

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-02)
Medical Savings Accounts and Health Care Coverage of Dependents and Children
(Reference Committee K)
(December 2002)

EXECUTIVE SUMMARY

Council on Medical Service Report 3 responds to Resolution 109 (I-01), which calls on the AMA to study the issue of medical savings accounts (MSAs) and appropriate health care access and coverage for dependents and children. The resolution also calls for the study of the use of incentives within MSAs to encourage parents to obtain appropriate preventive medical care for their children or dependents, including how this is accomplished in other countries.

Council Report 3 (I-02) finds that, despite disappointing enrollment in MSAs to date, MSAs have demonstrated potential to expand coverage to considerable numbers of uninsured, including children. Remarkably, about half of all MSA policies are issued to families with children, and nearly 40% are issued to the previously uninsured.

The Health Insurance Portability and Accountability Act of 1996 placed rigid constraints on MSA benefit design, prohibiting first-dollar coverage of preventive services except in a handful of states where such coverage is mandated. Nonetheless, a survey of MSA experience in the U.S. and abroad turned up no evidence of MSAs restricting utilization of preventive care. When MSAs and similar MSA-style “consumer-driven health care” plans are permitted the flexibility to vary benefit design, they invariably provide first-dollar coverage of preventive services or other direct incentives to utilize preventive services, indicating strong market demand for coverage of preventive services.

The Council believes that MSAs should be allowed the same flexibility as other forms of health insurance to vary patient cost-sharing requirements for different types of services. Accordingly, the Council recommends that MSAs be allowed, but not required, to offer first-dollar coverage of preventive services. Given market demand for preventive services, the Council believes that flexibility to innovate plan design would lead to more generous coverage of preventive services by MSAs as the norm.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - I-02
(December 2002)

Subject: Medical Savings Accounts and Health Care Coverage of Dependents and Children

Presented by: Cyril "Kim" Hetsko, MD, Chair

Referred to: Reference Committee K
(Elizabeth P. Kanof, MD, Chair)

At the 2001 Interim Meeting, the House of Delegates adopted as amended Resolution 109, which calls on the AMA to study the issue of medical savings accounts (MSAs) and appropriate health care access and coverage for dependents and children. The resolution also calls for the study of the use of incentives within MSAs to encourage parents to obtain appropriate preventive medical care for their children or dependents, including how this is accomplished in other countries. The Board of Trustees referred the requested study to the Council on Medical Service for a report back at the 2002 Interim Meeting. This report examines incentives to utilize preventive care services under MSAs in the U.S. and elsewhere, and under new MSA-style health plans.

BACKGROUND

MSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a personal savings account to be used only for qualified medical expenses. MSAs provide affordable protection against high medical costs and greater patient control over use of health services. Patients with MSAs have incentives to utilize health care in a cost-conscious manner because they spend from their own accounts and/or out of pocket before meeting the deductible, and because unspent account balances accumulate and accrue interest from year to year. High deductibles keep premiums low, making MSAs more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with zero cost sharing for in-network services and limits on total out-of-pocket costs. Two common criticisms leveled against MSAs are that they appeal disproportionately to relatively young, healthy, and wealthy individuals; and that they create incentives to avoid or limit spending on health care, thereby restricting use of services such as children's preventive care.

The MSA Demonstration

Although MSA products have been available in some states since the 1980s, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a five-year national demonstration of MSAs, extending the tax advantages of traditional employment-based health insurance to MSAs.

1 HIPAA also imposed numerous restrictions that did not encompass the variety of high-deductible
2 plans already being offered. The following factors have hampered the growth of MSAs:

