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**MEDICAL SAVINGS ACCOUNTS:
A POLICY ANALYSIS**

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I. INTRODUCTION

Medical savings accounts represent a relatively new proposed solution for our health care cost growth problem. While general support for cost containment is widespread, strategies for restraining cost growth vary considerably, from governmental price setting or premium controls to an emphasis on competition to discipline the market, with many variants in between.

Managed care and health system integration are both gaining momentum as employers and governments abandon traditional indemnity insurance and unfettered fee-for-service medicine to pursue lower costs and high quality without resorting to governmental regulation. Modern managed care systems attempt to control costs and quality through *systems* approaches--utilization management techniques, provider profiling, provider payment incentives--that attempt to enforce cost-effective norms of behavior and treatment patterns. Strong government controls over health care reflect a different type of systems approach in which the goal is to exert power over providers, often in the form of administered prices, on behalf of patients and taxpayers.

The philosophy behind a medical savings account (MSA) approach represents a fundamentally different strategy for cost control, elevating the role of the individual above that of any system. MSAs are personal funds established by individuals or their employers to pay current out-of-pocket medical costs and to accumulate funds for future expenses. Many current proposals call for these accounts to be combined with high deductible or catastrophic health insurance policies that would cover certain medical expenses once the insured spends beyond a substantial deductible. MSAs would give the individual, rather than managed care professionals or third party payers, full control over how resources are allocated for health care services below this high deductible amount. Since individuals would view spending on at least some health care as competing for other desired consumption goods, they would presumably be more careful in

deciding when to use such services. And even above the deductible, many supporters envision relatively few controls on choice of providers or use of services.¹ In this sense an MSA approach is consistent with a philosophy that emphasizes individual choice.

By making the individual responsible for health service utilization and providing financial incentives to use less care, MSAs should heighten awareness of the costs of care, and proponents argue that better health resource allocation decisions would thus be made. But, as described here, an MSA approach is neither a new idea nor one which is in any way prohibited at present. Individuals can choose to establish savings accounts to pay for their out-of-pocket costs, and employers can even offer cafeteria plans that include flexible spending accounts that carry special tax sheltered spending. Only 16 percent of workers in firms with 500 or more employees take advantage of flexible spending accounts today (Foster-Higgins, 1995). Further tax benefits, it is sometimes argued, are needed to stimulate the growth of MSAs. And it is here where public policy concerns are centered.

Changes in the tax treatment of MSAs constitute the usual method proposed for such increased incentives. Essentially the argument is one of leveling the playing field. Tax deductibility for premiums paid on employer-provided plans is unlimited, encouraging very rich benefit packages. Out-of-pocket spending, on the other hand, is deductible only if it exceeds 7.5 percent of a family's income or if employers establish flexible spending accounts that allow tax free withdrawals. Flexible spending accounts, however, are restricted to voluntary employee contributions, and families are at risk for losing the remainder of their contribution if their

¹Although it is possible that even such catastrophic plans will increasingly be combined with techniques of managed care, the attractiveness of this approach is usually that it allows individuals to avoid such restrictions. That is, it makes it possible to retain an indemnity approach to insurance.

expenses in any one year do not exhaust the account. Allowing employer contributions to MSAs to be excluded from taxable income or allowing individual contributions to be deducted from income would give the accounts the same standing as premiums in the tax code. But is expanded deductibility desirable public policy?²

MSAs have been thrust to center stage by widespread political support in the 104th Congress and in some state legislatures. An MSA provision for the under-65 population, very similar to H. R. 1818 (Archer-Jacobs), was included in the 1995 Balanced Budget Act which passed both houses of Congress (but was vetoed by the President). MSAs were included in the Republicans' Medicare reform proposal as well. The policy community has also devoted considerable attention to this strategy. A number of recent papers have examined various issues raised by MSA proposals (Pauly, 1994; Jensen, 1995; Pauly and Goodman, 1995; Tanner, 1995; Ferrara, 1995; American Academy of Actuaries, 1995a and 1995b; Rodgers and Mays, 1995; White, 1995; Eichner et al. 1995; Minnesota Department of Health, 1994; Thorpe, 1995).

