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MSAs for Everyone, Part II

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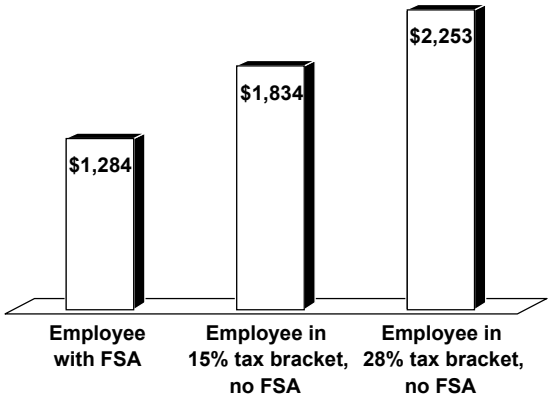
Medical Savings Accounts (MSAs) are usually associated with large deductibles. For example, under a federal pilot program, in order for employers and their employees to make tax-free deposits to MSA accounts, patients must incur $1,550 or more in expenses before the insurance kicks in. All the expenses below the deductible are to be paid from the MSA or directly out of pocket. Once the deductible is satisfied, the insurance acts like any other health plan.

The problem is that relatively few people have high-deductible health plans. And only a few insurers offer them. Finding an insurer with a qualifying health plan has been a major obstacle in bringing MSAs to the market. Most Americans have health plans with low deductibles, or in the case of HMO coverage, no deductible at all. But they still have out-of-pocket expenses — sometimes very large expenses. They may have copayments, which are a flat dollar amount that must be paid when receiving services — say $25 for a visit to a physician's office, or $10 to fill a prescription with a generic drug and $25 to fill a prescription with a name-brand drug. Other plans may have substantial coinsurance provisions, such as requiring the patient to pay 20 percent of all expenses within a network and 40 percent of those outside the network. And virtually every health plan has gaps in coverage — excluding, for example, chiropractic care or acupuncture or prescription drugs.

Flexible Spending Accounts. Is there a way to combine the benefits of MSAs with the needs of people in ordinary health plans? Some people think the answer is yes and the mechanism is Flexible Spending Accounts (FSAs). Out-of-pocket health care expenses can add up quickly, often to thousands of dollars in a single year. So in 1978 Congress enacted Section 125 of the Internal Revenue Code to allow workers to pay out-of-pocket expenses with pretax funds. Section 125 enables workers to divert some of their own money into FSAs to pay for direct health care expenses or their share of insurance premiums. They can also divert money separately for dependent care. Money in FSAs is exempt from both income and payroll taxes. But only employers can set up the programs. Unlike IRAs, workers cannot set up FSAs independent of their employers.

FIGURE I

Average Cost to Employee of Insurance Contribution
(1993)



Source: Bureau of Labor Statistics.

The use of FSAs has grown slowly over the years. According to William M. Mercer, Inc., a benefits consulting firm, 56 percent of employers offered FSAs in 1998, but only 19 percent of employees took advantage of them.

One consequence is that employees spend a lot more than they have to for employer-provided health insurance. The Bureau of Labor Statistics reported in 1993 (the latest year for which figures are available) that 76 percent of employees in medium to large firms had to pay all or part of their health care premiums. The average employee contribution for family coverage was $1,284. As Figure I shows:

- A worker in the 15 percent income tax bracket had to earn $1,834 in gross income to have enough money left over after income and payroll taxes to pay his or her $1,284 premium contribution.
- A worker in the 28 percent income tax bracket had to earn $2,253.

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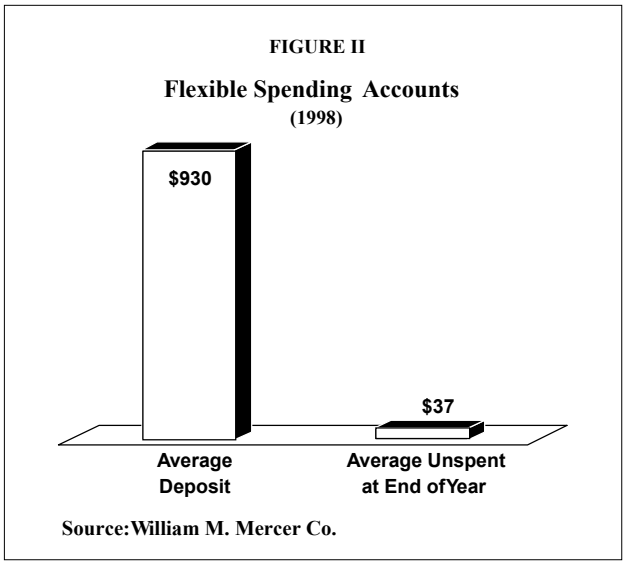
■ That means the workers paid $550 and $969, respectively, in unnecessary taxes to earn enough to pay the premium.

Use It or Lose It. One big reason more employees don't exercise the FSA option is a "use-it-or-lose it" provision. If workers don't spend all the money in their FSAs by the end of the calendar year, they lose the unspent amount, forfeiting it to their employers. The law that Congress passed in 1978 contained no such provision, but the Internal Revenue Service (IRS) created it with a regulation in 1984. Since it is often extremely hard to predict at the start of the year what a worker's out-of-pocket expenses will be, most workers have decided not to risk forfeiting their money.

The use-it-or-lose it provision prompts many participants in FSA programs to scramble to spend all their money on needless services at the end of the year. For example, in a *Washington Post* article, "Patients Rush to Use Benefits," on December 30, 1999, reporter Martha Hamilton described how optometrists, dentists and plastic surgeons are besieged at year's end by patients trying to use up their balances. But even with the year-end rush, many employees still forfeit funds. Hewitt Associates, another benefits consulting firm, reported that 20 to 25 percent of FSA participants forfeited funds in 1994, with the average forfeiture between $127 and $184. According to the Mercer survey, workers who participated in FSAs set aside an average of $930 in 1998, and about 4 percent went unspent. [See Figure II.] By contrast, employees in a typical MSA plan have about half the MSA deposit in the account by year's end.



From Use It or Lose It to MSAs. Now there are proposals in both the House and Senate to fix this situation. In 1998 Sen. Robert Bennett (R-Utah) introduced a bill allowing workers to roll over up to $500 in unspent FSA money into an MSA, Individual Retirement Account (IRA) or employer-sponsored retirement account. This legislation is now part of the Senate's version of the Patients' Bill of Rights, S.1344. Nearly identical language has been introduced in the House as HR.27 by Rep. David Drier (R-Calif.). Mr. Drier's version would also allow rollovers into Education Savings Accounts. These provisions are currently under consideration in the Patients' Bill Of Rights conference committee, which may increase the allowable rollover to $1,000.

The FSA rollover provision will also enable people with lower deductibles or HMO coverage to set aside some money to pay their out-of-pocket expenses. The money left in the account at year's end will roll over into the next year and gain interest as long as it is unspent. Over time, these funds can help people pay premiums and health care expenses when they are between jobs. Individuals who decide to opt for a higher-deductible plan in the future will already have a fully funded MSA to cover the deductible in the first year of coverage. Eventually, they also will be able to pay for their own long-term care needs when they are older, without spending down their assets to become eligible for Medicaid or being a burden on their children.

The FSA rollover provision will be a major step forward in creating a new health care system that is both cost-effective and accountable to patients.

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