- 3
- 4 • Enrollment in qualified MSAs is restricted to the self-employed or employment groups of 50 or
5 fewer.
 - 6 • The number of MSA policies that can be issued is capped at 750,000. (Policies issued to the
7 previously uninsured do not count toward this limit.)
 - 8 • The MSA demonstration is for a limited time.
 - 9 • Deductibles and out-of-pocket limits are narrowly proscribed, with no allowance for
10 geographic variation in health care costs. For 2002, deductibles for individual policies must be
11 between \$1,650 and \$2,500, with out-of-pocket limits of \$3,300; for families, deductibles must
12 fall between \$3,300 and \$4,950, with out-of-pocket limits of \$6,050. (Amounts are adjusted
13 annually for inflation.)
 - 14 • Either the employer or the employee may contribute to the savings account, but not both in the
15 same year, and annual contributions cannot exceed 65% of the deductible for individuals and
16 75% for families.
 - 17 • A family must meet the entire deductible before coverage applies, in contrast to standard
18 industry practice of including both family deductibles and lower, per-person deductibles. (For
19 example, a family policy might provide coverage to all family members once the family's
20 cumulative expenses exceed \$4,000 but also provide coverage to any individual family
21 member whose expenses exceed \$2,000, even if total family expenses are less than \$4,000.)
 - 22 • Individuals purchasing an MSA mid-year face the full deductible but may only contribute to
23 the savings account on a prorated basis.
 - 24 • Rigid benefit design does not allow for features such as first-dollar coverage of preventive
25 services, except as mandated by state law.
 - 26 • Several states and the District of Columbia expressly prohibit high-deductible plans and,
27 therefore, MSAs.
- 28

29 HIPAA included provisions for the evaluation of the MSA demonstration. The U.S. Treasury
30 Department was directed to report annually to Congress on the number of MSA policies issued, the
31 number issued to the previously uninsured, and the reduction in tax revenues due to deductibility of
32 contributions to MSA accounts. HIPAA also required the General Accounting Office (GAO) to
33 contract with an organization with expertise in health economics, health insurance markets, and
34 actuarial science to conduct a comprehensive study of the effects of MSAs in the small-group
35 market. This report, which was due to Congress by January 1999, was intended to assess the effect
36 of MSAs on adverse selection; health costs, including the impact on premiums, use of preventive
37 care, consumer choice, and the scope of coverage of high deductible MSA plans.

38
39 Early MSA Experience

40
41 Since the establishment of the MSA demonstration, enrollment has been lower than expected, far
42 below the participation cap set by HIPAA. Rigid, complex rules regarding account contributions
43 and benefit design discouraged eligible individuals from enrolling in MSAs. Eligibility and
44 participation limits and uncertainty about future availability discouraged insurers and insurance
45 brokers from investing in product development and marketing. Despite these obstacles, roughly
46 100,000 policy holders have enrolled in HIPAA-qualified MSAs, and some large employers choose
47 to offer non-qualified MSAs despite the fact that they do not receive federal income tax relief.

1 Although overall enrollment has been low, MSAs have expanded coverage to a greater-than-
2 expected number of previously uninsured individuals and families. Nearly 40% of those who
3 established HIPAA-qualified MSAs during 1997 were previously uninsured (General Accounting
4 Office, December 1998). Approximately 70% of policies issued by three leading MSA companies
5 were for households of two or more, with about 50% of all policies issued to families with children,
6 and 10% to families headed by single parents (Bunce, Cato Institute, August 2001). Researchers
7 from the RAND Corporation found that MSAs would not disproportionately attract younger,
8 healthier individuals (Goldman, et al., *Health Services Research*, April 2000). Similarly, the
9 Archer MSA Coalition reports that nearly 95% of MSAs policyholders are over age 30 and
10 approximately a third are over age 50 (forthcoming). Available data suggests that the great
11 majority of MSA enrollees do not reach their deductibles in a given year, and up to 80% have
12 unspent MSA account balances at the end of the year (Bunce, 2001; Bond et al., *Benefits*
13 *Quarterly*, 1996). Since the inception of the MSA demonstration, MSA enrollees have had
14 increased investment choices for account balances. MSAs seem to have achieved cost-containment
15 goals, saving both enrollees and employers on total premium and out-of-pocket expenditures (Bond
16 et al., 1996).

