Medical Savings Accounts

Obstacles to Their Growth and Ways to Improve Them

by

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Executive Summary

In 1996 Congress created a demonstration project permitting small employers and the self-employed to establish up to 750,000 tax-free Medical Savings Accounts (MSAs). However, lawmakers imposed a number of restrictions that limit who can purchase MSAs and thwart the ability of MSAs to work properly. As a result, only some 100,000 to 150,000 MSA plans have been purchased so far. Why have they been slow to catch on? How can their use be increased?

MSAs are personal savings accounts that must be combined with high-deductible health insurance. Account holders typically use their MSA funds to pay small and routine health care bills, while relying on health insurance to pay more costly ones. Under the demonstration project passed by Congress, certain individuals or their employers may make annual tax-deductible contributions to an MSA of up to 65 percent of the policy's deductible for individual coverage and 75 percent of the deductible for family coverage. Qualified deductibles range from a minimum of $1,500 to a maximum of $2,250 for an individual and from $3,000 to $4,500 for a family.

Money not spent during the year may be left in the account to grow tax free. In addition to medical expenses, MSA funds may be used to pay health insurance premiums when people are between jobs.

The MSA legislation has restrictions that are not applied to other health insurance plans. For example, the current pilot program permits only 750,000 MSA account holders, and restricts those to the self-employed and businesses with 50 or fewer employees. Major insurers are reluctant to enter so small a market, concluding that its size does not warrant the marketing of a new product. Insurers are also deterred because the demonstration project only lasts four years, with no certainty it will be continued beyond that time.

The range of allowed deductibles is not wide enough to justify offering several different options, so a number of companies offer only one option — for example, $2,000 for individuals and $4,000 for families. Furthermore, while these deductibles are not unusual among standard high-deductible plans, they are intimidating to many middle-income Americans, especially those used to low deductibles.

Another problem is that MSA tax-free deposits are limited to 65 percent of the individual deductible and 75 percent of the family deductible. The remaining gap could leave individuals and families exposed to significant out-of-pocket expenditures.

Current law limits cost-sharing (out-of-pocket expense) to $3,000 for individuals and $5,500 for families, including the deductible. But that restriction created another problem. Traditional insurance also typically limits total out-of-pocket exposure, but exceptions may be made for services such as psychiatric

care. However, the MSA cost-sharing limit does not allow for this exception. Therefore the law discourages coverage of services such as mental health and prescription drugs that frequently have a high coinsurance requirement.

Explaining the MSA concept is quick and easy, but it takes time for an insurance agent just to outline the deductible limits and other restrictions to a prospective client. As a result, many insurers are reluctant to offer MSA plans and purchasers don't understand them.

MSAs also face regulatory problems. For example, confining MSAs to the small-group market exposes them to all the onerous regulations state governments have imposed on this market during the past 10 years. In addition, health insurance in the small group market must include state-mandated benefits that may not be compatible with MSAs.

The final MSA bill was the result of a number of political compromises, and had very little to do with health policy, economic research or market demand. Congress needs to make a number of reforms.

1. *Allow a wider range of deductibles.* Removing the limits on deductibles would give insurers more flexibility to create MSA products that meet the needs of consumers rather than the desires of bureaucrats.

2. *Allow unlimited cost-sharing.* There is no reason for Congress to dictate the out-of-pocket exposure in MSA plans. Most insurance policies already include a cap on an insured person's out-of-pocket expenses. While such caps will likely be more for MSA plans with high-deductible policies than for a low-deductible policy, the market, not Congress, should make that decision.

3. *Allow the deductible to be fully funded at any time of year and by any combination of employer/employee contributions.* People who begin coverage in January need to be able to protect themselves in case something happens early in the year; those who enroll later in the year need the same protection. Permitting both employer *and* employee contributions and allowing MSAs to be fully funded at any time during the year will help account holders set aside the money to pay their deductibles.

4. *Lift the group size limit.* Congress could keep the enrollment cap of 750,000 accounts, but should allow larger employers to become part of that total.

5. *Fix the state mandate problem.* Congress could preempt all state mandates for MSA plans, or at least allow plans to be adjusted to comply with a state's mandates.

These simple amendments would go a long way towards correcting the problems in the current MSA program. They also would demonstrate that Congress is serious about including MSAs among options for health care financing.

Introduction

In 1996 the 104th Congress created a Medical Savings Account (MSA) demonstration project as part of the Kassebaum-Kennedy health insurance reform legislation. Tax-advantaged MSAs are personal savings accounts that must be combined with high-deductible health insurance. Account holders use MSA funds for small and routine health care expenditures, and their health insurance covers more costly medical events. [See Figure I.] The MSA legislation took effect January 1, 1997.[1] In addition, as part of the 1997 Balanced Budget Agreement, Congress created a Medicare MSA demonstration project, but that legislation does not take effect until January 1999.