While we review some of the arguments addressed in other papers, we particularly focus on how MSAs might work in practice, how they interact with other insurance and reforms, and what issues are raised that are of particular relevance for state policies on MSAs. MSAs are being considered as additions to our current health care system, and it is essential to view them in that context in addressing these questions.

II. HOW AN MSA WOULD WORK

²And beyond the issue of desirability, are extra tax benefits necessary to stimulate these insurance arrangements if they are so attractive?

A wide variety of proposals could fit under the rubric of medical savings accounts, so it is important to establish some boundaries for our analysis. In this paper, when we refer to an MSA proposal, we mean a combination of the purchase of a catastrophic insurance policy and the establishment of an account from which individuals could draw to pay medical bills not covered by that insurance. This account would receive preferential tax treatment.

How such policies would work in practice depends upon how much premiums would go down as compared with other types of plans, how employers would respond to that difference, and how generous and for whom the tax deductibility would be. Given the range of possibilities, it is difficult to offer definitive answers about the impact of MSAs. Consequently, we focus on a relatively standard approach and then discuss how such variations might affect the analysis of MSAs in the section on state variability. Consider first the building blocks of a generic plan.

The Elements of MSA Proposals

There are three basic elements of an MSA proposal: (1) the features of the catastrophic insurance plan offered in conjunction with an MSA; (2) the tax rules for the MSA and any associated spending; and (3) eligibility rules for the tax treatment of the MSA.

Catastrophic Plan Features

Instead of a traditional insurance package, an MSA approach would use a catastrophic insurance policy that protects families only after a certain amount of out-of-pocket expenditures is paid by the family directly. For example, the deductibles might be \$2,500 for individual coverage and \$5,000 for family coverage. Only after covered expenditures have exceeded those amounts would insurance pay anything. At that point, the insurance could be fully comprehensive or also contain copayments and other restrictions. Further, the insurance might

include benefits that are often not offered under traditional insurance policies -- e.g. vision or dental care.

To help pay for out-of-pocket expenses, the family would set up a medical savings account. If this arrangement is established through an employer, the employer and/or the worker could contribute to the MSA, potentially reflecting savings to the employer from subsidizing a smaller insurance package.³ Individuals and families who do not fully deplete their account in any year would be allowed to carry over that amount into the future, building a larger cushion against future expenses, or withdrawing it under certain circumstances.

Insurance policies that are alike except for the size of their deductible will vary in price by less than the full amount of the deductible (American Academy of Actuaries, 1995a). At any given time, some families that purchase insurance will spend very little on health care while others will spend much more. But exactly because most people would spend less than \$2,500 in any year, the cost of providing insurance for the first \$2,500 in health care spending is considerably less than \$2,500. Further, since many policies already have deductibles and copayments, then the difference in what is covered between a standard policy and a policy with a \$2,500 deductible would further limit any expected reduction in the premiums from shifting to a catastrophic policy. For example, in 1995, deductibles on conventional policies offered by employers of medium and larger sized firms averaged \$257 for singles and \$603 for families. Over 80 percent of these policies also required copayments of at least 20 percent (KPMG, 1995). The differences in price of the insurance might widen somewhat, however, if use of services falls

³An employer could choose to offer the same dollar subsidy to all workers, for example, regardless of what plan was chosen. Alternatively employers could vary the subsidy to compensate for a sicker mix of patients in traditional plans. We discuss these issues in a companion paper (Nichols, Moon, and Wall, 1996).

for those choosing an MSA option.

After accounting for these various factors, the American Academy of Actuaries estimated a price difference of \$508 in the premiums for two plans alike except for a \$1,300 difference in the size of the deductible. Families with few medical expenses would benefit from the lower premium, but those with higher spending might exceed the \$603 in savings, exposing them to more risks. The burdens are likely to be particularly high for those with low and moderate incomes, for whom this extra risk constitutes a higher share of income.

Tax Rules for the MSA

The tax rules could also vary considerably. First is the issue of whether the tax preference would be in the form of a credit or a deduction. The difference is important. A credit does not vary with the marginal tax rate, so lower income taxpayers receive the same absolute benefits as do higher income taxpayers. A deduction, on the other hand, favors those in the highest tax brackets, for the benefit is larger the higher is the marginal tax rate (see Pauly and Goodman, 1995). In general, MSA proposals rely upon deductions, at least in part because that is the way that employer-sponsored premiums are now treated.

