Myths About Medical Savings Accounts: Rhetoric versus Reality

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JUNE 22, 2001

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Executive Summary
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Floor amendments will be offered during the Senate's consideration of the Patients' Bill of Rights that would make Medical Savings Accounts (MSAs) universally available and would substantially alter current MSA policy. Similarly, it is expected that the House will soon introduce a Patients' Bill of Rights that also includes a number of provisions that would expand the use of MSAs. Unfortunately, much of the rhetoric about the importance of expanding MSAs seems to be based more on myth than reality. The economic evidence discussed in this report contrasts the following myths and realities.

Myth: *Expanding MSAs will expand health care coverage and reduce the ranks of the uninsured.*
Reality: Substantial expansion of MSAs would much more likely degrade health care coverage for all but the wealthy and could increase the number of uninsured.

Myth: *MSAs reduce the cost of health insurance for the uninsured and the under-insured.*
Reality: Premiums for traditional insurance could increase by more than 60 percent if healthy people drop their traditional insurance to enroll in MSAs, according to recent studies.

Myth: *MSAs provide the greatest help to the sick and poor.*
Reality: Currently, MSAs appeal to the healthiest and wealthiest, not the sickest and poorest.

Myth: *MSAs encourage private savings for medical expenses.*
Reality: MSAs create a tax shelter for the wealthy.

Myth: *MSAs are the most cost-efficient way of expanding health care coverage.*
Reality: Research shows that existing federal programs deliver health care to the uninsured at lower cost to the government.

Myth: *MSAs increase consumer choice.*
Reality: With wide-spread use of MSAs, consumers – especially those with serious or chronic health problems – will have fewer options for comprehensive, low-deductible health insurance.

Myth: *Expanding MSAs will benefit employees who receive MSA contributions from their employers.*
Reality: Employers will have incentives to make smaller contributions to MSA accounts, ensuring that only high-paid employees benefit.

Myth: *MSAs encourage cost effectiveness by discouraging unnecessary use of medical services.*
Reality: There is no conclusive evidence on the amount of savings created, and some important services may be cut back.

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Myths About Medical Savings Accounts: Rhetoric versus Reality

Medical Savings Accounts (MSAs) are tax-advantaged personal savings accounts for unreimbursed medical expenses. Currently, MSAs are available to taxpayers who have no insurance, or only insurance with a high deductible. Employer contributions to MSAs are not subject either to income or employment taxes, while contributions made by individuals are deductible in determining adjusted gross income. The funds may be retained in MSA accounts and invested in stocks and bonds, with investment earnings accumulating free of tax. Withdrawals are also not taxed if they are for medical expenses not covered by insurance.

A limited number of MSAs became available under these rules as a demonstration that began in 1997. These MSA provisions are scheduled to expire after December 31, 2001, unless Congress acts to preserve them.

The Bush Administration's proposal to expand the use of MSAs will likely serve as the basis for many proposals to amend the Patients' Bill of Rights on the Senate floor. The Administration proposal would make MSAs available to individuals and employees working in any size business (instead of employers with less than 50 employees), allow MSA use on a permanent basis, remove the 750,000 limit on the number of people who can participate in MSAs, and lower the deductible allowed in plans that include MSAs. These changes would increase MSAs attractiveness as tax shelters for the wealthy.

Unfortunately, much of the rhetoric about the importance of expanding MSAs seems to be based more on myth than reality. The economic evidence discussed in this report shows that the reality is quite different from several popular myths.

Myth: ***Expanding MSAs will expand health care coverage and reduce the ranks of the uninsured.***

Reality: **Substantial expansion of MSAs would much more likely degrade health care coverage for all but the wealthy and could increase the number of uninsured.**

The key to affordable health care is to spread the costs as broadly as possible across the largest group of beneficiaries. MSAs do the opposite. The Government Accounting Office (GAO) has found that insurers do not target the uninsured while marketing MSAs. Instead they target highly-paid professionals, farmers and ranchers, partnership firms, and association groups.