During the 1996 legislative debate, proponents argued that MSAs would be very popular, while opponents argued that MSAs would destroy the health insurance market. Both groups were wrong. MSA sales have been slower than predicted, and there appears to have been no negative impact on the health insurance market. Indeed, early indications are positive, as a number of previously uninsured people appear to have purchased MSAs. However, the government has done little analysis of the MSA project and has postponed a comprehensive study it was to have done.

"MSA sales have been slower than predicted."

Now that MSAs have been on the market for 18 months, what is known about them and the marketing effort that resulted from the legislation? Why have they been slow to catch on? How can they be improved? What needs to be done next? This study answers these and other questions about MSAs.

This analysis is not based on polls or scientific research. As the General Accounting Office (GAO) has discovered, it is extremely difficult to conduct surveys of the small numbers of people who have signed up for an MSA. Broad-based national survey techniques such as telephone interviews would not reach a large enough sample of MSA account holders to be significant, and insurance companies understandably are unwilling to allow researchers access to their customer databases in order to question account holders about their experience with MSAs.

Instead, this analysis is based on monitoring of the MSA market — the products and marketing efforts that have been used to date and frequent off-the-record discussions with the insurance executives most closely involved in the product.

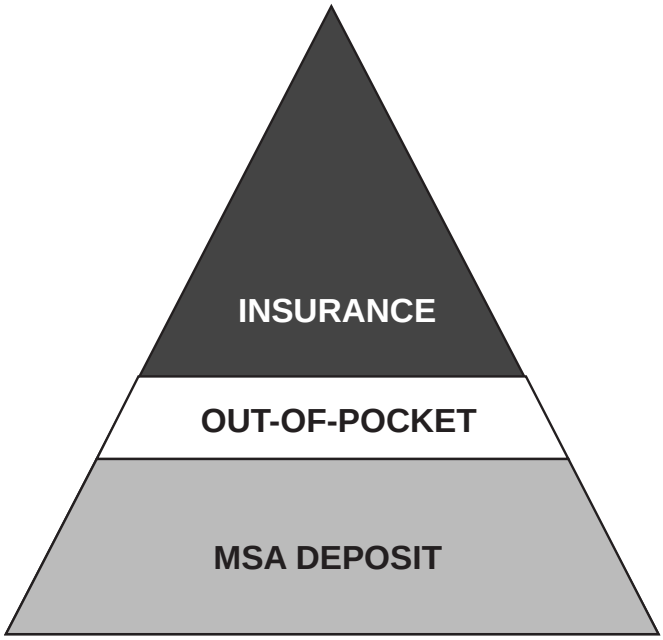
Outline of the MSA Legislation

The agreed-upon demonstration project is quite modest, but it is a start. The agreement permits:[2]

"Patients spend MSA deposits first; insurance covers major expenses."

FIGURE I

Traditional MSA



- An annual tax-deductible contribution to the MSA — up to 65 percent of the policy's deductible in the case of individual coverage and 75 percent of the deductible for family coverage — when combined with a health insurance policy with an annual deductible of $1,500 to $2,250 for an individual and $3,000 to $4,500 for a family.
- Tax-free buildup of money in the MSA and tax-free distributions of MSA funds for medical expenses.
- Maximum out-of-pocket expenses (including the deductible) of no more than $3,000 under an individual policy and $5,500 under a family policy.
- Funds withdrawn and used for nonmedical expenses to be considered as income and subject to income taxes, plus a 15 percent penalty — unless such withdrawals are made after age 65 or the onset of a disability.
- At death, any remaining MSA balance to be includible in the decedent's gross estate, under rules similar to those applicable to Individual Retirement Account (IRA) funds.
- No "sunset" provision for MSAs; those who get them may keep them.

Unfortunately, the restrictions Congress imposed on MSAs not only limited the number of people who can buy them, but also made their purchase and maintenance very complex.

- Only employers with 50 or fewer employees, along with the self-employed, are permitted to obtain a tax-free MSA.
- The demonstration project is limited to four years and 750,000 policies. There is no limit on the number of dependents covered or the number of uninsured who may apply, but once the 750,000 cap has been reached, no more MSA applicants may be accepted.
- Small businesses that switch to an MSA plan may grow to 200 employees within the four-year demonstration project, but additional employees would force the company to drop its MSA program or put new employees in a different plan.

Addressing Problems with the MSA Legislation

"The demonstration project restricts the number who can have an MSA."

Analyzing the MSA demonstration project is not easy for several reasons. For one thing, it is extremely difficult to conduct research on a program that is spread so wide and thin. While the legislation allowed for a total of 750,000 previously insured account holders over a four-year period, perhaps only 100,000 to 150,000 MSA plans have been purchased so far. The law also allowed uninsured persons to obtain accounts without being included in the tally, making it even more difficult to know how many MSA policies are in effect.