A tax deduction would be allowed up to a certain amount -- usually either the deductible in the catastrophic policy, a set limit, or the contributions into the account, whichever is lower. If the contribution comes from the employer, it would be excluded from income -- in the same way that other fringe benefits are excluded. If the deduction is allowed to be as high as the insurance policy's deductible, this would represent a potential expansion of deductibility for any given family who chooses an MSA option. In the example above, the premium differences are only \$508, but depending upon how the deduction is set up, an individual could qualify for an

additional \$1,500 in deductions from taxable income.⁴ Further, most MSA approaches allow the full range of health benefits now contained in the IRS code to be treated as legitimate expenses. These allowed expenses include a broader range of services than are now covered by most insurance plans. Consequently, tax benefits could be increased by the MSA approach.

Who is Eligible for the Favorable Tax Treatment of the MSA?

Finally, eligibility rules can vary as well. If allowed only for employer-subsidized insurance, any tax expansions would be limited to a subset of the population. But if the concern is with leveling the playing field in terms of who can deduct the costs of health care, both self-employed individuals and workers without employer-subsidized insurance now have less generous coverage of their premiums than workers with employer-subsidized coverage. Consequently, allowing everyone to establish tax preferred MSAs would at least offer them some expanded protections, although it would also represent a substantial extension of tax deductions. Further, if anyone could potentially be eligible for an MSA, other criteria for limiting its use would likely be necessary. For example, do families have to have a catastrophic plan to qualify or could they just establish an MSA for excess medical expenses?⁵ Are costs of insurance allowed to be treated as part of this account -- e.g. long term care insurance or dental insurance, but also standard health insurance for those who are not now allowed to deduct it? Without careful limits, the possibilities and potential tax loss quickly expand. However, setting such limits prevents a true leveling of the playing field and disenfranchises many of those who now pay

⁴And particularly if the individual is allowed to carry over this tax excluded amount, this higher deduction can be taken each year for many years.

⁵This would allow, for example, Medicare beneficiaries to establish such an account for out-of-pocket costs which can be quite high under the traditional plan, since there is no out-of-pocket limit under fee-for-service Medicare.

more out-of-pocket for health care spending as compared with those eligible for employer-sponsored MSAs.

Proposed Federal Legislation

A specific proposal at the federal level was contained in the Balanced Budget Act of 1995. Although the act was vetoed by President Clinton, some type of MSA legislation is likely to be considered in 1996 either as a stand-alone bill or attached to some other legislation. At present, Congressional interest seems to rest more with MSA legislation than with other types of insurance reform.⁶ Also unknown, however, is whether an MSA bill would be signed by President Clinton or whether there are enough votes in the Congress to override any veto.

The MSA approach in the Balanced Budget Act requires that a catastrophic plan be held with a minimum deductible of \$1,500 for single coverage and \$3,000 for family coverage. The legislation would presumably include all individuals covered under such plans, extending substantially the potential deductibility of expenses for the self-employed and persons with no employer-sponsored coverage. Tax deductibility would be limited to either the deductible of the catastrophic insurance policy, or to \$2,000 for single and \$4,000 for family coverage, whichever is lower. These limits would be indexed to medical inflation and thus allowed to grow over time. Qualifying expenses include those now in the Internal Revenue Service code -- which are quite broad -- and several limited types of insurance premiums including long term care insurance. Balances in the account not used in one year could be used in later years.

⁶In fact, although unanimously voted out of the Senate Labor and Human Resources Committee, the future of the insurance reform bill offered by Senators Nancy Kassebaum and Edward Kennedy that would ensure limited portability, guaranteed renewal, and other reforms in the private insurance market is quite uncertain at this writing. Opposition has centered around portability from employer-sponsored to individual insurance, which the bill would guarantee under certain conditions.

This legislation also contains several key restrictions. Interest from the account would be taxable as income. Further, if an employer contributed to the MSA, any additional contribution by the employee would not be deductible, even if the employer's contribution was less than the maximum allowed. This limits the extent of deductibility allowed. Distributions taken out of the account for purposes other than medical expenses would be taxable, and a 10 percent penalty would be assessed. The Congressional Budget Office has estimated that this provision would reduce federal income tax revenues by about \$2.7 billion over seven years.