MSAs naturally appeal to the healthiest and wealthiest. MSAs give people a tax incentive to buy high-deductible health insurance, which is attractive to people with low or no expenses or to high-income earners who can pay for the deductible. Those who have lower incomes – which includes most of the uninsured – would be unable to accumulate substantial savings in their MSAs very quickly, leaving them exposed to substantial risks under a high-deductible plan and even higher risks if the MSA is their only source of health care coverage.

As the wealthy and the young with low medical costs move to MSAs, the insurance market will likely become segregated between the healthy and the less healthy. Called "adverse selection," this market segmentation increases the premiums for less-healthy individuals because they are no longer pooled with healthier individuals. The resulting increase in costs for non-MSA plans may cause employers to cease offering comprehensive coverage or to raise the share of premiums that employees pay. As a consequence, insurance becomes less available, more expensive, and more people become uninsured.

Myth: ***MSAs reduce the cost of health insurance for the uninsured and the under-insured.***

Reality: **Premiums for traditional insurance could increase by more than 60 percent if healthy people drop their traditional insurance to enroll in MSAs.**

When MSAs and low-deductible coverage are offered as alternatives, healthy people are disproportionately drawn to the cheaper MSA plans, leaving the sick in the low deductible, more comprehensive plans. As the American Academy of Actuaries has noted: "The greatest saving [from MSAs] will be for the employees who have little or no health care expenditures. The greatest loss will be for the employees with substantial health-care expenditures. Those with high expenditures are primarily older employees and pregnant women." Evidence from a GAO survey confirms that insurance companies set premiums for MSAs based on the assumption that adverse selection will take place: "insurers expect relatively better health status and lower utilization by MSA enrollees...and price their products accordingly."

Premiums for traditional insurance could increase by more than 60 percent if healthy people drop their traditional insurance to enroll in MSAs, according to the Urban Institute. MSA expansion would crowd out comprehensive coverage because these expansions would raise costs in traditional plans enough to render health insurance unaffordable for many employers and employees.

Myth: ***MSAs provide their greatest help to the sick and poor.***

Reality: **Currently, MSAs appeal to the healthiest and wealthiest, not the sickest and the poorest.**

Higher-income people benefit more from MSAs for a number of reasons. High income people face the highest marginal tax rates, so the benefit of tax-free savings is worth more to them than to lower-income people. Further, those with higher incomes are more likely to be able to afford high deductibles than are low-income people, and higher-income people are more likely to receive employer-paid premiums and MSA contributions than are lower-income people.

Currently, MSAs impose a 15 percent penalty for non-qualified withdrawals, that is, for withdrawals for purposes other than paying medical expenses. Some proposals would reduce or even eliminate this penalty. Without the 15 percent penalty, MSAs would become a favored tax-savings vehicle for the rich. Even with the penalty, it would take only about seven years for taxpayers in the 31 percent bracket to realize tax savings from an MSA that would exceed the value of both the future

tax liability and the 15 percent penalty for withdrawals for non-medical purposes, according to a report by the Congressional Research Service. Expanding eligibility for the accounts would mean that millions more taxpayers could use MSAs as a way to shelter income from taxation.

Myth: ***MSAs encourage private savings for medical expenses.***

Reality: **MSAs create a tax shelter for the wealthy.**

A report by Westat for the GAO contains evidence that MSAs are seen as tax shelters by the wealthy. The Westat report notes that: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses." A New York Times article in 1998 featured an example of a relatively well-off MSA holder who chose to pay medical expenses with other funds, leaving his MSA deposits to grow tax-free.

Several factors make MSAs an attractive tax shelter for wealthy individuals. Investment earnings in MSAs are allowed to accumulate tax-free. There are no income limits on who can contribute to an MSA, and the savings can be rolled over to a beneficiary upon the death of an account holder. While MSAs are designed to be used for medical purposes only, account holders can use the funds for non-medical purposes if they hold the account until retirement age. Further, as already indicated, the penalty for withdrawal for non-medical expenses is outweighed by the benefits of tax-free investment earnings for many high-income individuals.

