Policy Analysis

Cato Institute Policy Analysis No. 220: More than a Theory: Medical Savings Accounts at Work

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Executive Summary

Economists from across the political spectrum understand that one of the major factors driving health care costs is our third-party payment system that insulates consumers from the cost of their health care decisions. Medical savings accounts (MSAs) are the one health care reform proposal designed precisely to counter that fundamental cost-control problem. They restore direct incentives to consumers to control costs and stimulate true market cost-control competition.

MSAs are far more than a theory. Despite the heavy discrimination against them in the current income tax code, employers and workers across the country have already begun establishing and using MSAs in place of traditional third-party insurance. Among the companies currently using MSA-type insurance plans are Golden Rule Insurance Company, Dominion Resources, Forbes magazine, Quaker Oats, Indresco Corporation, and dozens of small businesses across the country. In all those companies, MSAs have proven highly effective at controlling costs, as well as highly popular among workers.

The experience of private companies currently using MSA-type approaches to reducing health care costs proves that MSAs can control rapidly rising health costs, while preserving both quality and patient choice. By enacting federal MSA legislation, Congress would establish a fully comprehensive cost-control system that would restrain costs without imposing rationing by either the government or insurance bureaucracies.

Introduction

In offering his health care reform plan last year, President Clinton said that one of his primary goals, in addition to universal coverage, was to control rapidly rising health costs. But ironically, the president's proposal, and similar proposals offered by both Democrats and Republicans, would only have made the fundamental problem worse.

By expanding to everyone traditional third-party insurance and covering more services, with minimal deductibles, the reform proposal would have actually maximized the perverse, cost-increasing incentives of third-party coverage. With a third party guaranteeing payment of all medical bills, neither patients nor doctors are significantly concerned about costs. The result is the cost explosion we have seen over the past 30 years.

Medical savings accounts (MSAs) are the one reform proposal designed precisely to counter the fundamental cost-control problem.[1] They restore direct incentives to consumers to control costs, which stimulates true market cost-control competition.

Moreover, they are the only reform proposal for controlling costs that is consistent with maintaining quality and consumer choice. All other cost-control proposals involve shifting more power and control to some third-party bureaucracy, either the government or insurance companies, that would then limit and ration care to reduce costs. MSAs put individual consumers in control of their own health care decisions. Consumers, not the government or insurance companies, decide whether a procedure or treatment is worth the expense.

MSAs are far more than a theory. Despite the heavy discrimination against them in the current federal income tax code, employers and workers across the country have already begun establishing and using MSAs in place of traditional third-party insurance. The results: MSAs are indeed highly effective at controlling costs, as well as highly popular among workers.

Why MSAs Work

The Third-Party Payment Problem

Economists from across the political spectrum understand that one of the major factors driving health care costs is our third-party payment system that insulates consumers from the cost of their health care decisions. In health care, a third party--a private insurance company or the government through Medicare and Medicaid--is usually paying the doctor and hospital bills for the patient (Figure 1).

As a result, the patient lacks market incentives to control costs. The patient is not concerned with avoiding unnecessary care or tests or shopping for the best priced care.[2]

Figure 1 Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990
[Graph Omitted]

Source: John C. Goodman and Gerald L. Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato Institute, 1992), p. 77.

Because consumers lack market incentives to control costs, doctors and hospitals do not compete to reduce costs. Because a third party is paying the bills, patients do not choose doctors and hospitals on the basis of cost-effectiveness, balancing cost and quality. Rather, they seek to maximize quality without regard to cost. If an extra procedure or test is of even the most marginal value, they will demand it. The result is runaway costs.

The incentive to ignore the cost of even marginal increases in quality can been seen particularly in the development and purchase of new medical technology and equipment. In most other markets, new technological advances operate to reduce costs. But in health care, observers have long noticed that such advances often seem only to sharply increase costs. That is because of the incentives. Health care providers are generally looking, not for new technological advances that would reduce costs to consumers, but primarily for those that will improve quality regardless of cost, because that is what patients are looking for.

The result has been a "medical arms race" with providers adding ever more expensive technology even if it produces only minimal increases in quality. Attempts to control the growth of medical technology outside a functioning market have resulted in arbitrary regulatory procedures and requirements, such as certificates of need, that limit consumer choice and have had an adverse impact on the quality of care without significantly affecting costs.