17

18 MSA Expansion Proposals

19

20 Legislation passed in 2001 and 2002 renewed the MSA demonstration through the end of 2003.
21 (Previously enrolled individuals may continue to have MSA coverage and make contributions after
22 2003 even if the program is not extended further.) MSA supporters have sought additional
23 legislation to eliminate many of the restrictions facing MSAs. Current Congressional and Bush
24 Administration proposals seek to make MSAs permanent; eliminate the group size restriction; lift
25 the 750,000 participation limit; lower minimum deductibles to \$1,000 for individuals and \$2,000
26 for families; allow contributions to be made by both the employer and the employee; increase the
27 maximum annual contribution to 100% of the deductible, with start-of-year contributions up to the
28 annual maximum; and allow MSAs to be offered through cafeteria plans. MSA expansion
29 proposals also include provisions to increase coverage of preventive services. In addition, while
30 there have been occasional proposals for Medicaid MSA demonstrations in several states, no such
31 plans appear likely to materialize in the foreseeable future.

32

33 COVERAGE AND USE OF PREVENTIVE SERVICES UNDER MSAs

34

35 Anecdotal evidence suggests that MSA enrollees did not restrict utilization of preventive services
36 (e.g., Bunce, 2001) but unfortunately, there is scant empirical evidence on the effect of MSAs on
37 utilization of preventive services. As noted earlier, HIPAA directed the GAO to conduct a study of
38 MSAs, including their effect on use of preventive care. However, low MSA enrollment has
39 prevented the GAO from conducting a comprehensive survey of MSA enrollees.

40

41 Benefit Design

42

43 In order to qualify as a high-deductible MSA plan under HIPAA, a plan is generally prohibited
44 from providing benefits before the deductible has been met. This HIPAA requirement supersedes
45 state benefit mandates – with one important exception: in states mandating coverage of preventive
46 services regardless of whether a deductible has been met, HIPAA explicitly grants a “safe harbor”
47 to high-deductible plans to provide first-dollar coverage for the specified services. For example,
48 states in which childhood immunizations are not subject to deductibles include Arkansas,

1 Oklahoma, Pennsylvania, Texas, and Wisconsin. Similarly, mammography is not subject to the
2 deductible or coinsurance, if any, in Oklahoma. Even with the safe harbor provision, conflict
3 between state benefit mandates and HIPAA criteria for high-deductible plans caused confusion
4 about what benefits were permitted or required. During the first two years of the MSA
5 demonstration, the GAO found that several plans offered first-dollar coverage for preventive care
6 where such coverage was not mandated by the state (i.e., in conflict with HIPAA-allowed benefit
7 design).

8
9 In all states, enrollees can use as much of their account balances as desired to pay for preventive
10 services (or any qualified services, including acupuncture, infertility treatments, laser eye surgery,
11 and other services not generally covered by insurance). When paying for preventive services from
12 MSA account balances or out of pocket, individuals are entitled to the discounted rates negotiated
13 by their PPO or other MSA plan. In addition, individuals sometimes negotiate further discounts,
14 especially when paying cash.

15
16 However, as with conventional health plans, MSA plans place limits on the amount of preventive
17 care that counts toward the deductible, or how much is covered once the deductible has been met.
18 One leading MSA vendor, Golden Rule, covers the following services under its high-deductible
19 MSA plan: mammography, Pap smears, prostate specific antigen (PSA) tests, routine physicals,
20 and related lab fees. Golden Rule places restrictions on coverage of routine physicals and related
21 lab work for adults over age 19 (but not for children) at \$150 per year once the individual has been
22 enrolled for a year. Another leading MSA vendor, Fortis, covers up to \$500 in wellness services
23 per person per year, with no waiting period.

24 25 Proposals to Allow Greater Preventive Coverage

26
27 Proposals to expand MSAs include provisions that would allow greater flexibility in covering
28 preventive services without jeopardizing plans' high-deductible status. The Medical Savings
29 Account Availability Act (H.R. 1524 and S. 1067) seeks to extend the "safe harbor" provision so
30 that high-deductible plans would be allowed, but not required, to provide first-dollar coverage of
31 preventive services in all states, regardless of state benefit mandates. Similarly, the Bush
32 Administration proposes allowing high-deductible plans to provide first-dollar coverage of up to
33 \$100 per person per year for allowable preventive services. The American Academy of Pediatrics
34 goes further, recommending that all MSA plans be required to provide first-dollar coverage for all
35 preventive health services for children.

