

Medical Savings Accounts: Health System Savior or Insurance Scam?

Howard K. Rabinowitz, MD

Medical savings accounts (MSAs) have emerged as one of the most controversial health policy issues currently being discussed by legislators, policy analysts, physicians, insurance companies, and businesses. For some, MSAs represent the greatest hope for the health care system; for others, they are a major insurance scam that could destabilize health care financing. Although MSAs have been around for a number of years, they have not been widely used. Recently, however, more than 15 states have enacted some form of MSA legislation, and major federal legislative initiatives have been proposed to allow them to be tax exempt, thereby promoting their use.

Last year MSAs were included in the Kennedy-Kassebaum health insurance reform bill (formally known as the Health Insurance Portability and Accountability Act, or HIPAA), the major piece of federal health care legislation passed in 1996. The bill provides portability of health insurance and coverage for preexisting conditions. Despite wide bipartisan support for the overall bill, MSAs (included in the House version but not in the Senate's) became the most contentious issue in the bill, delayed its passage for months, and almost derailed the entire piece of legislation. In the end, a compromise was agreed upon that allowed for a small-scale 4-year pilot program of MSAs, after which Congress will decide whether to let MSAs expand.

In the upcoming 1997 session of Congress, MSAs once again promise to be a major legislative issue, this time regarding their role in restructuring the Medicare program. Despite this

continued and intense focus on MSAs, however, they remain an exceedingly complex and largely untested new insurance product, with a number of theoretical advantages as well as some potential serious concerns regarding their impact on the US health care system. I will attempt to explain what MSAs are, the theory behind them, their potential advantages and disadvantages, who supports and opposes them, the details of the 1996 MSA legislation, and what the future direction of MSAs is likely to be.

What Is a Medical Savings Account?

MSAs are personal savings accounts (similar to individual retirement accounts) that are offered in conjunction with a high-deductible (ie, catastrophic) health insurance policy. Instead of purchasing a traditional health insurance plan, employers (or individuals) could buy a less expensive, high-deductible policy and put the difference in cost into a tax-sheltered MSA. Policyholders would then use the money in their MSA to pay for their own medical expenses that are not reimbursed, or not covered by health insurance. If health care costs turn out to be greater than the amount of money in their MSA, policyholders would then have to pay out of pocket until they reach the maximum amount for which their policy stated they were responsible. Above that amount, the catastrophic insurance plan would pay for all of their health care costs. If the money in the MSA were not used by the end of the year, it could accumulate and earn interest (tax free) for future years and be used for long-term care or for other purposes depending on the specific rules of the policy.

For example, as shown in Table 1, suppose that a person has a traditional indemnity health insurance policy (costing \$2700) that includes a \$200 deductible and a 20 percent coinsurance, with a \$1000 out-of-pocket maximum. The policyholder would have to pay for the first \$200 in

Submitted 13 August 1996.

From the Center for Medical Education Research and Policy, Department of Family Medicine, Jefferson Medical College, Thomas Jefferson University, Philadelphia. Address reprint requests to Howard K. Rabinowitz, MD, Center for Medical Education Research and Policy, Department of Family Medicine, Jefferson Medical College, Thomas Jefferson University, Suite 401, 1015 Walnut Street, Philadelphia, PA 19107.

Table 1. Comparison of Traditional Indemnity Health Insurance Policy with Medical Savings Account (MSA) Plus Catastrophic Policy.

Characteristics	Traditional	MSA + Catastrophic
Premium	\$2700	\$2000
Medical savings account	0	\$ 700
Deductible	\$ 200	\$1500
Coinsurance	20%	20%
Maximum out of pocket	\$1000	\$2500
Liability	\$1000	\$1800

medical expenses and 20 percent of the next \$4000 in costs (ie, \$800, or until costs reached the out-of-pocket maximum of \$1000). The insurance company would then pay all additional costs. The maximum individual liability with this plan would be limited to \$1000 per year.

The comparable high-deductible plan might cost only \$2000 to purchase, and the remaining \$700 could be placed in an MSA. This policy would have a much higher deductible of \$1500, a similar 20 percent coinsurance, and an out-of-pocket maximum (which could be partially paid for by the MSA) of \$2500. In this instance, subscribers would be responsible for paying the first \$1500 in expenses, and 20 percent of the next \$5000 in costs (ie, \$1000, or until they reached their out-of-pocket maximum of \$2500). If subscribers had less than \$700 in health care expenses in a given year, they could use the money in their MSA to pay for these expenses; any money remaining in the MSA could be saved and accumulate tax free in their personal MSA. If health expenses were greater than \$700 but less than the \$2500 maximum, they could use the money in their MSA to pay for the first \$700 but would have to pay the rest of the costs themselves. In this instance, an individual's maximum liability would be \$1800 per year (ie, \$2500 minus the \$700 from the MSA). All additional expenses greater than \$2500 would be paid for by the catastrophic insurance plan.

Will MSAs Work?