The evidence confirms the conclusion of the theoretical analysis: third-party payment is the main factor in rapidly rising health costs.

* The rapid increase in health expenditures in recent years has occurred in tandem with rapidly rising third- party payment. From 1965 to 1990 the percentage of health expenses paid by third parties soared from 48 percent to 79 percent. Over the same period health care spending as a percentage of gross national product doubled from 6 percent to 12 percent (Figure 2).[3]

Figure 2

Consumer Out-of-Pocket Payments vs. Health Care Spending
[Graph Omitted]

Source: John Tottie, "Cutting Health Care Costs: A Private-Sector Success Story," Citizens for a Sound Economy, Washington, April 9, 1994.

* Cost increases have been much greater for health care services with greater third-party payment and much less for those with lower third-party payment. Third-party payment covers 75 percent of hospital costs and 80 percent of doctors' bills. Yet it covers only 47 percent of dental bills, 26 percent of drug costs, and 32 percent of vision care. From 1965 to 1990 hospitalization costs, with the greatest third-party payment, increased over 350 percent in real terms after adjusting for inflation. Real doctors' costs, with the second most third-party payment, increased over 250 percent. But real costs for dentists, with lower third- party payment, increased 200 percent. And costs for drugs and vision care, with the lowest third-party payment, increased 150 percent, relatively close to the real growth of GNP of almost 100 percent over the period.[4]

* The rapid rise in health care expenditures has occurred mostly in expenditures by third-party payers rather than out-of-pocket payments. From 1960 to 1990 out-of-pocket health spending relative to personal income did not increase at all. Yet total health care spending relative to income tripled during that period.[5]

* The RAND Corporation conducted a rigorous scientific study of the health expenditures of 2,500 families from 1974 to 1982. The families were each provided with one of four different insurance plans, ranging from a zero deductible and all health expenses paid, to 5 percent of the first $1,000 in expenses paid and 100 percent after that. The families with no deductible incurred 53 percent more in hospital expenses and consumed 63 percent more in doctors' visits, drugs, and other health services than did the families with the highest deductible. Yet the study found no difference in health outcomes for the various groups.[6] Many other studies find similar results.[7]

* A recent econometric study published by the Cato Institute examined the different responses to different levels of third-party payment in health care and esti- mated that third-party payment had effectively doubled total health costs in the United States because of the effects of incentives.[8]

Third-party payment increases health costs in at least two other important ways. First, as indicated above, the degree of third-party payment varies greatly among different types of health services. That often leads patients and doctors to choose services with greater insurance coverage even though alternative services with less coverage may be at least as effective and less expensive overall. For example, a patient and doctor may choose hospitalization and surgery, which are completely covered by insurance, to treat a condition, even though the condition could be treated at least as well with far less expensive drug therapy, for which there is little or no insurance coverage. A recent study by the National Center for Policy Analysis estimates that that effect unnecessarily increases national health spending by about 16 percent, or $140 billion per year.[9]

Second, excessive third-party coverage with low deductibles unnecessarily and inefficiently increases administrative costs. Many relatively small bills must be submitted to and reviewed by the third-party payer and checked for accuracy. The payer must also maintain some system for ensuring that the prices charged are reasonable and that the services provided were medically necessary and appropriate. That often entails a costly bureaucracy of gatekeepers and medical reviewers, who add nothing to health care. Indeed, they often get in the way of good quality care. Economist Stan Liebowitz estimated that excessive third-party insurance unnecessarily adds $33 billion per year in administrative costs.[10]

The MSA Solution

MSAs are designed precisely to correct the third-party payment problem. They allow individuals to save money in tax-exempt accounts, in much the same way they can in individual retirement accounts (IRAs) now. They can use that money to pay routine medical expenses. Then, instead of expensive first-dollar insurance policies, they can purchase relatively inexpensive catastrophic insurance policies to protect themselves against major medical expenses.

For example, today it costs an employer more than $4,800 to provide health insurance for a typical American worker,

a spouse, and two children. Would it not be better if, instead, the employer bought a catastrophic policy (with, say, a $3,000 deductible) for approximately $1,800 and paid the worker the $3,000 difference? The worker could then put that money in an MSA (Figure 3). Any unspent money would roll over to the next year. Since 90 percent of Americans spend less than $3,000 per year on health care, in a very short time a worker would have a tidy pool of money available to use in the future. When the balance reached a certain level, the worker could transfer the funds to an IRA or other retirement fund.

