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Four Years of MSAs: The Lessons So Far

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The Medical Savings Account (MSA) pilot program expires at the end of this year unless Congress acts soon to extend it.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allowed small employers and the self-employed to set up a tax-favored savings account to pay for routine medical expenses, provided they also have an insurance plan that meets some very specific requirements. The requirements include a very narrow range of allowable deductibles and strict limits on other cost-sharing provisions and MSA contributions. The limitations and restrictions make the program needlessly complex and hard to understand for both insurance brokers and customers. And the fact that the pilot program was limited to four years, and available only to a small segment of the insurance market, has discouraged many insurance providers from participating.

To date, only about 100,000 "qualified" MSAs have been established, so conducting the kind of formal evaluation that Congress originally intended is difficult. However, information gathered and research developed over the past four years helps to answer critical questions about the MSA program.

Are MSA Regulations Too Rigid and Complicated? Congress was far too prescriptive in program design. For example, HIPAA set the deductible to fall within a very narrow range (between $1,500 and $2,250 for individuals). But no one had studied the market to determine the "best level," and because the law was so restrictive it was impossible for insurers to adjust to meet market demands. Some people already had deductibles of $5,000 or more and would have had to lower their existing deductible to qualify for the MSA. On the other hand, many people with lower deductibles (say, $200 or $250) might have been interested in gradually raising their deductible — to $500, then $1,000, then $1,500 or more — as they built up MSA funds to cover the growing deductible. It would have been far better for Congress to authorize the concept in broad strokes and see how the market evolved.

South Africa, for example, has allowed for much greater flexibility in MSA program design, and the results have been striking — MSAs are now the choice of one-half of those with private insurance in that market. As an example of the flexibility, Discovery Health offers a product whose deductible applies to "discretionary" expenses but not to inpatient care or prescription drugs for chronic conditions.

Health Care Spending and Family Income By Type of Plan

Plan Chosen	Average Health Spending	Average Family Income
Fee for Service	$ 5,853	$ 34,010
MSA	6,710	36,361
HMO	6,163	47,007
Decline Coverage	1,399	32,610
Covered by Spouse	5,641	53,120

Source: RAND Corporation.

Do MSAs Appeal Only to the Healthy and Wealthy? This was probably the most common argument in opposition to MSAs. No evidence ever supported this charge, and recent research by the RAND Corporation shows that the opposite is true. The study estimated which people would choose what kind of coverage in a small group environment. They found that those who chose an MSA were on average the highest-risk people and, as the table shows, were considerably less wealthy than those who chose HMO coverage.

The RAND researchers concluded, "HMOs are attractive to the wealthier workers" and "higher-income employees prefer to stay with the HMO." They added, "We see that the MSA is not attractive to exceptionally

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good risks, as some critics have hypothesized. Instead, these healthy people prefer to decline insurance." In other words, the wealthiest workers prefer HMO coverage, and the healthiest workers choose no coverage at all. In addition, they say, "We find that MSAs could be desirable to workers in firms that already offer HMOs or standard FFS [Fee-for-Service] plans. As a result, expanding MSA availability could make it a major form of insurance for covered workers in small businesses."

Do MSA Plans Deplete The Risk Pool? Another frequent argument was, "MSAs will deplete the risk pool and raise rates for those left behind." In fact, the United States has no single risk pool. It has tens of thousands of risk pools, and not one of them subsidizes the others. This simple fact of life was largely ignored until researchers from the (then called) Agency for Health Care Policy and Research pointed it out in the *Journal of Health Economics*. They said, "[Previous MSA studies] treat the employment-related health insurance market as a single entity (pool). In practice, however, the insurance market may not function as a single pool, and the insurance choices in one pool need not affect the premium in another pool."

Are MSAs Bad for the Sick? Still another argument was that MSAs might be good for 90 percent of the population but not for the 10 percent that consumes most of the health care in a given year. The argument might have merit if the same 10 percent consumed all the services every year. But researchers with the National Bureau of Economic Research showed that is not how it works. They examined actual claims data from a large manufacturing firm and discovered that "high expenditure levels typically do not last for many years." They modeled an MSA-type program and found that 80 percent of employees would have at least half of their total contribution left at retirement, and only 5 percent would have less than 20 percent left. This means that most people will have a chance to build up their MSA balance before reaching a major spell of illness, and the rest will have plenty of time to replenish their MSA once the spell is over.

Researchers from the Urban Institute tried to measure the "winners and losers" if the country as a whole switched to MSAs. This study had problems, but the general conclusion was correct: most people would gain from a switch to MSAs, including the very healthy and the very sick. Those who would lose have moderate expenses that fall within a range for which people will pay more out of pocket with an MSA than with a traditional fee-for-service indemnity plan. This range falls roughly between $2,500 and $5,000 in annual spending.

But very few people fall into that narrow range of spending and fewer still stay there for any length of time. The overwhelming majority can enroll in and fund their MSAs, so that money is available to cover their expenses when they do fall into this range. Further, in succeeding years they can replenish their MSA as they recover from their period of illness.

These points are reinforced by the South Africa study, which shows that MSA holders are not healthier than the general population and even the sick are better off with a well-designed MSA than with a traditional insurance plan.

Conclusion. Most of the concerns voiced about MSAs have been politically motivated and without merit. The results of serious research conducted over the past four years counter every accusation. Today, most people consider MSAs to be neither a panacea nor a problem, but simply another way to allocate resources to get the most from their health care dollars. Congress needs to open up the program so that all Americans can choose an MSA.

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