Because tax-exempt MSAs have never existed, all of the discussions regarding their impact on the health care system are theoretical. In addition, as for most insurance policies, the specific details can be designed in a myriad of ways, each of which would have a considerable impact. For example,

the level of deductible, the maximum amount of money that could be placed in the MSA, the maximum out-of-pocket costs, what to do with any leftover accumulations in the MSA, how to deal with tax issues, whether to offer MSAs within the Medicare program, and whether an individual could change between a traditional policy and an MSA plus catastrophic plan each year—all represent variables that could have enormous impact on how MSAs would work.

The basic theory behind MSAs is that the high deductible and the ability to retain unused MSA funds as personal savings will act as incentives to encourage subscribers to be more cost-conscious consumers, use fewer health care services, and search for lower cost providers, thereby decreasing health care utilization and costs. This theory is based on the assumption that many policyholders currently obtain medical services without regard to cost, or they receive unnecessary services, because their insurance pays for it. Also, MSAs would provide policyholders with more control over their choice of physicians and treatments.

Despite the potential of MSAs to introduce some degree of personal responsibility and fiscal control into the health care system, there are major concerns, many of which relate to the probable effect of MSAs on the financing of the overall health insurance system. The same issues that make MSAs appealing, such as the potential to save money, also encourage a skew in who would choose MSAs. Specifically, persons most likely to choose MSAs plus high-deductible plans are those who anticipate they will use few health services (ie, less than the amount in the MSA); this group represents a healthier population of users. In addition, those with sufficient financial resources to cover the larger maximum financial liability in case of unexpected illness (eg, \$1800 compared with \$1000 for the traditional policy) will be most likely to choose MSAs. Consequently, MSAs will probably attract subscribers who are healthy and financially better off. At the same time, those who expect their medical expenses to be greater than the amount in an MSA, especially those who have reduced ability to purchase health care services (ie, those with the greatest burden of illness, such as persons with chronic illnesses, heart disease, or cancer) are likely to reject MSAs, because they would be likely to pay the maximum liability each year and

therefore would pay less with traditional insurance than with MSAs.

Because a vast majority of the population is relatively healthy, MSAs are likely to be popular. A study conducted by the nonpartisan American Academy of Actuaries¹ estimated that most people would save money with an MSA, and the 17 percent of those who have no medical expenses in a given year would have the greatest gain, up to \$600 a year in one illustrative plan. But the few persons who have serious illness and the highest costs will see an increase in their yearly costs, with 8 percent of those with the highest medical expenses paying as much as \$900 more a year under the same plan. In addition, future premiums for those sicker persons who choose traditional plans could increase dramatically, possibly as high as 60 percent according to some estimates, as the amount of money normally saved for those with few expenses would no longer be available from the insurance pool to subsidize the care for those with the greatest expenses.

The concept of MSAs, therefore, directly contradicts that of insurance—pooling the premiums of the healthy and sick. With MSAs, those who are healthy get a rebate; those who are sick find less money in the insurance pool to pay for their care, thereby necessitating an increase in their traditional insurance premiums. In this way, risk selection allows the healthy to choose MSAs and pay lower costs, whereas the sick shun MSAs and pay increasingly higher premiums. Although MSAs might decrease the use of unnecessary health care, studies indicate that high-deductible plans will also discourage the use of necessary care, such as preventive services, and delay care for important services (eg, treatment of hypertension), the effect of which is worse for the poor, especially poor children.²

Although supporters of MSAs claim that they will save money, overall costs of health care might not decrease. Whereas MSAs will probably save some money by decreasing marginal and optional health care services and their associated administrative costs, MSAs will have no impact on the great majority of health care costs, those associated with necessary services and serious illnesses, that would exceed an individual's maximum liability (ie, covered by the catastrophic plan).

In fact, MSAs could actually increase the US health care system's overall costs. According to an

analysis by the Joint Committee on Taxation, making MSAs tax exempt will cost the US Treasury approximately \$2 trillion in lost revenues during the next 7 years. To the extent that MSAs support the continued inefficiencies of the current fee-for-service system, they might eliminate any progress managed care has made in controlling health care costs. Furthermore, although supporters argue that MSAs will lower administrative costs because there will be fewer claims submitted, others point out that they will also generate increased complexity in the tax codes, and increased record-keeping will be needed to justify MSA withdrawals.

The overall impact of MSAs might well depend on how all of these issues balance out, as well as whether policyholders see their MSA primarily as a savings account or as a health insurance account. In the latter case, the funds could be used as first-dollar payment of care and could actually increase utilization. A recent study by RAND³ suggested that all cost issues might well balance out and that MSAs are unlikely to decrease (or increase) substantially overall health care costs.

Different Perspectives on MSAs

In addition to examining the pros and cons of this issue, looking at those who support or oppose MSAs can reveal additional information regarding their likely future impact. Most physicians and physician organizations support MSAs primarily because they allow patients to choose their health care providers and to pay for medical care in a fee-for-service manner. In this way, MSAs are quickly becoming a major alternative to managed care. MSAs are also strongly supported by several insurance companies that specialize in them, most notably the Golden Rule Insurance Company, headed by J. Patrick Rooney, who has also been a major contributor to Speaker of the House Newt Gingrich.⁴ Finally, many congressional Republicans believe that MSAs will increase personal choice and make the health care market more competitive, whereas many small businesses and the self-employed see MSAs as an affordable alternative to traditional health insurance.