III. WHY THIS POLICY IS SO CONTROVERSIAL

An essential argument for MSAs as the solution to our health system's woes rests on the premise that the fundamental problem is overly comprehensive insurance for those who are insured, particularly in the lack of deductibles and copayments. This is a very different starting point than for those who see the fundamental problem as too much risk segmentation in the health insurance market and who emphasize reforms of the private insurance market.

The effect on costs and cost growth

Purely economic arguments in support of MSAs emphasize the distortion caused by the tax preference for comprehensive insurance and recommend correcting this distortion by extending the tax preference to MSAs and out-of-pocket spending (Goodman and Musgrave, 1993) or to catastrophic plans with MSA arrangements (Pauly and Goodman, 1995). There is little doubt that comprehensive indemnity coverage was encouraged by federal tax law and that it has contributed to our cost growth problem, though it is difficult to establish exactly how much (Newhouse, 1993). Further, if tax deductibility represents a distortion, then extending the

distortion to MSAs raises the question, “Do two wrongs make a right?” (Pauly, 1994). Indeed, many who oppose tax distortions as matters of principle and microeconomic policy see the solution not in extending deductibility but in restricting it with limits on the amount that can be deducted to the cost of a catastrophic policy. Such an approach would have the additional advantage of assuring that the initial health expenses are *fully* borne by individuals rather than being subsidized by their tax deductibility.

There is considerable evidence that patients use fewer health services when they pay more out of their own pocket for those services (Newhouse et al., 1993). There is less agreement about the magnitude of the effect that higher cost-sharing would have across all health care spending -- that is, on amounts above the deductible. Some advocates of MSAs have assumed rather large effects (Ferrara, 1995), whereas the professional economic literature suggests modest responsiveness to cost-sharing when compared with the price sensitivity of other goods (Morrisey, 1992). The effect of increased cost-sharing is not likely to be uniform across different services and may differ for different population groups as well (Morrisey, 1992; American Academy of Actuaries, 1995a). For example, low income groups are particularly sensitive to cost sharing, likely because of the relative burdens of such costs as compared with their resources (Newhouse et al., 1993). Indeed, one of the reasons why MSAs are thought to be so popular with higher income families is that the deductibles usually associated with such plans are not likely to be very constraining on behavior.⁷

Whatever the appropriate assumption about the magnitude of the net effect of higher cost-sharing, the highly skewed distribution of health spending must be taken into account when

⁷To some extent this defeats the purpose of a deductible high enough to change behavior.

considering the potential for MSAs to reduce health costs. Once the stop-loss -- that is, the maximum liability that a family faces from deductibles and copays -- in the related catastrophic policy is reached (which is often set at the level of the deductible) no cost-sharing obligations and incentives apply to the patient.⁸ Over 80 percent of health spending by individuals covered through employer-sponsored health plans is accounted for by people who spend more than \$2,000 and 60 percent of spending is actually over \$2,000.⁹ Thus, if a typical catastrophic policy as part of an MSA arrangement has a \$2,000 deductible and stop-loss, a majority of spending would be protected by insurance and hence not directly subject to the incentives established by the MSA/catastrophic approach.¹⁰ In addition, much of this high spending is associated with inpatient services, which are generally less responsive to price effects than more discretionary outpatient services. Further, since the tax-deductibility of MSAs in effect makes out-of-pocket spending up to the deductible tax free, some MSA arrangements could actually increase spending by reducing the effective price of out-of-pocket spending. This is most likely if the expenses which count toward the deductible are any IRS-defined medical expense, rather than those for the services covered by the post-deductible policy. If this is the case, the MSA has effectively enriched the benefit package (Pauly, 1994).

Finally, a one-time reduction in health spending as a result of widespread shifts to MSA/catastrophic arrangements, however large or small, does not necessarily translate into

⁸In practice, it is also possible to imagine that some catastrophic policies would adopt at least some managed care principles or seek discounted fees as a means of further holding down the costs of premiums.

⁹Urban Institute analysis of 1987 NMES data, in 1994 dollars.