36 37 MSAs IN OTHER COUNTRIES

38
39 Outside of the U.S., MSAs provide health insurance coverage to parts of the populations of South
40 Africa, Singapore, and China, and they have been considered in other countries, including South
41 Korea. International experience with MSAs varies in terms of how compulsory or voluntary
42 enrollment is, enrolled populations, coverage of dependents, flexibility in benefit design, covered
43 benefits, and direct incentives to utilize preventive services.

44
45 Although a majority of the South African population receives health services free at government
46 facilities, approximately 7 million people or 20% of the population have private health insurance.
47 In 1994, the Mandela Administration deregulated the market for private health insurance,
48 permitting any type of plan to compete for enrollees. Since then, MSAs have captured half of the

1 private market, while health maintenance organizations (HMOs) and other managed care plans
2 have been relatively unpopular. In contrast to the U.S., South African MSA deductibles vary by
3 type of service covered, with lower or no deductibles for hospitalizations, treatment of chronic
4 care, and preventive services. Some MSAs offer prizes such as airfare discounts for meeting health
5 and wellness guidelines. Although comprehensive data does not exist to determine whether MSA
6 enrollees forgo appropriate preventive care, patients do not appear to skimp on primary care in
7 such a way as to increase future health costs (Matisonn, National Center for Policy Analysis, 2000
8 and 2002).

9
10 In contrast to the U.S. and South Africa, MSAs in Singapore and China are part of government
11 programs with compulsory participation. In 1984, the government of Singapore instituted MSAs as
12 part of a broad program of forced savings based on the explicit goal of reducing government
13 subsidies (Goodman and Musgrove, 1992; Massuro and Wong, *Health Affairs*, 1995; and Hsiao,
14 *Health Affairs*, 1995). The city-state of Singapore has a population of approximately 3.5 million
15 and a modern health system. The government is involved in all aspects of the health system,
16 including operation of government health facilities, setting fees, and managing physician supply.
17 Health services are financed through three programs: Medisave, Medishield, and Medifund.
18 Under Medisave, workers are required to deposit 6 to 8% of their income into personal accounts to
19 pay for approved medical services for themselves and their dependents. Eighty-eight percent of
20 workers also participate in the optional Medishield program, whereby payroll deductions fund
21 premiums for catastrophic coverage (Masurro and Wong, 1995). The tax-funded Medifund
22 program provides indigent care. Oddly enough, neither Medisave nor Medishield provides
23 coverage for most types of outpatient care, creating a perverse bias toward hospitalization.
24 Medishield catastrophic coverage provides only partial protection and only in the case of
25 exceptionally high medical costs. At the end of 1996, 2.6 million Medisave accounts had total
26 balances equivalent to \$9.3 billion, with an average balance of \$3,600 (www.tradeport.org, 2002).
27 Because of restrictions on how MSA balances and other forced savings can be invested, accounts
28 have, in practice, become vehicles for funding home ownership and college education. Medisave
29 MSAs do not provide direct incentives for utilization of preventive services, although MSAs
30 generally provide long-term incentives to maintain health in order to avoid future medical
31 expenses. In addition, Singapore has a strong public health education program, and government
32 facilities offer free immunizations and heavily subsidized screening for cancer, heart diseases,
33 hypertension, and diabetes. Infant immunization rates surpass those of the U.S. (e.g., 96-98% for
34 TB, DPT, polio, and measles (UNICEF, 2000)).