Figure 3
How MSAs Work
[Graph Omitted]
Source: Cato Institute.

With MSAs, therefore, workers would effectively be spending their own funds for noncatastrophic health care. As a result, they would have full market incentives to control the costs of such care. They would seek to avoid unnecessary care or tests and look for doctors and hospitals that would provide good quality care at the best prices. That, in turn, would stimulate true cost competition among doctors and hospitals. Since consumers would be choosing on the basis of cost as well as quality, providers would compete to minimize costs as well as maximize quality, as in a normal market. Moreover, since patients and health providers would be concerned with reducing costs, developers of innovations and new equipment would compete vigorously to produce new items that reduced cost as well as improved quality.

Data on health costs and premiums, as well as the experience discussed below, show that the amount saved in premiums by switching to a policy with a $3,000 deductible would be almost enough in the first year alone to cover costs below the deductible with no greater out-of-pocket payments by the insured than under a traditional policy.

In addition, the distorting effect of varying third- party coverage for different services would be eliminated, because funds in an MSA would be equally available for all health care services. Finally, administrative costs would be sharply reduced. About half of all health expenses would no longer have to be submitted to and processed by third- party payers. Those payers would no longer have to monitor and check payments to determine whether they were accurate, whether the price charged was reasonable, and whether the service was medically necessary and appropriate.

That would add up to an enormous reduction in spiraling health costs. Moreover, MSAs are the only means of controlling health costs consistent with consumer choice and people's control over their own health care. Other proposed health care reforms, such as managed competition, would force people into health maintenance organizations (HMOs), in which a bureaucracy working for the insurer ultimately decides what care patients will get, or include global budgets, under which the government dictates how much may be spent on health care, reducing resources and ultimately services for the middle class and the elderly.

The public proved in the health care debates of last year that it will not accept such rationing and third-party control of its health care. MSAs are not only the most economical means of controlling costs, they are the only politically feasible reform.

Other Advantages of MSAs

In addition to controlling costs, MSAs would provide several other advantages. First, MSAs would improve the quality of health care. Patients paying for their own health care out of MSAs would not have to worry about obtaining permission or approval from third-party gatekeepers, or whether the insurer would pay for the services or treatment that would be best for them. Increasingly, patients are being given lower quality drugs, pacemakers, joint replacements, hearing aids, and other items because the third- party payer refuses to pay for the more expensive higher quality ones. That would no longer be the case with MSAs. To the extent that patients paid for health care out of their own MSAs, they would eliminate the excessive third- party interference, which is increasing today, in the doctor-patient relationship.

Second, MSAs would help to reduce the number of uninsured. Those without employer-provided coverage would be able to get the same tax advantages that are provided today only to those who do have such coverage. That would reduce the net cost to the uninsured of purchasing coverage. MSAs would also enable the uninsured to rely on low-cost

catastrophic coverage and reap the benefits of avoiding unnecessary expenses, through end-of-year rebates of unspent MSA funds. In addition, with MSAs the uninsured would escape most of the cost of the many unnecessary benefits state governments require be included in insurance policies, as such mandates would have only a small impact on the cost of a high-deductible catastrophic policy. Finally, MSA funds could be used to pay premiums for catastrophic insurance during periods of unemployment, enabling workers to maintain coverage during such periods.

Third, MSAs would be completely portable. Workers could take their MSAs with them from job to job. Consequently, workers could avoid "job lock"--being tied to their current jobs only to keep the health insurance they provide.

Finally, MSAs would provide funds that could be used in the future for long-term care, for long-term-care insurance, or for other postretirement medical needs not covered by Medicare.

More Than a Theory

Medical savings accounts have long been advocated by academics, health economists, and others in the public policy community. However, increasingly, MSAs are far more than a theory. Employers and workers across the country have already begun to adopt them. They are finding that the cost savings, efficiencies, and other advantages of MSAs outweigh even the stiff disincentives for using them under current tax law. Examples of the leading MSA programs in use, and how they have worked, are discussed below.

Golden Rule Insurance Company

Perhaps the leading example of MSAs at work is Golden Rule Insurance Company in Indianapolis, Indiana. The 1,300 workers at that company have the option of choosing either traditional insurance coverage or an MSA. Traditional coverage includes a $500 annual deductible and 20 percent copayment on the next $5,000 in expenses, for maximum out-of- pocket payments of $1,500 per year.