The legislation also included certain "enrollment thresholds" that spread permissible enrollment over the four-year period. If more signed up for an MSA than the enrollment threshold permitted, additional MSA enrollment would be stopped before the end of the demonstration project in 2001. As it has turned out, far fewer accounts have been opened. And even the maximum number of MSAs would amount to less than three-tenths of 1 percent of the population of the country, making it difficult for insurers or the government to get a large enough survey sample to know how people are responding to the incentives inherent in MSAs.[3]

However, close examination of the MSA legislation and conversations with Health Care Financing Administration (HCFA) officials, employers, insurers and account holders provide a fairly complete picture of the impediments to MSA purchase and expansion.

Complexity. While explaining the MSA concept is quick and easy, it takes time for an insurance agent just to outline the deductible limits and other restrictions to a prospective client, either an individual or a small employer. Imagine a presentation that goes something like this:

> An MSA is a tax-free savings account with a high-deductible health insurance plan. In order to qualify, the high-deductible plan must have a deductible of between $1,500 and $2,250 for an individual and between $3,000 and $4,500 for a family, with an out-of-pocket limit of $3,000 for an individual and $5,500 for a family. Once you have a plan like that, you can open a Medical Savings Account and contribute 65 percent of your deductible if you are an individual or 75 percent of your deductible if you are a family. Only the self-employed or companies with 50 or fewer employees may participate. If you get the MSA from your employer, only you or your employer, but not both, can contribute to the MSA in a single year.

Even a knowledgeable health policy analyst's eyes would glaze over with that explanation, which does not even include the penalty for nonmedical withdrawals or the prohibition on other coverages.

"Only markets can fine-tune deductible levels."

Deductibles. Deductible levels are precisely the kind of issue that can be fine-tuned only in the market. No one can predict ahead of time what the optimal deductible level will be for different market segments and population groups. Yet the MSA legislation dictates the size of deductibles, and it has driven some insurers and individuals out of the MSA market.

The range of allowable deductibles — between $1,500 and $2,250 for an individual policy and $3,000 and $4,500 for a family policy — is not wide enough to justify offering several qualified policies or explaining the pluses and minuses of, say, a $1,500 vs. a $2,000 deductible. As a result, a number of companies have stopped offering a choice of deductibles. Rather, they provide one deductible option within each category, e.g., $2,000 for singles and $4,000 for families.

Another problem is that deductibles do not reflect geographic differences in medical costs. For example:

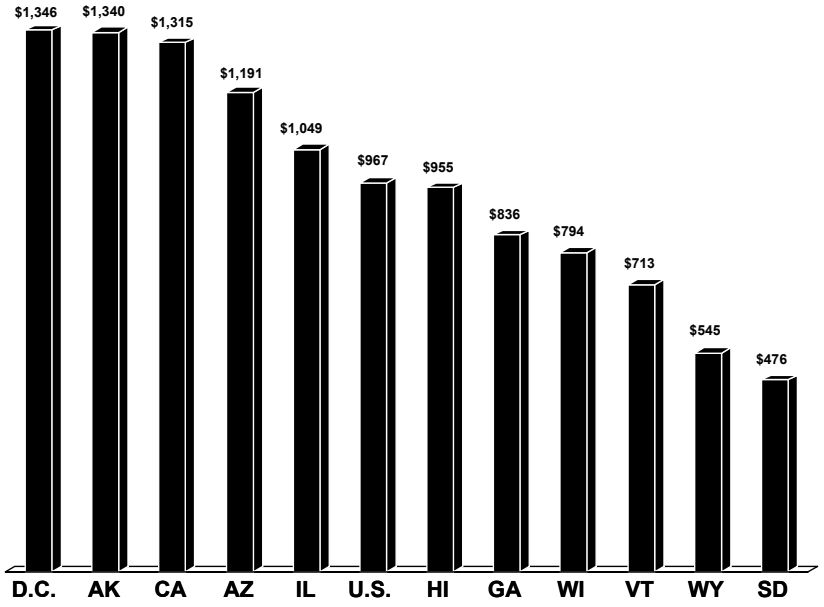
- According to the American Hospital Association, the cost per day of a hospital stay in 1995 ranged from more than $1,300 in California, Alaska and the District of Columbia to $476 in South Dakota.[4] [See Figure IIa.]
- According to 1993 claims data from the Metropolitan Life Insurance Company, the cost of a vaginal childbirth ranged from more than $8,000 in New York and New Jersey to $2,700 in Wisconsin.[5] [See Figure IIb.]

