the deductible have already met a large part of the out-of-pocket maximum, so once people reach the catastrophic level, they have no strong incentive to use in-network providers.²⁸

²⁶ General Accounting Office, pp. 3-7.

²⁷ Personal communication with Greg Scandlen of Health Benefits Group, June 8, 1998.

²⁸ General Accounting Office, pp. 7-9.

Another explanation for slow MSA growth may be that a large proportion of people simply prefer to have front-end coverage, even if that may not seem to be a “good deal” financially. Most well-insured people have, for a number of years, had comprehensive coverage. In addition to ensuring that they will not suffer the burden of catastrophic expenses, this coverage has required them to pay little in the way of out-of-pocket payments even for more routine kinds of medical care. Perhaps the pervasiveness of such comprehensive coverage has conditioned people to be very risk-averse. Or perhaps they may simply not want to have to consider finances when deciding whether or not to seek medical care or when choosing among treatment alternatives. Although it may seem to be irrational to pay for front-end coverage (since, as noted earlier it is not insurance and is more costly on average than paying out of pocket), many people may be willing to pay a “surcharge” for the convenience and peace of mind of not having to weigh medical costs against benefits. In other words, the popularity of comprehensive coverage plans may not be due entirely or even primarily to the favorable tax treatment of employer-sponsored plans²⁹ but rather to a strong preference by many people for comprehensive coverage.

At this stage, it is probably too early to judge whether some of the problems envisioned by the critics, particularly those related to adverse selection, will surface. Likewise, it is not possible to test whether the benefits seen by MSA proponents will be realized. The number of people in such plans is too small to have much impact on the rest of the market.

The Future

It is worth speculating about what would be necessary for MSAs to be more successful. The proponents might argue that over time they will sell themselves, since, as noted

²⁹ In fact, it would be interesting to know what proportion of people covered by employer-based plans even know of—let alone understand the implications of—the favorable tax treatment. The likelihood is that, contrary to the view of most economists, many workers think that the employer bears the burden of the employer’s share of the premium, so that they do not think of having an option between having the employer contribute to health insurance or getting higher money wages. If that is so, it suggests that people do not choose comprehensive coverage because of the favorable tax treatment of employer-paid premium contributions.

earlier, the financial “winners” far outnumber the “losers” in any one year. But the other side of the argument is that most winners will become losers in some year, and if people are very risk averse or simply uncomfortable with making a major change in their coverage, they may not choose the “rational” economic option.

If large numbers of employers were to offer *only* the MSA option, enrollments would obviously increase. But that seems unlikely, especially among large employers, many of whom have just gone through a period of trying to channel people into managed care plans. This process has not always been well received by employees, and employers might be concerned that another major change would further alienate employees. Smaller employers may find the option attractive, especially if the employer’s cost is lower. But many small employers do not offer coverage now, and the mere presence of MSA plans is not likely to change that because MSAs are not likely to be dramatically more affordable.

If actual experience with MSAs proves that the incentives cause MSA enrollees to substantially reduce spending for health services (not caused by favorable risk selection), such plans would become substantially less expensive than those with front-end coverage. A large enough difference would undoubtedly cause some additional people to switch from comprehensive plans to MSAs. But such large premium differences may not occur because, as noted earlier, by far the bulk of medical expenses are incurred by people who spend more than the maximum out-of-pocket payment required of MSA plan enrollees; at this point, the incentive to be cost-sensitive disappears.

If people become increasingly alienated from managed care, the MSA option might become more attractive. People who are spending their own money do not have to get anybody’s permission to see a specialist or go to another provider. But it is hard to understand how MSA plans can stay competitive in terms of price if they do not also “manage” care or otherwise constrain consumption once people hit the catastrophic level, since it is these people who incur most of the costs for any kind of insurance.

Measuring MSAs Against Reform Objectives

MSAs were supported and passed into law because significant numbers of people were convinced that they could achieve legitimate public policy objectives. The MSA experiment is designed to determine whether those objectives can be realized, so it is premature to give any definitive assessment. But it is useful to consider how MSAs might or might not help achieve various reform objectives. (In many respects, such a discussion is a summary of points already considered.)

Cost

Because the MSA approach should discourage some consumption of medical services, national health care costs could be expected to decline somewhat. Clearly, the magnitude depends upon the number of people choosing this MSA approach, as well as other factors such as the level of the deductible. As noted, however, almost all projections see the cost reduction as being modest.

Administrative costs should be reduced somewhat, as noted, because many people covered by MSA plans would never submit claims since they would not exceed the high deductible in any particular year.