35
36 In the early 1990s, China faced uncontrolled increases in health care costs, due in large part to a
37 lack of patient cost-sharing on the demand side and fee-for-service payments on the supply side
38 (Yip and Hsiao, *Health Affairs*, 1997). As part of a series of reforms, in 1994, the government
39 undertook a pilot test of MSAs in two cities, with a combined population of 5 million, for workers
40 of large state enterprises. Based on initial cost-containment success, MSAs were expanded to 40
41 more cities in 1996, and to additional cities including Shanghai and Beijing, the capital, in 1999
42 (Frontier Centre for Public Policy, Canada, 2002). Under the original program design, 11% of
43 employees' cash wages are divided almost evenly between individual MSAs and a social risk-pool
44 fund. As in Singapore, participation is mandatory but unlike Singapore, workers' dependents are
45 not covered by MSAs. An MSA pays for the worker's medical expenses until account balances are
46 exhausted, at which point the individual pays a sliding-scale deductible equal to 5% of annual
47 wages. Coverage from the risk-pool fund then takes effect, though with a system of copayments
48 and coinsurance. Since the inception of the program, required account contributions have been

1 geographically adjusted, and local variations in benefit design have been allowed. For example, on
2 the island of Hainan, MSA accounts pay for outpatient care, whereas hospitalizations are not
3 subject to the deductible. Although there is no direct evidence on the effect of MSAs on utilization
4 of preventive services in China, data from one of the initial pilot cities indicates that the program
5 promoted a marked shift from inpatient care to outpatient care (Liu et al., *International Journal of*
6 *Economic Development*, 1999).

7 8 CONSUMER-DRIVEN HEALTHCARE PLANS 9

10 In recent years, a “consumer-driven healthcare” movement has taken off in the U.S., emphasizing
11 greater individual choice, patient cost-consciousness, and provider competition. The movement is
12 embodied by new MSA-style health plans that include personal health savings accounts and high-
13 deductible coverage. Unlike HIPAA-qualified MSAs, these consumer-driven plans have greater
14 flexibility in benefit design and are available to employers regardless of size, though not generally
15 to self-employed individuals. Interest in consumer-driven plans was bolstered by June 2002 IRS
16 guidance permitting unused personal account balances, called health reimbursement arrangements
17 (HRAs), to roll over from year to year. The IRS guidance also allows for HRAs to be portable by
18 giving employers the option of allowing former employees continued access to account balances
19 after employment has ended. It remains to be seen whether employers will opt to make HRA
20 account balances portable. In contrast, MSA account balances are owned by the individual and,
21 thus, are always fully portable. Another difference between MSAs and HRAs is that only
22 employers may contribute to HRA accounts, whereas, as noted earlier, either the employer or the
23 individual may contribute to MSA accounts, but not both in the same year. Finally, HRA funds
24 may be used strictly for health care expenses, whereas MSA funds can be used for other purposes,
25 albeit with a sizeable tax penalty.

26
27 Consumer-driven plans exhibit greater variation in benefit design than MSAs because plans are
28 tailored to employers’ specifications, particularly in the case of large, self-insured employers not
29 bound by state benefit mandates. Nonetheless, virtually all consumer-driven plans include
30 incentives for appropriate utilization of preventive services, indicating market demand for such
31 coverage. Employers offering consumer-driven plans alongside conventional plans normally
32 modify boilerplate coverage so that preventive benefits match across plans. Based on the
33 philosophy that information is essential for sound decision making, consumer-driven plans
34 reinforce financial incentives with patient education programs. These programs typically involve
35 newsletters, Web-based access to evidence-based disease management guidelines and other
36 medical information, customized e-mails—including reminders of scheduled inoculations and
37 screenings, nurse hotlines, and close management of chronic conditions.

38
39 Both Definity Health and Aetna HealthFund consumer-driven plans cover 100% of expenses for
40 eligible preventive care obtained within network. Definity’s coverage for children typically
41 includes well-child care visits, immunizations, and screenings for lead blood levels, vision, hearing,
42 and blood pressure. Adults are covered for routine annual physical exams, related x-rays and
43 laboratory tests, immunizations, and the following periodic age- and gender-appropriate
44 screenings: cholesterol and HDL levels, clinical breast exams, mammograms, Pap smears, routine
45 pelvic exams, colorectal cancer screening, digital rectal exam, and PSA tests. Similarly, Destiny
46 Health’s consumer-driven plan provides first-dollar coverage for services deemed
47 non-discretionary, including preventive care, as well as most care associated with chronic
48 conditions and hospitalizations. (Destiny is modeled after MSAs offered by its South African

1 parent company, Discovery Health.) Thus, patients in these plans need not spend account balances
2 nor meet deductibles in order to obtain preventive services. Patients also can choose to consume
3 additional preventive services not covered by the plan by paying for them out of their accounts or
4 out of pocket. In this case, patients pay discounted rates, as under MSAs.