A deductible of $2,000 per person in New York City does not go nearly as far as the same deductible in Lincoln, Neb. Insurers thus look for an average within the limits permitted by the MSA legislation that will meet the widest possible demand. However, deductibles of $5,000 to $10,000 are not uncommon in the individual market, especially in higher-cost areas. Consum-

"The deductibles do not recognize geographic differences in medical costs."

FIGURE IIa

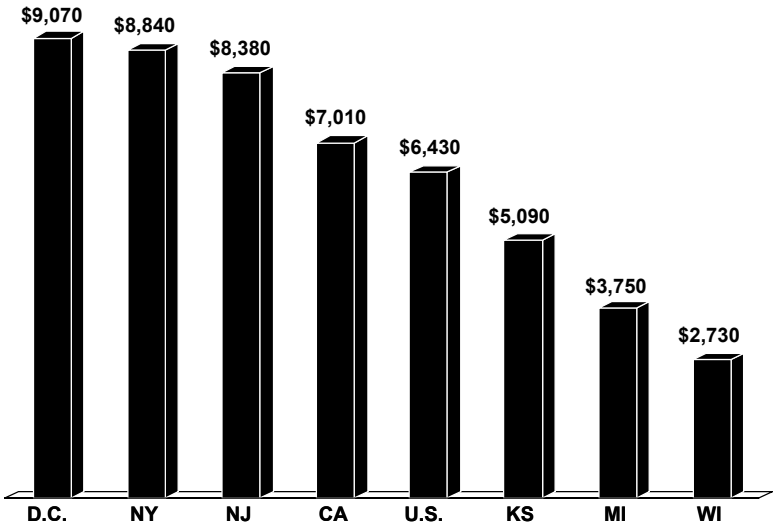
Average Per-Day Hospital Costs
(1995)



Source: *Source Book of Health Insurance Data*, Health Insurance Association of America, 1998, based on data from the American Hospital Association.

FIGURE IIb

Cost of Vaginal Childbirth
(1993)



Source: *Source Book of Health Insurance Data*, Health Insurance Association of America, 1998, based on data from Metropolitan Life Insurance Company.

ers wanting such high deductibles actually have to lower their deductible amounts to purchase an MSA plan under the current legislation.

By contrast, many people still retain low-deductible programs of $100 or $250. For these people, a $1,500 deductible may be too big. They might be more comfortable moving first to a $500 deductible, then to $1,000, then to $1,500 and so on. This would give them time to build an account balance in their MSA to protect themselves against sudden exposure.

Cost-Sharing. MSA opponents were successful in limiting the amount of cost-sharing (that is, the out-of-pocket expense) to $3,000 for individuals and $5,500 for families. These numbers include the cost of the deductible. However, no other health insurance program in America has similar federal restrictions on cost-sharing. HMOs, PPOs and traditional fee-for-service plans have no such restrictions. The limit on cost-sharing makes it difficult for managed care to encourage the use of network providers. Indeed, some patients may choose nonparticipating providers because the sooner they reach the out-of-pocket limit, the sooner they receive 100 percent benefits. The consequence is simple — when cost-sharing is lower, premiums are higher. So the MSA program cannot control costs and utilization after the account holders meet their deductible.

"MSA opponents limited the amount of cost-sharing, making premiums higher."

Coverage Limits. The cost-sharing restriction can lead to another anticonsumer consequence by discouraging coverage of services such as mental health and prescription drugs that frequently have a high coinsurance requirement. If the plan pays 50 percent of the cost of these services and the patient pays 50 percent, the cost-sharing limit is reached very quickly. But if the plan does not cover the service at all, and the patient has to pay 100 percent of the cost, none of that counts towards the cost-sharing limit. Thus, a provision intended to protect consumers from high out-of-pocket costs can force carriers to provide no coverage at all for some important benefits.

MSA Contributions. The 65 percent allowable contribution for individuals and 75 percent for families again makes the program needlessly complex and hard to explain. It is also difficult to imagine the rationale for such a provision. If 75 percent is good enough for a family, why isn't it good enough for an individual?

In fact, why should people be prohibited from fully funding their MSA in the first year? As it is, an individual who purchases a $2,250 deductible policy may contribute only $1,462.50 to the MSA, leaving $787.50 as an unfunded deductible. No other program requires deductibles of that magnitude, or any deductible at all. Before switching to the MSA, the same person might have had a policy with a $250 deductible, but Congress did not object to that. Legislators never complain when all but $250 (or $100 or $0) of an individual's health expenses are covered by tax-free premiums. Why should they object when the same person funds the MSA with tax-free dollars to cover all but $250 (or $100 or $0) of out-of-pocket costs?

The inability to fully fund the MSA is one of the greatest obstacles in the market. People worry that they will purchase an MSA in January and get sick in February, without sufficient money in the account to cover them.