Access

MSAs might help increase access in several ways. People who choose MSA plans rather than managed care would generally have greater freedom of choice of providers and would not have to go through a gatekeeper or utilization review process to see a specialist or get some particular kind of treatment. Delays would be reduced. The offset is that, because they are paying out of pocket, some people might be deterred from getting needed care, especially preventive services.

MSA plans should have somewhat lower premiums than comprehensive plans. That might induce some employers to offer coverage that do not do so now, and it might make coverage affordable for some employees that find the expense of comprehensive plans beyond their reach. But because the cost reduction is likely to be modest, the additional

number of people who get coverage is likely to be quite small. Furthermore, if MSA plans increase risk segmentation, the people who remain in comprehensive plans might end up paying much higher premiums.

So in terms of the broad access problem—finding a way to provide coverage for the more than 40 million people lacking coverage—MSAs are unlikely to do much to solve the problem. The basic reason that people lack coverage is that the cost is more than they are able or willing to pay. No reform policy now on the horizon is likely to reduce the cost of coverage to such a point that many of these people will purchase coverage. Without either subsidies or a government policy that requires coverage, the bulk of these people are likely to remain uninsured.

If access is defined to include choice, MSAs, as noted, might expand choice of providers. On other hand, if large numbers of people choose MSAs, over time the premiums for comprehensive plans might, because of adverse selection, rise to such a degree that firms would be forced to eliminate the option of comprehensive coverage. People who prefer that option would not have the choice.

Quality

It is questionable whether widespread enrollment in MSAs would have a significant effect on quality. Present attention to quality has been sparked, in large part, by the movement to managed care: competing plans have strong incentives to cut costs, and the buyers need to know whether that adversely affects quality. The need for such knowledge has put employers in the forefront of efforts to measure quality and to pressure health plans to improve their performance. Competition among health plans will not go away, no matter how successful MSAs are, and neither will the forces that cause costs to rise. It is thus likely that the incentives to find better ways to cut costs and therefore to measure and promote quality will remain in force. The quality-measurement boat is speeding ahead and will not be easily turned around.

Equity

It is not possible to assess the equity of any policy without bringing value judgments to bear. And one reason that people disagree about the desirability of MSAs is that they start with different value judgments. The people who believe in “social insurance” principles generally believe in the desirability of spreading risks and costs more evenly across the population, which means that healthy people pay more than the costs of the care they use. It is this sentiment that has been behind many of the efforts to reform state and federal laws that regulate the health insurance market for small employers. Thus supporters of insurance reform generally see the increased risk segmentation that MSAs are likely to produce as being inequitable.

In contrast, supporters of MSAs, particularly certain insurers active in this market, tend to believe that people should pay for coverage commensurate with their risk (although they believe in some degree of risk pooling, since the alternative is that every individual self-insures). They see broad risk spreading as an inequitable subsidy from the healthy to the less healthy.

Without attempting to decide this issue, it is useful to recall who the winners and losers are likely to be under MSA catastrophic plans. About 75 to 80 percent of workers, according to one estimate, could gain by switching from comprehensive coverage to MSAs. Winners are likely to be healthier, younger, and male and to be paid lower wages (even though MSAs are likely to appeal to wealthier workers, who can afford the higher out-of-pocket expenses). Sicker and older people will tend to be losers.³⁰

Conclusion

The evidence is still out on the role MSAs will play in a reformed health system. The early evidence suggests that both the strong advocates and the harsh critics may have overstated the case. The proponents *wanted* and expected MSAs to gain a large market share, and they expected significant improvements in the health system as a result. The

³⁰ Nichols, Moon, and Wall, April 1996.

critics *feared* MSAs would prove popular, and the results would be bad. So far, neither expectation has been realized. People have not flocked to buy MSA coverage, so their impact on the system has been minor to this point.

MSAs may ultimately take their place among a range of coverage options, including HMOs, PPOs, and various point-of-service alternatives. If they meet the needs of a certain portion of the market—without severely exacerbating risk segmentation problems—perhaps they will serve a useful purpose by giving people a broader range of choices.

Whatever they are, MSAs are not a panacea for the problems of the health system. In the first place, they may simply not prove to be very popular in the long run. But even if they account for a significant share of the market in the future, they will probably not make a major long-term impact on health care cost escalation. They are unlikely to have a significant impact on the number of uninsured. They will not appreciably influence the quality of care.

The problems of the health system will not be solved by any single policy reform. They generally have multiple causes and will require a whole range of policy solutions, and these solutions will have to evolve over time. To think otherwise is not to have learned from the last 25 years of efforts to reform the health system.