

Medical Savings Accounts

Why the American Medical Association Supports Medical Savings Accounts

What are MSAs?

A Medical Savings Account (MSA) is a vehicle for individuals to fund health care. It is a tax-deferred bank or savings account set up for individuals and families to pay for their health care expenses and medical insurance, and to allow them to accumulate savings to pay for future medical expenses and for more general uses after retirement.

Anyone would be eligible to choose an MSA as an alternative to current ways of funding medical care. For an employee choosing an MSA, the employer would purchase a high-deductible (catastrophic) insurance policy for the employee and deposit cash into an MSA each year in lieu of providing the employee low-deductible insurance or enrollment in a Health Maintenance Organization (HMO). The price of the catastrophic policy plus the cash deposit should equal the cost of the alternative coverage. The employee then would use the cash in the MSA to pay for ordinary health expenses until the deductible of the catastrophic policy is met. Unspent balances would be invested and accumulate earnings that are tax-free.

The self-employed and others would establish MSAs by purchasing a high-deductible policy and depositing the amount of the deductible in the MSA account. Like employee accounts, health expenditures from the self-employed MSA should be tax-free, and accumulated balances earn interest, which is also tax-free.

The self-employed and others would establish MSAs by purchasing a high-deductible policy and depositing the amount of the deductible in the MSA account. Like employee accounts, health expenditures from the self-employed MSA should be tax-free, and accumulated balances earn interest, which is also tax-free.

What are MSAs Intended to Accomplish?

MSAs have been proposed as a measure of health system reform. The basic objective is to provide stronger incentives for consumers to be price-conscious in shopping for and purchasing health care than are presented by standard health coverage.

HMO members and medical consumers with traditional insurance are insulated from prices and do not perceive the full cost of consuming health care resources. Therefore, they do not exert as much pressure on providers for economic efficiency as they would if they were spending what they perceive to be their own money or paying the full cost of medical care more directly out of their own pockets. The result is that many prices are higher than they otherwise would be, and many providers are less efficient than they could be.

Because unspent MSA balances accrue as savings, consumers will treat MSA balances as their own money rather than someone else's (i.e., the insurance company or the employer's). This will have the effect of making prices more meaningful in the market for medical care. Meaningful prices will stimulate price competition among health care providers, which will operate to constrain the rate of growth in health care prices and spending. As a result, both medical care and medical insurance will become more affordable, relieving pressure on health budgets of

government and business as well as individuals who are currently not insured and pay for medical care out-of-pocket.

MSA legislation was included in the budget bill passed in the first session of the 104th Congress, which was vetoed by the President. Even though federal legislation has not been enacted, 15 States have enacted MSA legislation so far. Without the exemption from federal taxes, however, the incentives for savings are not significant, because unspent MSA balances are taxed as regular income.

MSAs are currently offered as a health benefit option by more than 2,000 employers. Because MSAs are not afforded the same tax treatment as other health benefit options, the federal government is discriminating against those who do choose the MSA option. Federal tax laws must be amended to allow unspent balances in MSAs to be carried over to subsequent years without penalty.

Benefits of MSAs to Consumers

- **Value:** Consumers will get more for their money with high-deductible insurance. The first \$1,500 to \$2,000 of insurance benefits cost more in premiums than is returned to consumers in claims. In contrast, the money paid for health care from the MSA will be subject to nominal administrative charges.
- **Choice:** Better choice among therapies can be made based on their value to the patient. Equal tax-treatment of out-of-pocket spending will reduce incentives to select among competing therapies solely on the basis of insurance coverage.
- **Patient-physician Relationship:** With consumers making their own health care spending decisions, the physician-patient relationship will be freed from the intrusion of third-party payors. Physicians will not face external pressure to withhold beneficial care or to obtain third-party authorization for proposed treatments, an often time-consuming process.
- **Increased Access:** MSAs place fewer restrictions on the range of medical services covered. Current benefit plans often limit certain services, products, or equipment. With MSAs, consumers have increased access to services not typically covered, including long-term care services, eye care services, and prescription drugs.
- **Portability:** The individual ownership feature of MSAs enhances job mobility by removing the "job-lock" feature of traditional employment-based coverage. Furthermore, accumulated funds in MSAs would provide a source of funds for workers who become unemployed to purchase bridge insurance when they are between jobs. The current cost of continuation insurance is prohibitive for many persons.
- **Savings:** Because funds deposited in MSAs will not be subject to a "use it or lose it" rule when federal legislation is passed, MSA balances can become an important savings vehicle and source of funds for purchasing long term care insurance and other post-retirement needs not covered by Medicare.
- **Relief:** Because most or all of the catastrophic insurance deductible will be funded by the MSA, consumers' out-of-pocket expense will be minimized. These savings will be

significant to those whose liability for deductibles and co-payment under traditional insurance is a heavy economic burden.