End-of-year Sales. Allowable contributions to the MSA are prorated for the number of months an account holder is in the program during each calendar year. For example, if someone purchases an MSA in October, he is allowed to contribute only 25 percent (3/12ths) of the allowable annual contribution, but he is still subject to 100 percent of the deductible. Thus if a person buys a policy with a $2,000 deductible in October, he may contribute only $325 to the MSA ($2,000 x .65 = $1,300/12 = $108.33 x 3 = $325) even though he is subject to the full $2,000 deductible if he gets sick. This makes third- and fourth-quarter sales almost impossible.

Employer/Employee Contributions. That only the employer or the employee, but not both, may contribute to the MSA in a calendar year makes very little sense, especially when the total allowable contribution is capped. There is no similar restriction on contributions to health insurance premiums. Employers and employees often share the cost of traditional insurance. And by using a Section 125 (Flexible Spending Account) plan, the employee premium contribution is tax-free. Employers are free to increase the employee share of the premium payment so that the employer can make the maximum contribution to the MSA, and neither the employer nor the employee is paying more than before. This can and does happen today. For instance, one midwestern company with 12 employees has always paid 75 percent of the cost of employee health insurance and the employees have paid the other 25 percent. The employee contribution is tax-free due to the use of a Section 125 Premium Only Plan (POP). When this company switched to an MSA, it faced a dilemma. Because only employers *or* employees could contribute to the MSA in a given year, it could not extend the 75/25 ratio to the MSA contribution. The company realized that it could reduce its share of the premium payment to 50 percent and use the savings to fully fund the MSA on a tax-free basis. Employees then paid the other 50 percent of the premium through the tax-free POP. Neither side paid more; they reapportioned the money to maximize the tax advantages.

"Employers and employees often share the cost of traditional insurance — but not MSAs."

Still, the employer had to make the decision, so the worker's well-being was left to the whims of the boss.

Enrollment Limits. The current MSA law limits enrollment in two ways, each of which restricts the market differently.

- The program is available only to small groups and the self-employed.
- The total number of enrollees is limited to 750,000.

Although the 750,000 limit has not been approached, its presence has restricted the program in important ways. It has kept the biggest players such as Chase Manhattan Bank and Prudential Insurance out of the market. They chose not to develop products for so limited a market. While this has been a blessing for smaller and newer insurance companies, they have less market presence and clout than the big companies. Public awareness has suffered as a result.

The small group market is the toughest and most volatile in the health insurance business. For example:

- Small employers are not innovators when it comes to employee benefits.
- They lack the time and expertise to evaluate new benefits.
- They lack the human resources staff needed to look for ways to make their benefits more efficient or to explain a new program to employees.

Limiting sales to 750,000 and to small companies or individuals is doubly damaging. It restricts the program to the hardest-to-serve market segment — and the one with the fewest resources. Plus, it is redundant. If the program is restricted to 750,000 account holders, why should it also be restricted to small employers?

Regulatory Problems

To design and implement the regulations that govern the accounts, the MSA legislation looked to the Internal Revenue Service. As a result, MSAs are even more cumbersome.

"Confining MSAs to the small-group market exposes them to onerous state regulations."

State Regulations. Confining MSAs to the small-group market exposes them to all the onerous regulations state governments have imposed on this market during the past 10 years. Over the decade, the National Association of Insurance Commissioners (NAIC) has led a systematic campaign to "reform" the small group market. These reforms have included:

- Requiring guaranteed issue or open enrollment for health insurance.
- Requiring community rating or modified community rating of premiums.
- Requiring that all plans offer a limited choice of standardized benefits.
- Providing subsidies to carriers that cover more than a "fair share" of high-risk enrollees.

The merits and demerits of these changes can and have been argued endlessly. But there can be no question that the result has been increased

costs, less choice and a substantial increase in the number of uninsured during this period. The NAIC has acknowledged that its campaign to impose the regulations had nothing to do with increasing the affordability of coverage, but was intended to "stabilize" the market.[6] Apparently, they define stability as fewer companies offering fewer choices for coverage — leading, ultimately, to less competition. Today, entire states and regions of the country are shunned by the health insurance industry because insurers cannot afford to do business under these conditions. Several states have repealed these misguided "reforms," but no free market for small-group health insurance exists.