¹⁰Arguably, some people would know they could not avoid exceeding the deductible and stop-loss in a given year, and they would have little incentive to contain costs on the first \$2,000, either. At the same time, the higher deductible might restrain spending for some who had high spending, perhaps reducing their total below \$2,000 so that it is all subject to the higher deductible.

reductions in the rate of cost growth. And it is the growth in spending that most concerns analysts regarding health care costs. That is, the shift in type of policy could result in a one time reduction in the base, but after that, the causes of growth in costs could largely be unaffected. Many analysts believe technological improvement is the major reason health care costs continue to grow year in and year out (Newhouse, 1993), and much of this technology is heavily used in inpatient settings (Weisbrod, 1991) -- where patients' costs are likely to exceed the high deductible of a catastrophic policy. Thus, high priced procedures and techniques may actually face less market discipline if we move to an open-ended fee-for-service policy that fully protects families above the deductible as compared with pressures on technology in a managed care context. It is possible, therefore, that widespread MSA/catastrophic indemnity arrangements could actually increase long run health care cost growth rates. While MSAs may have other desirable effects depending on one's point of view, significant aggregate reductions in health care costs are not likely to be among them.

Tax Revenue Losses from MSAs

As noted earlier in the section on how the MSA/catastrophic approach would work, most of the existing proposals would expand the deductibility of health care costs. Revenue losses would increase. Although advocates of this approach tend to be skeptical of projected losses, the revenue consequences concern opponents on both sides of the political spectrum. On the left, critics argue that these approaches will be most appealing to higher income individuals and families who can afford to pay a substantial amount out-of-pocket. Combined with the fact that deductions also favor higher income families who fall into higher marginal tax brackets, the distributional impacts are such that this policy will exacerbate some of the inequities in the

current tax treatment of health insurance. Further, depending upon who is covered by the MSA policy, some of the existing inequities that allow employer-subsidized insurance to be deductible but individually-purchased insurance to have little or no tax preference would be retained or perhaps worsened.

On the right are opponents of MSAs who object to the distortions created by extending deductibility of insurance. If allowing deductibility of insurance helps to encourage people to overuse health services, the problem remains in place when it applies to out-of-pocket spending, particularly if that out-of-pocket spending is broadly defined. If so, it would be better to eliminate all deductibility of health premiums and spending, or to limit it, for example, to the actuarial costs of a catastrophic policy. In that way, the bias for comprehensive insurance would be eliminated and no further distortions would be created.

Selection Issues

Finally, MSAs remain controversial because of their potential to split the health insurance market, or at least some parts of the market. Critics of MSAs believe that they may seriously harm the risk pools of comprehensive products sold to a single group. MSA/catastrophic plans are likely to be appealing to younger, healthier workers who would gain financially from a high deductible, lower cost plan because they use few health resources at any one time. This issue is discussed in more detail in a companion paper (Nichols, Moon, and Wall, 1996) which simulates the possible effects within a firm. Because most workers are healthy, a large majority -- 75 to 80 percent -- would be financial gainers from the MSA approach (assuming no benefits from the higher insurance protection).

But our findings also indicate a strong likelihood that MSAs cannot effectively coexist

alongside other traditional indemnity plans within a firm. With even modest selection, premiums for traditional indemnity plans would rise very rapidly. For example if just one quarter of all the winners in an average firm chose the MSA while everyone else remained in a traditional indemnity policy, the indemnity premium would rise by nearly two thirds (Nichols, Moon, and Wall, 1996). Thus, firms are likely to offer only an MSA/catastrophic option if they want their employees to have such policies rather than adding MSAs to a set of other available plans. And while managed care and MSAs might coexist as choices, they represent such different approaches to health care that employers might simply choose one or the other, especially if a majority of workers in a given firm strongly preferred one or the other arrangement. Even though the potential for risk selection is less certain between MSAs and managed care, the *threat* of selection creating instability may also contribute to an either/or mentality. If MSAs effectively drive out other types of plans, issues such as burdens from high deductibles on those with low and moderate incomes become even more relevant.