Alternatively, each worker can choose an MSA. For family coverage under this option, the employer purchases a catastrophic policy that pays all expenses over $3,000 each year. The employer then deposits $2,000 in a personal MSA for the worker's family. Those funds can be withdrawn for health expenses below the deductible, leaving a maximum potential out-of-pocket expense of only $1,000. For individual coverage, the employer purchases catastrophic insurance covering all expenses over $2,000 each year. The employer then deposits $1,000 in the worker's MSA that can be used for medical expenses, again leaving a maximum out-of- pocket expense of $1,000. Whether coverage is individual or family, the worker can withdraw remaining MSA funds at the end of the year for any use.

Golden Rule first offered the MSA option to its workers in 1993. Approximately 80 percent of the workers chose MSAs that year. Those workers each withdrew an average of $600 in remaining MSA funds at the end of the year to use however they chose. In 1994 about 90 percent of the workers chose MSAs.

Health care costs dropped precipitously for those workers. In addition to the $600 average remaining funds for each worker, health costs above the $3,000 deductible dropped 40 percent from previous projections in 1993. Workers who saved on costs below the deductible ended up not spending the substantial amounts over the $3,000 deductible that they would have spent with traditional insurance.

At the same time, Golden Rule employees increased their use of preventive care. About 20 percent of the workers with MSAs reported that they used their MSA funds to pay for a medical service they would not have bought under the traditional health insurance policy. That is because the MSA provided funds at hand that they could use to pay for such services, whereas the traditional policy imposed deductible and coinsurance fees that actually discouraged the use of such services. Moreover, the traditional policy might not cover some services, and the uncertainty alone discouraged workers from obtaining preventive care. But workers know that MSA funds can be used for whatever services they choose.

Finally, even the sickest workers were better off under the MSAs at Golden Rule. Those workers faced only a maximum out-of-pocket cost of $1,000 every year with the MSA. Under traditional insurance, those workers could incur annual maximum out-of-pocket expenses of $1,500.[11]

Dominion Resources

Another company that uses MSA incentives is Dominion Resources, a utility company in Virginia with 200 employees. Workers there may choose coverage with an annual deductible of $3,000 for families and $1,500 for individuals. Workers with family coverage who choose the high-deductible option save almost $1,100 per year in premiums, which they may keep in personal MSAs and use for expenses below the deductible. For individuals the annual premium savings is almost $500 per year.

In addition, workers whose expenses stay below the deductible receive a share of the company's health care savings. In 1992 the company paid $800 in such bonuses to each worker who qualified. Workers can also receive a wellness rebate of $600 each year based on five key health factors--blood pressure, weight, smoking, cholesterol, and seat belt use. The rebates can be saved in each worker's MSA. MSA funds can be withdrawn for any expense, health-related or other, at any time.

Approximately 80 percent of the company's workers have chosen the high-deductible option. Since 1989, when the new system was started, the company's health costs have risen less than 1 percent per year, compared to 20 percent per year for other companies in Virginia. By 1992 the company was underspending its projected health budget by almost one- third. The program is highly popular among workers, who are able to control much of the system's funds directly and gain personally from conserving on health expenses.[12]

Golden Rule's Experience with Small Business

Golden Rule Insurance Company has also now sold MSA coverage plans to a number of small businesses. One example is Templeton Oldsmobile in Virginia with 81 employees. Workers there can choose traditional insurance that provides family coverage with a $100 annual deductible for each of as many as three family members and up to $1,500 in additional copayment charges, for maximum out-of-pocket payments of $1,800 per year. Individual coverage includes a $100 annual deductible and up to $500 in additional copayment fees, for maximum annual out-of-pocket payments of $600.

With an MSA, in contrast, a family gets a catastrophic policy that pays all expenses over an annual deductible of $2,000. The employer then contributes $1,000 to the worker's MSA, leaving the worker with maximum annual out-of-pocket expenses of only $1,000, compared to $1,500 under the traditional policy. The individual worker gets a catastrophic policy that pays all expenses over a maximum annual deductible of $1,500, with $750 contributed to the worker's MSA, for a maximum out-of-pocket expense of $750. The worker can withdraw any unspent MSA funds at the end of the year for any purpose.