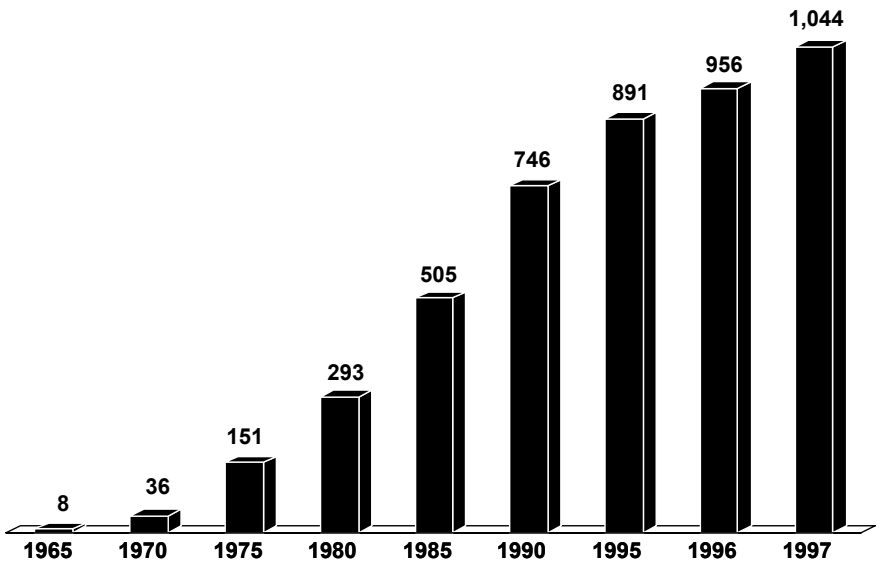
Unfortunately, the MSA law confines Medical Savings Accounts to that market segment that was devastated by the regulations — the small-group market. Virtually none of the state laws apply to employers with 50 or more workers, regardless of whether they are self-funded or purchase fully insured plans.

Mandated Benefits. The other restriction in the small group market — long-standing and partially acknowledged by Congress when it wrote the MSA law — is the prevalence of state-mandated benefits. A state mandate is a requirement that an insurance company offer specified benefits in an insurance plan. Thus legislatures may require insurers to cover mammograms, as they have in 46 states. By contrast, legislatures may require insurers to offer

"Today, there are more than 1,000 state mandates."

FIGURE III

Growth in State-Mandated Benefits



Source: "State Legislative Health Care and Insurance Issues: 1997 Survey of Plans," Blue Cross Blue Shield Association.

only specified benefits or providers. In that case, employers may accept or decline the service or provider. In 1965 there were only seven state-mandated benefits; today there are more than 1,000. [See Figure III.] Many of them cover basic providers such as podiatrists and treatments such as drug and alcohol abuse, but some cover nonmedical expenses such as hairpieces and marriage counseling.[7]

Generally, mandated-benefit laws are well-intentioned and aimed at helping some particular group of constituents. However, they always increase the cost of health insurance, forcing some people to cancel their coverage. The increase depends on the nature of the legislation, the geographic location and the usage patterns of a particular population. For example, utilization of mandated coverage for drug abuse treatment would likely be higher in states with larger inner-city populations such as California and New York than in, say, Utah.

"Mandates can significantly increase the cost of a health insurance policy."

A recent analysis prepared for the National Center for Policy Analysis by the actuarial firm Milliman & Robertson estimates the costs of 12 common mandates and finds that, collectively, they can increase the cost of insurance as much as 30 percent. Most states have between 30 and 40 mandates. Their economic impacts vary, but as a whole they can significantly increase the cost of a health insurance policy.

The problem for the MSA legislation is that many of these laws require first-dollar coverage for the affected service, but Congress prohibited first-dollar coverage for an MSA-compatible insurance policy. For example, a law might require that alcoholism treatment be covered without any deductible or copayments, or it might require that 80 percent of the costs of the first 10 office visits to a mental health provider be covered. But the MSA law forbids any coverage for most services below the deductible.

Congress made a half-hearted attempt to address this issue by allowing the high-deductible plan to cover state-mandated preventive services benefits, but not all mandates can be considered preventive in nature. In fact, the Health Insurance Association of America (HIAA) has identified nine states — Connecticut, Kansas, Maryland, Minnesota, New York, North Dakota, Pennsylvania, Rhode Island and Wisconsin[8] — with mandated benefit laws for small groups that disqualify plans from offering MSAs. The Council for Affordable Health Insurance (CAHI) has done a similar search and also identified nine states plus the District of Columbia — this list includes Delaware and Maine but excludes Rhode Island and Wisconsin — that have disqualifying mandates.[9]

Some of the states, notably Kansas and Wisconsin, reportedly have amended their mandate laws to allow for MSAs. The others apparently have not. *This means that state mandates render more than one-fifth of the population of the United States ineligible for an MSA*, in addition to the other constraints placed on the program.[10]

Regulatory Delays. The Internal Revenue Service was still issuing substantive regulations as late as April 22, 1997 — four months after the effective date of the law.[11] Because of the substance of these late regulations, some companies had to recall their marketing material, retrain their agents and reprogram their computers. Others chose not to participate in the MSA program. Plus, as indicated above, the prorating of contributions makes MSAs hard to sell in the latter half of the year, so the late regulations effectively removed an entire year from MSA marketing.