What about MSAs in the individual or very small group market? At present, there is less pooling in this market since there is already so much medical underwriting. In addition to offering only one policy, small firms will normally be experience-rated. Thus, the market segmentation discussed above has effectively already occurred, at least to some degree. MSAs might further solidify discrepancies in insurance costs between those with sicker employees and those with healthier ones, however. In addition, many individuals seeking coverage already often must accept high deductible policies as a matter of routine. This then raises less of a selection issue and more one of the revenue losses of extending tax preferences to this group of the

population.¹¹

One might wonder why MSAs have not already been more widely adopted by small firms and individuals even absent a tax preference. On the other hand, many states have been trying through insurance reforms to combine the risk pools for small firms and in some cases for individuals. In that case, MSAs may create some incompatibility issues. This is the subject of the next section.

IV. ACTIVITY AT THE STATE LEVEL

States have not waited for the federal government to enact MSA legislation. A number of them have moved on their own to at least some degree, and others have passed resolutions urging the federal government to act. This is particularly interesting since states' relatively low income tax rates limit the power of tax preferences to make MSA/catastrophic approaches more attractive. But states have a long history of enacting legislation regarding health insurance. Insurance is regulated at the state level, and a broad range of states have actively sought to establish reforms in private insurance to expand its availability and level the overall playing field. Thus, it is natural to expect them to also consider MSAs. In general, however, the states that have been most active in insurance reform are less likely to have passed MSA legislation. This is not surprising, since MSAs and other insurance reforms represent competing philosophies as is discussed in more detail following the section describing what states have done with their MSA legislation.

Specifics of State Legislative Approaches

¹¹This could certainly be justified on equity grounds, however, since such individuals do not now have any tax benefits for health care unless their costs exceed 7.5 percent of their incomes.

Seventeen states have enacted some type of MSA provisions, each with a number of different variations on the degree of tax relief offered or the terms establishing who qualifies for such treatment. Of the 13 states' approaches that we examined,¹² four required the program be established through an employer and nine would allow either individuals or employers to establish MSAs. This latter approach, which is consistent with most federal legislative proposals, allows a broader scope of potential participation. But unlike the MSA proposal contained in the Balanced Budget Act, most of the state acts do not limit the deductibility of the MSA account to *either* the employer or employee contribution. Rather, both could contribute, potentially increasing the dollars placed in MSAs and thus, the amount of tax-preferred out-of-pocket spending.

Only one state, Michigan, has set up its MSA as a credit rather than a deduction. As described above, deductibility favors those with higher incomes who fall into higher tax brackets. This is less of an issue for states, however, since many states have relatively flat income tax rates, reducing the differences between credit and deduction approaches. For example, several states have flat marginal income tax rates -- that is, only one rate applies to all incomes. Further, only three of these 13 states had brackets that continued to increase for families with incomes over \$50,000. In general, the rates reach a maximum at a relatively low income. Finally, since states have much lower income tax rates than the federal government, the potential impact of any MSA proposal is limited if it only reduces state tax liabilities. Montana's maximum marginal tax rate of 11 percent is the highest of the 13 states we examined, followed by New Mexico at

¹²These include: Arizona, Colorado, Idaho, Illinois, Indiana, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah and West Virginia. A summary of their MSA legislation can be found in a Council for Affordable Insurance report (Craig, 1993). Four other states also have at least partial legislation in this area (IHPP, 1995).

8.5 percent (ACIR, 1995). Illinois has an MSA provision, but only a 3 percent income tax rate, suggesting that it has little leverage in inducing employers or individuals to move in this direction.

States also vary in the maximum amount in an MSA that is eligible for preferential tax treatment. The most common amounts are \$2,000 and \$3,000 for single persons. Unlike the federal legislation described above, nine of the plans also allow interest on the MSA to be treated as tax free as well. Further, seven states allow individuals to withdraw unused balances at the end of each year with no penalty (although that balance must then be treated as income). Others usually require the balance to be retained for future use. A 10 percent penalty for unauthorized withdrawal is typical. Thus, these are relatively generous MSA allowances and would go well beyond the proposal contained in the Balanced Budget Act, but revenue losses are limited at the state level because of the lower income tax rates that apply.

