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MSAs for Everyone, Part I

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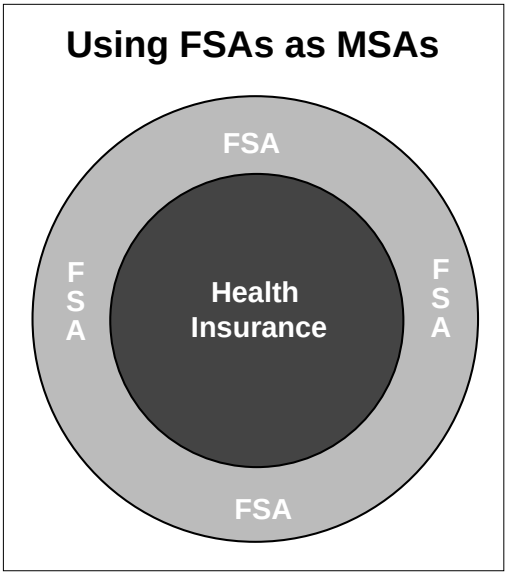
Medical Savings Accounts (MSAs) give patients direct ownership of and control over a portion of their health care dollars. They have two main advantages. First, when people spend their own health care dollars, they become more careful and prudent consumers of care than when they spend other people's dollars. The result is lower health care costs and better value for the money spent. Second, when patients pay the bills, doctors and other providers are more likely to act as the patients' agents rather than as agents of a third-party payer. The result is care that better meets the patients' needs.

Current MSA Law. Unfortunately, the tax law discriminates against MSAs. Whereas the law excludes employer payments for third-party insurance from employees' taxable income, it fully taxes most MSA deposits. The exception is a pilot program Congress created in 1996 for the self-employed and businesses with fewer than 50 employees. MSA deposits made under this program are tax-free and must be combined with high-deductible health insurance. The patient uses the MSA to pay small and routine health care bills, while the health insurance covers major expenses. Money not spent during the year may be left in the account to grow tax-free. MSA funds may also be used to pay health insurance premiums when people are between jobs.



Restrictions on MSAs. While the pilot program was a major step forward in national health policy, Congress saddled MSA plans with so many restrictions that their popularity and growth have been disappointing.

- Current law permits the sale of only 750,000 MSA policies over a four-year period. Thus in contrast to the experience with Roth IRAs, the MSA market is too small to induce large insurers to aggressively market an MSA product nationwide.
- The law also requires tax-advantaged MSAs to be combined with a minimum across-the-board deductible of $1,500 for individuals and $3,000 for families — levels that are too high for many families of modest means.
- Health plans cannot vary the deductible by type of health service, e.g., by charging higher deductibles for discretionary services and lower deductibles for nondiscretionary services.
- Because of the requirement of a high, across-the-board deductible, 75 percent of the people with employer-provided health insurance cannot have a MSA because they are enrolled in an HMO.

The South African Example. In contrast to the U.S. experience, MSAs flourished during the 1990s in Nelson Mandela's South Africa. By now, MSA products have captured more than half the market for private health insurance in that country. Thanks to a favorable ruling from the South African equivalent of our Internal Revenue Service, employer deposits to an MSA get the same tax treatment as employer payment of insurance premiums. Thus South Africa's MSA products compete on a level playing field with other forms of insurance, including Preferred Provider Organizations (PPOs) and HMOs.

Since the South African government never passed a law dictating an MSA design, MSA plans developed in a relatively free market. Moreover, these "free market MSAs" are different, and in some ways more attractive, than the U.S. version. For example, one of the most popular plans has first-dollar insurance coverage for most hospital procedures — on the theory that within hospitals patients have little opportunity to exercise choices. On the other hand, a high deductible (about $1,200) applies to "discretionary expenses," including most services delivered in doctors' offices.

South Africa's more flexible approach also allows more sensible drug coverage. While the high deductible applies to most drugs for ordinary patients, a typical plan pays from the first dollar for drugs that treat diabetes, asthma and other chronic conditions. The reason is obvious: encouraging patients to skimp on drugs that

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prevent more expensive-to-treat conditions from developing would be counterproductive.

Reforms in Progress. How can Americans get access to the same kinds of MSA products routinely available in South Africa? Surprisingly, the answer may lie in Patients' Bill of Rights legislation now in conference committee on Capitol Hill. Under the legislation, MSAs would be made permanent and available to everyone. They would still have to be combined with an across-the-board minimum deductible, which would be lowered to $1,000 for individual policies and $2,000 for families. However, there are two provisions that can make MSAs adapt to any insurance plan, including HMOs.

Converting FSAs into MSAs. Currently employees with cafeteria plans may make pretax contributions to a Flexible Spending Account (FSA) to pay health expenses not paid by the employer's plan. But because these accounts are governed by a "use it or lose it" rule (anything left in the account at year-end is forfeited), the financial incentives are the opposite of those created by MSAs. The Senate bill would change these incentives by allowing the patient to roll over $500 at year-end — into an IRA, 401(K) or MSA — or leave the money in the FSA. The conference committee is considering making the figure $1,000. This provision would turn a use-it-or-lose-it account into a use-it-or-save-it account. In other words, FSAs could become MSAs, at least partially.

The FSA/MSAs would solve a number of the problems people currently face in the health care system.

- The accounts would be completely flexible — in effect wrapping around any third-party insurance plan, including an HMO, PPO, Point of Service (POS) plan or traditional indemnity insurance — providing funds with which to pay medical expenses not paid by the plan. [See the figure.]
- Since these accounts belong to the individual, not the employer, FSA/MSAs would be portable, allowing the individual to take them from job to job and use them to pay health expenses when the individual is between jobs.
- The wraparound feature would assist people who chose to purchase services outside of their health plan. For example, enrollees in HMOs and other managed care plans could use the funds to pay for doctor visits, diagnostic tests and other services not paid for by their health plan. Participants in POS plans could use their funds to pay fees charged by non-network physicians, which are often considerably higher.
- Contributions to these accounts would be strictly voluntary and could easily be integrated with the employee's personal savings plans.
- Contributions could be made by employers as an alternative to spending more for third-party insurance, giving employers and insurers much more flexibility in designing plans. For example, they could provide first-dollar coverage for services like preventive tests and high deductibles for others without jeopardizing the ability of the insured to have an MSA.

Making the Deductible Flexible. But what about employees who do not have access to a cafeteria plan? If Congress made one small change in the legislation, it could take care of that problem. Instead of requiring a $1,000 across-the-board deductible in order to qualify for an MSA, the Patients' Bill of Rights should require $1,000 worth of "exposure." Most HMOs, for example, provide some mental health care, but limit the number of visits or impose a dollar maximum on the plan's benefits. These restrictions leave the insured at risk for much more than $1,000 out of pocket. Substituting "exposure" for "deductible" would allow almost everyone to qualify for an MSA with his or her current health plan.

Conclusion. Congress could easily empower patients not by encouraging everyone to have high deductible health insurance, but by modifying existing legislation to allow a savings account to be combined with any health plan. Such modifications would allow every American to own an MSA and would fundamentally change the way the health care marketplace works. It would give people more access to health care, more choice and more protection — that is, more rights — than any proposal currently before Congress.

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