State Regulatory Resistance. State insurance department approval of MSA plans has been extremely slow in many states, even though the insurance products are not substantially different from those already on the market. For example, Blue Cross Blue Shield of Louisiana filed for approval of its plan in June 1997, then waited until November of that year for state insurance department approval.[12] The delay may have been due to bureaucratic inefficiency, personal opposition to the idea of MSAs by the regulators or resentment of congressional meddling. In any case, state insurance departments often oppose innovative solutions.

Where Are We Today?

Considering the circumstances, it is remarkable that the MSA program has been as successful as it has. In addition to the legal and regulatory obstacles mentioned above, the industry has faced:

- The daunting prospect of forming strategic alliances with banks, investment firms, credit card companies and third-party administrators for the first time ever.
- The need to convince agents to market a brand-new product that is not well recognized by the public, is difficult to explain and carries with it lower compensation due to a smaller premium base on which commissions are calculated.
- The dangers of being associated with a controversial political issue whose opponents use venomous rhetoric.

In spite of all the obstacles, Medical Savings Accounts are an important alternative to other forms of health care financing. They may not be for everybody, but they offer people more control over their own health care needs and financing. MSAs are the only viable alternative to managed care today. Indeed, they could be viewed as a safety valve for the managed care industry — an option for those who dislike and resent the external constraints of managed care.

"In spite of obstacles, MSAs are an important alternative form of health care financing."

As premium inflation returns and the consumer and political backlash against managed care grows, policymakers may be grateful that there is an alternative already on the books. MSAs are no longer a new and untested idea — they are a reality in the marketplace. While many of the inflated expecta-

tions of MSA advocates have not been realized, neither have the predictions of doom presented by the opponents materialized.

Reports from the field indicate that enrollment is growing steadily. The shakeout period is over, alliances have been built, agents are being trained and awareness is growing. There will probably be 125,000 accounts on the books by the time of the next IRS census, with accelerating growth after that, mimicking the adoption curve for other new ideas and technologies. A few daring souls go first. If they are satisfied, they tell their friends and a multiplier effect occurs. More companies enter the market, which increases public awareness and accelerates acceptance even more.

What Congress Can Do

The final MSA bill was the result of a number of political compromises, and it had very little to do with health policy, economic research or market demand. There is nothing mysterious about the specific provisions. The program was meant to be a pilot, a test of how MSAs would work.

Some of the issues that were hotly debated turned out to be inconsequential — like the 15 percent penalty for nonmedical withdrawals. By contrast, in some cases MSA advocates were right on target. For example, they correctly predicted that state mandates would present a real obstacle to MSA policies, and they anticipated the difficulty and confusion that would arise from the employer/employee contribution rule. But a number of unanticipated problems have emerged. For example, the disincentive to establish an MSA at the end of the year was never considered. There was some discussion of the restrictions on cost-sharing, but most MSA advocates considered the issue unimportant — probably because they took the illustration of what an MSA would look like literally. (The illustration: Take a $4,500 policy, buy a high deductible plan for $3,000 and put $1,500 into the MSA. This was oversimplified merely to illustrate the concept. It should not have been used to define the plan design).

MSA Reform. With the benefit of this experience, we can make some specific recommendations for improving the MSA law.

1. *Allow a wider range of deductibles.* The Medicare MSA provisions passed as part of the Balanced Budget Act of 1997 took a giant step in this direction. They defined an MSA plan as having a deductible of no more than $6,000. This allows companies to tailor their products to the specific needs of the market. A similar limit on MSAs for those under 65 would give insurers more flexibility to create MSA products that meet the needs of consumers rather than the desires of bureaucrats.

"MSAs need a wider range of deductibles."

2. *Allow unlimited cost-sharing.* The Balanced Budget Act provision for Medicare MSAs also incorporated this idea. It is commonplace today for managed care plans to have 100 percent coverage for network providers, but

"High-deductible insurance also needs cost-control incentives."

only 80 percent for those outside the network. This encourages people to stay in the network, but allows them to go elsewhere for services if they prefer. The high-deductible insurance portion of the MSA package has the same needs for cost control as any other health insurance plan and should not be prohibited from using these elementary incentives. Most insurance policies already include an out-of-pocket cap on how much money an insured person can spend. While such caps will likely be more for MSA plans with high-deductible policies than a low-deductible policy, the market, not Congress, should make that decision.

3. *Allow the deductible to be fully funded at any time of year and by any combination of employer/employee contributions.* People who begin coverage in January need to be able to protect themselves in case something happens early in the year; those who enroll later in the year need the same protection. The tax deduction can still be tied to the calendar year, but many companies have renewal dates that start in the middle of the year, and their employees should not be excluded or shortchanged. Permitting both employer *and* employee contributions and allowing MSAs to be fully funded at any time during the year will help account holders set aside the money to pay their deductibles.