Why the AMA Supports MSAs

The AMA has supported the MSA concept since 1981 when it encouraged business to develop the concept into a health benefit option for employees.

In 1986, the AMA recommended MSAs as an approach to encouraging individuals to save toward medical needs in retirement. Over a period of time, widespread use of MSAs could eventually lead to the self-funding of health care during retirement. This would reduce the financial burden on the Medicare program which otherwise cannot sustain the growth in demand for medical care from the elderly population in conjunction with the declining ratio of pre-retirement persons contributing to their support.

The AMA also supports MSAs as a method for individuals to fund the costs of long-term care. The financial burden of long-term care is a serious problem for many Americans as well as government. Making up 12 percent of national health expenditures, about 36 percent comes from personal resources, 41 percent from Medicaid, and 23 percent from other, primarily public, sources. Only 1 to 2 percent of long-term care expenditures is funded by private insurance. Government cannot sustain the projected growth in long-term care expense; MSAs are one approach to relieving the burden by "privatizing" the financing of long-term care.

The AMA also endorses MSAs as an approach to assure patients' freedom of choice in health insurance. In particular, it is a direct way to operationalize the concept of individually owned insurance for the purpose of achieving portability of insurance for employees who may switch employers from time-to-time. The lack of portability is an impediment to job mobility manifested in "job lock" which makes many employees reluctant to change jobs because they fear losing health insurance coverage.

MSAs are a market approach, rather than a regulatory approach, to our health system problems, particularly that of the rising cost of medical care. Rather than achieving cost containment through government regulation of prices through price controls, and imposing arbitrary government-imposed ceilings or "global budgets" on expenditures as many have proposed, the AMA believes that it is better to let individuals decide what health care should be produced and how much health care is worth through their individual control over expenditures in the marketplace. MSAs accomplish this by letting individuals determine the value of health care by spending their own money -- rather than what they perceive as someone else's money when they have traditional health coverage -- on health care.

MSAs will strengthen the market for medical care by giving patients the opportunity to choose to be maximally involved in their medical care choices and decisions. For those who choose MSAs for their medical coverage, price will become a more important consideration in their choices, an element in the market, which is seriously lacking at the present time. Furthermore, MSAs have the potential for substantially improving the physician-patient relationship, which physicians feel has been significantly eroded by the increasing intrusion of third parties with the growth of managed care.

Criticisms of MSAs and AMA's Response

- *"MSAs are only for the young, healthy and wealthy."*

AMA Response: Although individuals who have chronic conditions or episodes of acute illness do spend more on medical care, they could be economically better off with MSAs than with traditional coverage, for two reasons. First, most individuals with traditional coverage are responsible for a deductible and co-payment and are liable for significant out-of-pocket costs; with MSAs, these amounts will be largely pre-funded because any out-of-pocket expense is incurred only after MSA funds are exhausted. Thus everyone, including the financially disadvantaged, will potentially have less out-of-pocket costs with MSAs. Second, consumers will get more for their money with high-deductible insurance. The first \$1,500 to \$2,000 of traditional benefits cost more in premiums than is returned to consumers in claims. In contrast, the money paid for health care from the MSA will be subject to only nominal administrative charges.

It is also important to remember that the other alternative to traditional coverage -- HMOs and other forms of managed care that limit out-of-pocket liability --is not the preferred option for those with chronic or frequent acute illness. This is because they limit choice of physician and other providers, and tend to restrict access to treatment in other ways. MSAs will provide complete freedom of choice to individuals who want to manage their own medical care.

- *"By removing the young and healthy from traditional insurance pools, MSAs will raise the cost of insurance to the old and sick and eventually destroy our health insurance system."*

AMA Response: Who is making this argument? They are the ones who have already benefited from significant favorable selection: the giant insurance companies who have bet their corporate futures on continued favorable selection of their managed care products. These organizations have been able to grow and prosper because they have appealed to the young, relatively healthy population, which spends less.

Providing choices will in fact lead to some adverse selection because people will choose the options that are most advantageous to them. This is why HMOs and their derivatives prospered so well during the last decade. Their continued growth and prosperity is threatened if a new alternative that may be preferred by their clientele is allowed to compete in the market. The AMA is in favor of expanding choice rather than restricting it as the opponents of MSAs wish. The market should ultimately determine whether MSAs are preferred to the other alternatives, and vice-versa.