5
6 Although Lumenos offers employers the option of first-dollar coverage of preventive services
7 (e.g., with caps of \$300 for individuals, \$450 for two-person policies, and \$600 for families), it
8 encourages coverage of preventive services through “wellness accounts.” Under this benefit
9 design, a specified portion of the health savings account does not roll over, providing patients with
10 incentives to spend at least that much per year. The amount designated for non-rollover is
11 generally between 15 and 20% of the annual account deposit, or between \$125-250 for individuals,
12 \$200-400 for two people, and \$300-500 for families. Again, additional expenditures can be
13 financed out of the regular portion of the health savings account. Lumenos provides enrollees with
14 age- and gender-specific guidelines for utilization of preventive services, but does not differentiate
15 between preventive and non-preventive covered services for purposes of “wellness account”
16 spending. Thus, someone spending at least the designated amount solely on non-preventive
17 services would not face forfeiture of the wellness account, unless the spending was on services not
18 covered by the plan. The decision not to monitor services counting toward the wellness account is
19 based on the principle that patients and physicians should be free to make individualized care
20 decisions while being informed by, but not bound by, practice guidelines.

21
22 Consumer-driven plans offer other innovative features designed to encourage appropriate
23 utilization of preventive services and healthful lifestyle choices. Under the Lumenos plan,
24 employers may offer additional account deposits of \$50-100 to enrollees who complete a
25 confidential health risk assessment. Like its South African counterpart, Destiny includes a “Health
26 Vitality” program modeled after airline frequent flyer programs. Enrollees who meet health and
27 wellness guidelines earn rewards such as health club memberships, hotel accommodations, air
28 miles on major airlines, and higher interest rates on health savings account balances.

29
30 Efforts are underway to launch a unique community-based, consumer-driven health plan in
31 Scituate, Rhode Island. Members of the Scituate Health Plan would pay approximately \$200 to
32 obtain preventive and routine care at no additional cost through a local primary care center.
33 Members or their employers would also contribute up to \$2,500 per year to a “patient savings
34 account” and purchase a high-deductible health plan from a private insurer. Plan backers hope that
35 it will become a model for other small towns.

36 37 RELEVANT AMA POLICY

38
39 Extensive, longstanding AMA policy supports promotion and expansion of MSAs (Policies
40 H-165.869, H-165.879, H-165.920, H-165.969, H-180.957, H-185.982, and H-270.969, AMA
41 Policy Database). The AMA supports MSAs as a means of increasing patient choice of both
42 coverage and physicians, as well as a means of promoting individual cost-consciousness in the
43 utilization of health services. Policy H-165.879 encourages utilization of preventive services by
44 MSA enrollees through patient education. Policy H-165.920(7) supports legislation allowing the
45 tax-free use of MSA accounts for health care expenses, including health and long-term care
46 insurance premiums and other costs of long-term care, as an integral component of AMA efforts to
47 achieve universal access and coverage and freedom of choice in health insurance.

1 Policy H-165.869(3) closely parallels current legislative proposals to expand MSAs by seeking to
2 repeal MSA demonstration status; eliminate group size restrictions; eliminate the participation cap;
3 remove limitations on minimum and maximum allowed deductibles; allow contributions to be
4 made by both employer and employee; and allow MSAs to be offered through cafeteria plans. In
5 addition, Policy H-165.869 seeks to increase the income tax deduction for the contribution to the
6 MSA to 100%, an objective that has already been achieved.