4. *Lift the group size limit.* The MSA concept needs to be tested in all market segments — from small to large employers with fully insured and self-funded plans. If Congress is concerned that the market will be overrun by new applicants, it can keep the enrollment cap of 750,000 accounts, but allow larger employers to become part of that total.

5. *Fix the state mandate problem.* The current situation in which MSA plans must comply with state mandates that prohibit the sale of MSAs needs to be changed. Congress could preempt state mandates to allow MSA plans (the best option) or at least allow plans to be adjusted to comply with a state's mandates.

These simple amendments would go a long way towards correcting the problems in the current MSA program. They also would demonstrate that Congress is serious about including MSAs among options for health care financing.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] PL 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), popularly known as the Kassebaum-Kennedy bill; the MSA provisions created a new section of the Internal Revenue Code, Section 220.

[2] For an analysis, see Merrill Matthews Jr., "Medical Savings Account Legislation: The Good, the Bad and the Ugly," National Center for Policy Analysis, Brief Analysis No. 211, August 19, 1996.

[3] In September 1997 the General Accounting Office awarded an $11 million contract to study the MSA program, as required by the enabling legislation, but then decided to wait until at least 350,000 accounts were established to attempt to survey account holders. Given that the 100,000 or so who have accounts are spread throughout the United States, it is virtually impossible to identify and interview those who have used an MSA. So we are left to rely on anecdotes and reports from the field. See Greg Scandlen, "GAO Awards $11 Million Contract to Study MSAs," *Patient Power Report*, vol. 2, no. 8, September 1997.

[4] *Source Book of Health Insurance Data*, Health Insurance Association of America, 1998, p. 110.

[5] Ibid., pp. 112-113.

[6] The introduction to an early (1990) draft of NAIC's "Small Employer Health Coverage Reform Act" states that in addition to making "adequate levels" of insurance available to employers, the act provides a vehicle "through which greater stability and predictability are achieved in the small employer market." A draft "Report of the Health Care Insurance Access Working Group" of NAIC, dated December 10, 1991, discusses this in detail. It calls for "a series of health care payment reforms that will: (1) stabilize the market; (2) correct or at least limit the impact of abusive rating and pricing practices; (3) guarantee the availability and renewability of products; and (4) attempt to deal with the affordability of needed products." But the report acknowledges that "these reform models are sailing on largely uncharted waters." And it cautions, "...states need to evaluate the cost impact of these models (because they) will have a noticeable cost redistributional effect. The result is that a larger number of small employer groups will see some rate increases than those who will see decreases.... In addition, the guaranteed issue component is anticipated to have an additive cost impact on all small groups." The report concludes, "Neither model does much to deal with the big issue — cost of health care." Three years later, a report sponsored by the Commonwealth Fund agreed, "While small-group market reforms may appear to stabilize the rates in the market, they are unlikely to solve the problems of affordability and availability of insurance." *Small-Group Market Reforms: A Snapshot of States' Experience*, February 1995.

[7] Susan S. Laudicina, Gretchen Babcock, Joan M. Gardner, et al., "State Legislature Health Care and Insurance Issues: 1997 Survey of Plans," Blue Cross Blue Shield Association, January 1998.

[8] *Patient Power Report*, vol. 3, no. 2, March 1998.

[9] "Medical Savings Accounts State Environment," Council for Affordable Health Insurance, May 18, 1998.

[10] Bureau of the Census, U.S. Department of Commerce, 1990.

[11] Internal Revenue Service, Ruling 97-20, April 22, 1997.

[12] *Patient Power Report*, vol. 3 no. 1, February 1998.

About the Author

Greg Scandlen is the founder and president of the Health Benefits Group (HBG), an independent consulting and publishing firm formed in 1995 to assist organizations in setting up Medical Savings Accounts and other patient-centered health care initiatives. HBG publishes the *Patient Power Report*, a monthly newsletter, and *HBG's Washington Weekly*, a faxed weekly memo.

Prior to forming HBG, he was Executive Director of the Council for Affordable Health Insurance, an association of small to mid-sized health insurance companies that are active in the small-group, individual and specialty lines insurance markets. Mr. Scandlen organized CAHI in early 1992, and it quickly became a preeminent voice for market-oriented health care reform, especially Medical Savings Accounts.

Mr. Scandlen was also the publisher of the *Health Benefits Letter*, a newsletter devoted to covering developments in health benefits reform on both the state and federal levels. He began this newsletter in January 1991 after having worked in the Blue Cross Blue Shield system for 12 years — most recently as Director of State Research in the Blue Cross Blue Shield Association's Washington office.

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