The traditional insurance pool, which is growing smaller and smaller as managed care's market share increases, is not different in principle from MSAs. The typical non-HMO health benefit has two parts: first a fund for passing routine expenses through the fringe benefit system tax-free; and a second part which is actually true insurance to cover rare and expensive episodes of illness. MSAs would put the routine expense fund directly under the employee's control, while insurable risks of illness would still be covered by insurance. If everyone with traditional insurance had an MSA, most would be better off because their coverage against insurable risks would remain unchanged while their routine expense money would go farther as a result of their not having to pay

administrative fees to insurance companies to process medical bills.

- *"Individuals choosing MSAs will be thrust into the individual insurance market and won't be able to get the less expensive group rates that employers negotiate with prepaid plans."*

AMA Response: Self-insured employers who make MSAs available to employees would simply add an additional choice (a catastrophic insurance plan) to those they already make available to employees. Employers who are not self-insured will negotiate with vendors of such plans in the same way they do with other plans they offer because they will have the same motivation as they do now to control their benefit cost and maintain employee satisfaction with the options they provide.

- *"MSAs will discourage people from spending money on preventive and primary care, and they will postpone expenditures until they are sicker and overall costs are greater."*

AMA Response: Health plans do not typically cover preventive services such as routine physical or dental checkups. Even when they do, many people do not take advantage of them even if there is no out-of-pocket cost because of the non-monetary cost (i.e., time and inconvenience) of consuming them. MSAs may actually encourage more use of preventive and routine services because they will not be subject to deductibles and copayments, so that many people may view their MSA fund as first-dollar-coverage for such services.

People will realize that investment in preventive services that are truly effective will save them money or make them better off in other ways over the long run, and they will make intelligent decisions. If for some reason they do not, certain services can always be mandated for coverage to easily correct the problem if warranted.

- *"Consumers cannot shop for medical care because they are not knowledgeable enough. Furthermore consumers cannot shop for medical care when they are sick, do not have the luxury of time or ability to postpone decisions as they do when shopping for ordinary goods and services, and are not necessarily rational when such decisions have to be made."*

AMA Response: Such a criticism rests on a misunderstanding of the manner in which most consumers arrange for medical care. Of course, few do shop around or can shop around when faced with an immediate need for treatment of a serious illness or injury. Rather, most consumers make long-term arrangements in anticipation of being in a situation where their ability to shop or make important decisions is compromised. The essence of the HMO as well as of the traditional patient-physician relationship with a regular personal physician is such an arrangement that establishes the general courses of action to be taken in case the patient has serious medical needs. Thus, one typically does not "shop around" when medical contingencies arise, but relies on pre-established relationships for dealing with problems. Medical needs, especially serious ones, are not highly predictable. Dealing with them requires advance planning and establishing relationships with providers who can be called on when medical needs arise.

- *"Since most medical expenditures are concentrated among a relatively few high-cost users, there is little room for savings at the low end of the expenditure distribution where*

MSA incentives operate."

AMA Response: While it is true that four or five percent of the population spend one-half of the total health care expenditure, it is also true that two-thirds of the total is on annual medical bills of \$5,000 or less. Thus, there is a much larger potential for MSAs to affect spending through incentives for economical choice than the high-end concentration considered alone suggests. Another savings that will accrue to use of MSAs is administrative cost due to the fact that insurance company processing expenses are much the same for a small claim as a larger claim, much of which will be saved by owners of high-deductible policies.

- *"MSAs are an untested theory; they should be tried on an experimental basis."*

AMA Response: Over 2000 companies, state and local governments have implemented MSAs. Despite the fact that the federal tax laws discriminate against those who choose an MSA rather than a tax-preferenced option, most employees who have the chance choose an MSA. Most of the experiences with them have been highly favorable. However, without the exemption from federal income tax that employer contributions to other health plans enjoy, the benefits of MSAs to employers, employees, and the economy are not fully realized, especially their potential to reduce out-of-pocket expenses for millions of low-earning Americans.

So far, 15 states have enacted MSA legislation, and legislation is pending in others. The federal government is lagging far behind the states in fostering workable approaches to our health care cost and affordability problems by persistently discriminating against those who choose an MSA when it is offered as a benefit option. The Congress should pass, and the President should sign, legislation now to make MSAs an option with equal tax treatment to all Americans.