Myth: ***MSAs are the most cost-efficient way of expanding health care coverage.***

Reality: **Research shows that existing federal programs deliver health care to the uninsured at less cost to the government.**

MSAs cost the federal government $3,600 to insure each previously uninsured person who purchases an MSA, because most of those who benefit from MSAs are not currently uninsured. In contrast, it costs about $1,178 to enroll previously uninsured children in Medicaid, according to research by Consumers Union in 1998. On average, insurance costs for the uninsured are likely to be comparable to costs for covering uninsured children.

Myth: ***MSAs increase consumer choice.***

Reality: **With widespread use of MSAs, consumers – especially those with serious or chronic health problems – will have fewer options for comprehensive, low-deductible health insurance.**

With significant expansion of MSAs, employers would be more likely to choose high-deductible health-care plan options for their employees because these plans would cost employers less. Over time, the health-insurance market would increase the number of high-deductible plans to meet this demand. At the same time, plans offering comprehensive coverage would become much more expensive as healthier people left them. Many employers might drop such plans, giving fewer options to consumers who need comprehensive coverage.

The Westat study for the GAO confirms that insurance companies would respond to changes created in the market by the expansion of MSAs. A year after the MSA demonstration legislation was passed in 1996, more than 50 insurance companies began offering plans with high deductibles.

Consumer choice would be further limited by the rising cost of traditional comprehensive plans. Younger, healthier workers would have a financial incentive to opt for the high-deductible plans. As a result, the pool of people in comprehensive health care plans would be older and more likely to have health problems. Insurers would raise the rates on comprehensive plans to account for this change.

Myth: ***Expanding MSAs will benefit employees who receive them from their employers.***

Reality: **Employers will have incentives to make smaller contributions to MSA accounts, ensuring that only high-paid employees benefit**.

Currently, deposits may be made to an MSA account either by an employer or by an individual, but not by both within the same year. In addition, non-discrimination rules require an employer to make comparable contributions to all employees. Because employers can only make contributions if the employee does not, most employers who currently offer these benefits make contributions large enough to cover a substantial portion of the deductible.

Recent proposals to expand MSAs would undermine the aforementioned regulations by permitting employers to set up MSAs that would primarily benefit high-income employees. Under the new provisions, both employers and individuals would be able to contribute to an MSA account within the same year, as long as the combined contributions did not exceed the cost of the deductible. As a result, the non-discrimination rules will become ineffective. Employers could deposit a small amount into the accounts of all employees.

Highly-paid staff could then supplement this deposit with a substantial portion of their own funds and exclude this amount from their taxable incomes. Lower-income employees would not be able to afford such large supplements. Also, they would receive smaller tax subsidies from their personal contributions to their MSA accounts, because they generally fall into lower tax brackets.

Myth: ***MSAs encourage cost-effectiveness by discouraging unnecessary use of medical services.***

Reality: **There is no conclusive evidence on the amount of savings created by discouraging use of medical services, and some important services may be cut back.**

Supporters of MSAs argue that if consumers have to spend more of their own money, instead of relying on third party payments, they will be less likely to seek unnecessary health care services. In an analysis of data from Rand, the Congressional Research Service concluded that "people react differently to cost-sharing depending on their economic circumstances."

Any savings incentive created under the current MSA legislation would be effectively eliminated by proposed changes to allow plans with lower deductibles to include MSAs. One such proposal would decrease the lowest allowable deductible from $3,100 to $2,000 for families and $1,550 to $1,000 for individuals. The Treasury Department estimates that, under the new proposal, over 90 percent of medical expenses would be made by people whose expenses exceed the deductible threshold. What little cost-consciousness there exits under current law will be eroded by lowering the deductible threshold.

An additional concern is that limiting some of the medical care that would be discouraged under high-deductible plans might actually raise medical costs in the long run. If preventive care is discouraged, for example, some conditions that can be treated very cheaply in their early stages may develop into conditions that are much more expensive to treat. Unfortunately, non-urgent care of this type is probably the medical expense most likely to be cut if deductibles rise.

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