7
8 Numerous AMA policies promote the use of preventive services, including childhood
9 immunizations and early detection screenings (e.g., Policies H-425.997, H-170.995, and
10 H-440.992). In addition, Policies H-425.987, H-165.880, and H-425.983 call upon insurers to offer
11 a wide variety of health insurance products that provide a range of clinical preventive services.
12 Policy H-440.992 specifically states that “there should be no financial barrier to immunization of
13 children.”

14
15 Finally, while AMA policy encourages patients to seek and insurers to offer products that cover
16 preventive services, it does not generally support mandating such benefits. Policy H-185.964
17 opposes new benefit mandates unrelated to patient protections, and Policy H-180.978 expresses a
18 preference for allowing insurance markets to operate freely rather than under government mandates
19 and controls.

20 21 DISCUSSION

22
23 Despite disappointing enrollment in MSAs to date, MSAs have demonstrated potential to expand
24 coverage to considerable numbers of uninsured, including children. Early MSA experience
25 indicates that, remarkably, about half of all MSA policies are issued to families with children, and
26 nearly 40% are issued to the previously uninsured. The Council on Medical Service anticipates
27 increased demand for MSAs as health insurance costs and premiums continue to rise and as
28 employees pay greater shares of premiums. The Council believes that it is critically important to
29 eliminate many of the restrictions facing MSAs, including temporary demonstration status, in order
30 to permit the natural rise in both demand and supply of MSAs. The Council further notes that in
31 the event of the death of the policyholder, MSA account balances can be inherited, enhancing their
32 ability to secure health expense coverage for spouses and children.

33
34 One concern about MSAs is that they may create incentives to limit health care spending, possibly
35 restricting utilization of preventive services. Rigid benefit design prohibits first-dollar coverage of
36 preventive services except in a handful of states where such coverage is mandated. However,
37 compared to being uninsured, MSAs provide greater incentive and ability to pay for preventive
38 services by making funds available solely for the purchase of health care, and by allowing enrollees
39 to pay discounted rates. MSAs also create long-term incentives for appropriate utilization of
40 preventive services in order to avoid future medical expenses. Available evidence on the effect of
41 MSAs on preventive services is minimal.

42
43 As previously discussed, a survey of MSA experience in the U.S. and abroad turned up no evidence
44 of MSAs restricting utilization of preventive care. When MSAs and related plans are permitted the
45 flexibility to vary benefit design, they invariably provide first-dollar coverage of preventive
46 services or other direct incentives to utilize preventive services. The experiences of South African
47 MSAs and new U.S. MSA-style consumer-driven health plans indicate strong market demand for
48 coverage of preventive services.

1 The Council recognizes that first-dollar coverage of preventive services blunts the ability of MSAs
2 to foster cost-conscious decision making, and that there is a tradeoff between promoting the use of
3 preventive services and allowing individuals to determine the relative costs and benefits of health
4 care services. Nonetheless, consistent with long-standing AMA policy on pluralism, the Council
5 believes that health plan benefit design should be determined by market demand rather than
6 mandates, and that MSAs should be allowed the same flexibility as other forms of health insurance
7 to vary patient cost-sharing requirements for different types of services. In particular, the Council
8 believes that high-deductible plans in all states should be extended a “safe harbor” to allow for the
9 coverage of preventive services regardless of whether the deductible has been met. Accordingly,
10 MSAs would be allowed, but not required, to offer first-dollar coverage of preventive services.
11 Given market demand for preventive services, the Council believes that flexibility to innovate plan
12 design would lead to more generous coverage of preventive services by MSAs as the norm.

13
14 The Council also believes that several additional changes to MSA requirements would enhance
15 their value to families. Specifically, enrollees should be allowed to deposit amounts up to the full
16 deductible, and with no limit on the fraction that can be deposited at any time during the year.
17 These modifications would improve household cash flow by permitting greater flexibility in the
18 amount and timing of funding MSA accounts. Finally, plans should be free to apply lower, per-
19 person deductibles to individual family members, in keeping with standard industry practice.
20 These changes would simplify understanding and marketing of MSAs, making them more
21 attractive to consumers, insurers, and brokers. The net effect of the proposed changes would be to
22 allow MSAs to compete with other forms of health insurance on a more even basis, and to improve
23 the potential for MSAs to bring affordable coverage to more patients, including the uninsured.