The remarkable fact is this: the total employer cost for MSA family coverage, including the MSA contribution, is $3,840.52, compared to $10,384.50 for traditional coverage. For individual coverage, the total MSA cost is $1,788.84 per worker, compared to $3,858.72 for traditional coverage.

Another good example is Halls Construction in Shawsville, Virginia, with 22 employees. The traditional family coverage there includes a $250 deductible for each family member up to a maximum of three, plus another $600 maximum in coinsurance expenses, for a maximum out-of-pocket expense of $1,350. The individual traditional coverage provides for a $250 deductible and $200 in maximum coinsurance expenses for a maximum out-of-pocket expense of $450.

With the MSA, a family gets a catastrophic policy paying all expenses over a $2,000 annual deductible. The em-ployer contributes $1,400 to an MSA for the family, leaving a maximum out-of-pocket expense of $600, compared to $1,350 under traditional coverage. Individuals get catastrophic policies that pay all expenses over a $1,500 annual deductible, with $1,050 deposited to an MSA, leaving a maximum out-of-pocket expense of $450, the same as under the traditional policy. Workers, of course, can withdraw any unspent MSA funds at the end of the year for any use.

For the employer, the total annual MSA cost for each family's coverage is $3,505.52, compared to $5,261.52 for the traditional policy. (The traditional policy costs about 50 percent more.) For individual coverage, the total em- ployer

cost is $1,954.68 for each worker, compared to $2,243.88 for the traditional policy, which costs about 15 percent more.

Golden Rule has sold similar MSA programs to Arlington Urology in Indianapolis with 16 employees; Medical Specialties Inc. in New Orleans with 17 employees; Numerics Unlimited in Dayton, Ohio, with 10 employees; Bobb Chevrolet in Columbus, Ohio, with 74 employees; Weiss Ale Hardware in Glenview, Illinois, with 11 employees; and Fred W. Laubie and Associates in Columbus, Ohio, with 11 employees.[13]

Thompson and Associates

Thompson and Associates, a health insurance marketing firm in Kansas, is marketing another MSA-type plan. They combine the funding of employer-provided health care and retirement benefits in one fund for each employee so that retirement funds for the workers automatically increase as the workers' health expenses decline. Under that approach, the employer purchases catastrophic health insurance that pays all expenses over $3,000 or $4,000 per year for each employee. The employer then puts an amount equal to the insurance deductible into an individual health and retirement account for each worker. Those funds can be used to pay for medical expenses below the deductible. Any unspent funds at the end of the year automatically go to support higher retirement benefits. The unspent funds can also be used to reimburse day-care expenses or to cover medical costs that may not be covered by the insurance, such as eye examinations and eyeglasses, dental care, and prescription drugs.

Thompson and Associates cites as an example a client who implemented the new system in 1983. The old health plan provided traditional insurance with a $100 deductible and 20 percent coinsurance payments on the next $1,000 in expenses, for a maximum out-of-pocket expense of $300. The new plan provides catastrophic coverage for all expenses over $3,000, with $3,000 deposited in each worker's individual savings account. The worker consequently has no out-of-pocket expense. Funds unspent at the end of the year automatically support higher retirement benefits, or they can be withdrawn for day-care or uncovered health expenses.

Remarkably, total health costs as a percentage of payroll fell by one-third in the first year, 50 percent below projected levels under the old plan. By 1991, nine years later, health costs as a percentage of payroll were still 24 percent below the 1982 cost under the old plan.

In addition, sick leave dropped precipitously from 7.5 percent of payroll in 1982 under the old plan to 0.1 percent in 1984 under the new plan. Apparently, employee efforts to avoid medical costs under the new health plan translated into fewer illnesses requiring sick leave. That prompted the employer to add a sick leave allocation to each worker's individual account, so sick leave is drawn from the account as well. Unspent sick leave funds are automatically left in the account for other purposes.[14]

Plan 3 Insurance

A health benefits consulting firm that markets insurance in the Washington, D.C., area, Plan 3 Insurance, is selling still another version of MSAs. Under this approach, the employer self-insures health benefits for workers but buys a catastrophic policy with a high deductible covering all of the company's health expenses above the deductible. For example, a firm with 20 workers might buy a policy covering all expenses above $100,000 for the workers as a group. Such a policy would cost only a small fraction of traditional first-dollar insurance coverage. The employer would then place the huge premium savings in a health fund reserve to pay for employee medical expenses below the deductible limit.