On the other hand, serious opposition to MSAs has been expressed by persons with chronic diseases as well as managed care insurance companies. In addition, many large employers (who see managed care as a way to control their health care

costs) are worried that MSAs will be difficult to integrate with managed care plans and are therefore concerned that their costs will rise. In fact, MSAs can currently be used only with fee-for-service plans, and a number of state and federal laws would have to be changed for MSAs to be integrated with managed care plans. Finally, most congressional Democrats, concerned that MSAs will become a tax shelter for the healthy and wealthy at the expense of the sick and poor, have opposed them.

Despite the wildly differing rhetoric of these groups, the American public seems particularly uninformed regarding MSAs. A recent survey from the Kaiser-Harvard Program on the Public and Health-Social Policy, released immediately before the passage of the MSA provision, showed that 67 percent of the population surveyed were unfamiliar with the legislation.⁵ In addition, many nonpartisan groups, such as the Employer Benefits Research Institute (EBRI),⁶ the American Academy of Actuaries,¹ and the Congressional Research Service,⁷ acknowledge that the MSA is essentially an untested policy that has many theoretical advantages and some potentially serious risks.

Summary of the Legislation and the Future of MSAs

The specific MSA proposal that was recently passed into law as part of the Kennedy-Kassebaum health insurance reform bill is a 4-year experiment beginning in 1997, limited to anyone who is currently uninsured and up to 750,000 persons nationwide who are self-employed or employees of businesses with 50 or fewer workers.⁸ In addition, the catastrophic plan would limit the deductible to \$2250 for individuals and \$4500 for families; it would limit out-of-pocket expenses to \$3000 for individuals and \$5500 for families. Annual contributions to the MSA would be limited to 65 percent of the deductible for individuals, and 75 percent for a family policy. Finally, the legislation would allow any money remaining in an MSA to be withdrawn by an individual for any reason (not necessarily medical) after the age of 65 years.

Despite the hope that this experiment could provide more information about how MSAs might actually have an impact on the health care system, the reality is that the MSA demonstration

project represented a political compromise and is more likely to postpone rather than inform the policy debate. The MSA provision allows the concept of tax-exempt MSAs to be included in law, thereby creating the possibility for its future expansion; at the same time, it limits its impact substantially, thereby restricting any potential harm to individuals or the system. After 4 years, however, it is probable that there will be too few MSA policies in any one area to measure their impact in any region, because policyholders will be spread out across the country. In addition, only a small percentage of healthy persons will develop serious illness or face a catastrophically expensive illness during the next 4 years. As a result, despite future attempts to analyze the impact of the MSA experiment of 1996, the most likely outcome is that supporters will claim victory and detractors will claim that the experiment did not adequately test the potentially serious problems of MSAs.

Although many effects of MSAs on cost, utilization, and risk selection can be addressed in legislation, as with all insurance, many will also be decided by employers, insurance companies, and consumer behavior. In reality, however, MSAs are likely to achieve some of what both supporters and opponents claim. MSAs are a popular concept because they are financially advantageous to a great majority of the population. They will probably increase consumer choice and might decrease overall health care costs slightly. Not all will save, however; insurance companies, the healthy, and some employers might, but the sick and poor might not. MSAs are unlikely to have any important impact on access to care, and they are unlikely to preserve the current fee-for-service system of reimbursement. It is unclear what impact they will have on quality. Their greatest potential risks are primarily for the health care system as a whole, as well as for those with the largest burden of illness.

Future debate on MSAs should focus on the balance and interaction among all these various issues, not on whether MSAs are right or wrong. Even though legislation to make MSAs tax exempt has recently been passed, MSAs will continue to be a frequently discussed health policy issue and will almost certainly be revisited in congressional discussion—during the 1997 session of Congress regarding Medicare—and in 2001.

References

1. Medical savings accounts: cost implications and design issues. Washington, DC: American Academy of Actuaries, 1995.
2. Newhouse JP, RAND Corporation Insurance Experiment Group. Free for all? Lessons from the RAND Health Insurance Experiment. Cambridge, Mass: Harvard University Press, 1993.
3. Keeler EB, Malkin JD, Goldman DP, Buchanan JL. Can medical savings accounts for the nonelderly reduce health care costs? JAMA 1996;275:1666-71.
4. Freudenheim M. Health plans that can put cash into worker's policies are finding favor. New York Times 1995 August 29:A8(col 1), A15.
5. Kaiser Family Foundation release. July 30, 1996.
6. Fronstein P. Medical savings accounts: issues to consider. EBRI Notes 1995;16(7):1-7.
7. Lyke B, Congressional Research Service. Medical savings accounts: background issues. CRS report for Congress no. 96-409 EPW. Washington DC: Congressional Research Service, 1996.
8. Langdon S, Rubin AJ. Health insurance bill fight ends with deal on savings accounts. Congressional Q Wkly Rep 1996 Aug 3:2198-99.