24
25 The Council notes that full income tax deductibility for contributions to MSAs, as called for in
26 Policy H-165.869(3)(c), has already been achieved; and that removing the MSA demonstration
27 status, as called for in Policy H-165.869(3)(a), would make MSA account deposits tax deductible
28 on a permanent basis. The Council believes that deposits to MSA accounts should continue to be
29 tax deductible until such time as legislative enactment of Policy H-165.920(12), which supports the
30 replacement of the present exclusion from employees’ taxable income of employer-provided health
31 expense coverage with tax credits for individuals and families.

32
33 Finally, the Council notes that establishment of an MSA to be offered to AMA physicians through
34 AMA medical programs, as called for in Policy H-165.869(5), has already been achieved. The
35 Council favors continued promotion of MSAs by the AMA to its members.

36 37 POLICY RECOMMENDATIONS

38
39 The Council on Medical Service recommends that the following be adopted and the remainder of
40 the report be filed:

- 41
42 1. That the AMA reaffirm Policy H-165.920(7), which strongly supports legislation promoting
43 the establishment and use of medical savings accounts (MSAs) and allowing the tax-free use of
44 such accounts for health care expenses, including health and long-term care insurance
45 premiums and other costs of long-term care, as an integral component of AMA efforts to
46 achieve universal access and coverage and freedom of choice in health insurance. (Reaffirm
47 HOD Policy)

- 1 2. That it is the policy of the AMA to strongly support allowing contributions to medical savings
2 accounts (MSAs) to continue to be tax deductible until legislative enactment of Policy
3 H-165.920(12), which supports replacement of the present exclusion from employees' taxable
4 income of employer-provided health expense coverage with tax credits for individuals and
5 families. (New HOD Policy)
6
- 7 3. That the AMA modify Policy H-165.869 by addition and deletion to read as follows:
8
- 9 Our AMA: (1) continues to incorporate advocacy of medical savings accounts (MSAs)
10 prominently in its campaign for health insurance market reform;
11
- 12 (2) enhances activities to educate patients about the advantages and opportunities of MSAs;
13
- 14 (3) continues to advocate repeal of the current restrictions on MSAs by: (a) Permanently
15 repealing the limit on the number of MSAs and removing the demonstration status of the
16 project; (b) Expanding eligibility to employees of any size employer and to any individual; ~~(c)~~
17 ~~Increasing the income tax deduction for the contribution to the MSA to 100%; (dc)~~ Allowing
18 both employees and employers to contribute to MSAs; (d) Allowing annual MSA deposits up
19 to 100% of the deductible, with no limit on the fraction that can be deposited at any time
20 during the year; (e) Reducing the permitted annual minimum deductibles and allowing
21 unlimited annual maximum deductibles; (f) Allowing MSAs to be offered in cafeteria plans
22 provided by employers; (g) Allowing individuals with pre-existing medical conditions, who
23 have been covered by medical insurance during the previous 12 months, to participate in an
24 MSA without penalty; and (h) Allowing those covered by MSAs to collectively form a group
25 purchasing arrangement for pharmaceuticals and other services; (i) Extending a "safe harbor"
26 to high-deductible plans in all states to allow for the coverage of preventive services regardless
27 of whether the deductible has been met; (j) Allowing high-deductible plans issued to families
28 to apply lower, per-person deductibles to individual family members.
29
- 30 (4) continues to monitor and encourage the efforts by companies to develop, package, and
31 market innovative products built around MSAs; and
32
- 33 (5) ~~explores the formation of a~~ continues to promote MSAs being ~~to be~~ offered to AMA
34 physicians through its own medical insurance programs. (Modify Current HOD Policy)
35
- 36 4. That the AMA encourage the General Accounting Office (GAO) to continue its efforts to
37 conduct a comprehensive survey of medical savings account (MSA) enrollees, including the
38 effect of MSAs on utilization of preventive services. (Directive to Take Action)

References for this report are available from the AMA Division of Socioeconomic Policy Development.