Compatibility of MSAs and Other Reforms

One of the important issues regarding MSAs is their compatibility with other health care reforms enacted by many states (and now being considered at the federal level). Four types of health insurance reforms are commonly discussed in the states: full or modified community rating, guaranteed issue and limits on pre-existing condition restrictions, portability, and purchasing cooperative rules.¹³ In general, the philosophy of private insurance reforms enacted by states has been to seek ways to expand the risk pools for small group or individual markets. The motivation is usually to reduce the segmentation that makes insurance less expensive for the healthy but unaffordable or even unavailable for small groups or individuals with health problems

¹³States are more likely to require some but not all of these features. In particular, community rating is often not part of reforms.

(or even with any history of health problems).

The philosophy behind MSAs is quite different, however. The emphasis there is on restructuring insurance products in such a way as to appeal to a particular segment of the market. In fact, many supporters of MSAs (including the insurers who offer such plans) are actively opposed to requirements for guaranteed issue or other reforms that seek to prevent segmentation.¹⁴ The emphasis of MSA supporters is on keeping insurance costs low both through rewarding those who use fewer services with the use of a high deductible, and implicitly by seeking to attract a healthier population. In this way, insurers specializing in MSAs can carve out a niche in the market by offering low premiums to selected small firms, for example. Those who favor insurance reform, on the other hand, recognize that it may modestly raise costs for those who already have insurance, but by making it affordable to others, they argue the resulting system would ultimately benefit those who are now healthy but may someday find themselves on the unfavored side of insurance underwriting. In practice, MSA and small group reform approaches to public policy toward health insurance markets are diametrically opposed.

Community Rating

Pure community rating -- that is, requiring that insurers make no distinctions in premiums charged for different groups or individuals -- works best in an environment where all plans are either alike or equally attractive to persons with varying health risks. If a state were to adopt pure or even age-adjusted community rating, a health plan that attracts healthier than average individuals would be particularly advantaged compared with those that enroll a broader cross-section of individuals. Further, when community rating is combined with guaranteed issue,

¹⁴For example, the Council on Affordable Insurance (Craig, 1993; Craig et al., 1993) has written extensively in support of MSAs and in opposition to guaranteed issue and other reforms.

requiring an insurer to take all comers, plans that naturally discourage sicker beneficiaries are in a better position to offer lower premiums, or to keep premiums competitive and make larger profits. Individuals attracted to such plans are also better off because they will face somewhat lower premiums and do not have to effectively subsidize sicker families and individuals. Non-MSA indemnity insurers could be at a disadvantage in such an environment and might be unable to offer competitive products (see Nichols, Moon, and Wall 1996).

The result could be that MSAs could displace comprehensive indemnity policies as the most common form of un-managed care. This may be desirable if the goal is to move more people into catastrophic-like insurance, but not if the goal is to assure today's full range of choice in health insurance policies.¹⁵ MSAs are often promoted as achieving both of these goals, but in practice they are likely to be incompatible. Although the likelihood of driving out other insurers is lower if the requirements are not pure community rating but rather allow age bands or some variation within various demographic groups, the basic problem still remains. It is likely not a coincidence that states that have moved to adopt pure or modified community rating are not among the states with MSA laws on the books (IHPP, 1995).

MSA supporters might argue that pure indemnity insurance has already shown that it cannot compete on price with managed care plans over the long haul, and so indemnity's evolution into MSA/catastrophic hybrids will at least keep fee-for-service medicine and absolute provider choice available for some. The point is not to argue that one form of indemnity/fee-for-service survival is preferred to another, but that the MSA/catastrophic "solution" in combination with some form of community rating is likely to generate problems in risk pooling.

¹⁵On the other hand, insurance reforms may raise premiums somewhat, placing some plans beyond the reach of low and moderate income families.

Guaranteed Issue, Pre-Existing Condition Restrictions and Portability

Private insurance reform in a voluntary market usually recognizes that pure guaranteed issue puts insurers at a disadvantage because some individuals will be tempted to forego any insurance until the time that they need coverage. Insurance rates would thus rise since insurers would be less likely to enroll healthy individuals whose costs would help to hold down the premiums to others. As a consequence, small group market reforms usually do not offer guaranteed issue unless combined with pre-existing condition restrictions. In that case, pre-existing condition restrictions are intended to encourage people to purchase insurance *before* they get sick.

Because of the political difficulty of guaranteed issue requirements, state reforms often focus on portability -- that is, the requirement that someone who has insurance from one source must be allowed to continue it or have the equivalent offered to them when circumstances change, e.g., when they change jobs or move. However, full portability requirements are also incompatible with MSAs. Portability assures individuals that they can keep health insurance over time. But if portability requires comprehensive insurers (i.e. insurers with low deductible plans) to cover those who previously had MSA/catastrophic combination plans, then those who become sick while in an MSA can easily convert to comprehensive insurance. Burdens would likely be shifted onto the comprehensive insurers, particularly for care that is at least somewhat discretionary in terms of timing. This raises the same general problem that healthier individuals will choose less comprehensive policies until the moment they know they are facing heavier health care expenses. If they can switch plans with no restrictions, then comprehensive insurers are likely to have a less desirable risk group and have to raise their premiums for all enrollees.

Thus, in a market where MSA/catastrophic plans co-exist with comprehensive plans, any portability would work best if limited to like plans in order to level the playing field. But this limits protections because many individuals cannot choose what types of plans they are offered through their employers. If their employer only offers a MSA/catastrophic plan, for example, they may face difficulties in obtaining insurance from a new employer. This results in “job lock” and other problems that private insurance reforms often seek to resolve.

Purchasing Cooperatives

We have concluded that MSAs could present problems in a health plan choice environment within a large firm. Would such approaches to health insurance also be an uncomfortable fit with purchasing cooperatives that seek to allow small firms or individuals to be able to choose from a variety of health plans? Uncertainty concerning risk selection that would benefit MSAs might make managed care plans and other types of plans reluctant to join an alliance that contained MSAs as an option. This uncertainty might make it difficult to launch voluntary cooperatives. No cooperative at present offers an MSA product. Competition on the basis of modest differences in benefit structures, quality measures, and price are considered to be key to successful ventures. When the plans are very different it may be difficult for consumers to make good choices since price will vary with risk selection, not the quality or efficiency of the health plans.

Overall, states with the most aggressive insurance reforms, including guaranteed issue and at least modified forms of community rating, do not also have provisions for MSAs (IHPP, 1995). MSA states do, however, often have at least some reforms, particularly some type of portability, on the books. It will be interesting to observe whether these two competing approaches can

successfully co-exist in states if MSAs begin to expand substantially over time.

VI. SUMMARY AND CONCLUSIONS

This paper has explored the merits and drawbacks of proposed and enacted MSA legislation, with special attention given to state activity and the potential consequences that MSA arrangements hold for insurance markets, employers, and individuals.

We draw several general conclusions. MSAs represent an approach to health care cost control that elevates the autonomy of the individual patient in contradistinction to a managed care system or other more interventionist public strategies. Widespread adoption of MSAs could lower costs modestly because people will reduce total health spending in the face of higher out-of-pocket obligations, though probably not as much as some MSA advocates have claimed. MSAs are not likely, however, to affect the long run rate of cost growth appreciably.

Most workers are healthy and thus would gain financially by switching to MSAs from comprehensive insurance arrangements. But in large part because the healthy would be attracted to MSAs, comprehensive indemnity insurance will likely have trouble surviving in competition with MSA/catastrophic arrangements since adverse selection effects would push premiums upward for comprehensive plans. Managed care might attract similar health risks as MSA/catastrophic plans and be able to maintain a stable equilibrium market in the long run, but it is not clear at the present time which if either would eventually dominate.

As a consequence, the relatively unhealthy will likely end up paying more for health insurance or out-of-pocket than they do now. If they stay in traditional plans, premiums will rise; if they move into MSAs (perhaps because that is their only alternative), their out-of-pocket

expenses will rise. This equity issue takes on additional resonance when one considers that higher-income, healthy persons are the most likely to be attracted to the MSA approach, for they have the wherewithal to bear the greater financial risk of a high deductible policy and the most to gain, per dollar, from making out-of-pocket spending tax preferred.

State MSA proposals are generally more generous than the federal proposals, but low state income tax rates and basically flat state income tax structures will likely limit the attractiveness of MSA/catastrophic plans in the absence of a change in federal law. Further, small group reforms enacted at the state level, since they tend to emphasize reducing risk segmentation in the small group and individual markets, are often in conflict with MSA approaches to health reform.