The employer covers all employee health expenses with no out-of-pocket costs for the worker. But the employer sets a reference amount equivalent to a high deductible, perhaps $3,000 per year, and allows employees who incur less in covered health costs to withdraw the difference from the health fund reserve after a waiting period of three years.

The three-year waiting period allows the funds in the reserve to grow. That allows the employer to set the reference deductible at higher and higher levels over time, covering a higher proportion of total health spending with the cash rebates. Moreover, while funds are in the employer's health fund reserve, investment returns on the funds are tax-free.

In the last five years Plan 3 has sold such health plans to nearly 60 small businesses with an average of 10 to 20

workers each. One example is the Rubber Manufacturers Association, which provides coverage for 30 employees and 20 retirees. It now pays only about 25 percent of its health funds to an insurer, which covers all health expenses over $10,000 for each employee. The rest of the funds go into the health fund reserve, which has grown to about $90,000. During the five years the new plan has been in effect, health costs to the employer have not increased at all. Moreover, last year the employees were able to withdraw $12,000 from the health fund reserve as a result of the lower costs. This year such employee withdrawals are expected to total $20,000.

Another example is Clinical Radiologists, with about 90 employees. In just two years under the program, employer health costs have been reduced by 30 percent. Combined employer savings over the years have totaled $180,000, or about 40 percent of total annual health costs at the start.[15]

Windham Hospital

Dramatic savings from using MSAs have also been achieved at Windham Hospital in Willimantic, Connecticut, with 1,000 employees. In 1993 the hospital switched from a pure first-dollar coverage plan with no deductible or co-payments to a plan with a $500 deductible. It also contributes $10 a week, or $520 per year, to an MSA for each worker. In addition, the hospital negotiated discounts for its employees when they pay for health services with MSA funds. The hospital itself offers discounts of 30 percent, area doctors offer price reductions of 20 percent, and drugstores cut prices by 10 percent.

Under the old plan, the hospital's employees used medical services 35 percent more than the community average. After one year under the new plan, however, the entire 35 percent excess was eliminated. Moreover, projected health costs for the hospital employees were reduced by about 50 percent.[16]

The Health Wealth Plan

Progress Sharing, an insurance-marketing firm in Saco, Maine, markets another MSA plan called Health Wealth. One of its clients is Spurwink School in Portland, with 220 employees. Under the plan, workers are offered a high-deductible policy, and premium savings are placed in a mutual fund account for each worker. The funds can be used to pay out-of-pocket health expenses or withdrawn for any purpose at the end of the year. Health costs at the school have actually dropped in four of the six years since the plan was adopted.

The Health Wealth plan is also used at Knox Semiconductors in Rockport, Maine, with 42 employees. The company has experienced only two premium increases in the six years it has used the program. It has saved $100,000 in health costs over the last three years alone. Progress Sharing has successfully implemented its Health Wealth program at 43 other small employers in Maine as well.[17]

Quaker Oats

The cereal-manufacturing firm provides workers with a high-deductible policy. It also pays $300 each year into the personal health account of each employee, which the worker can use to pay health expenses below the deductible. At the end of the year, workers can withdraw any unspent balance for any purpose. Over the past 10 years under this plan, the company's health costs have grown at a 6.3 percent annual rate, compared to more than double-digit rates for the rest of the country.[18]

Forbes

With 500 employees in New York, Forbes, Inc., pays each worker a bonus of $1,200, which is reduced by $2 for every $1 of medical claims the worker submits. The bonus can be spent or saved by the worker without restriction. In 1993 Forbes paid about one-third of its eligible employees the maximum $1,200 bonus. Yet its health costs fell 12 percent for the year, after falling 17 percent in the prior year, when the new system was started.[19]

Indresco Corporation

In 1993 Indresco Corporation provided its nonunion workers with health insurance subject to an income-related

deductible. Workers earning less than $30,000 have a $1,000 deductible and maximum out-of-pocket expenses of $4,000. Workers earning from $30,000 to $50,000 have a $1,500 deductible and maximum out-of-pocket expenses of $7,000. Workers earning over $50,000 have a $2,000 deductible and maximum out-of-pocket expenses of $10,000. Health costs for Indresco's workers fell 17 to 22 percent in the first year.[20]

Jersey City

Employees of Jersey City, New Jersey, will soon have an option for MSAs as well. Workers will each be able to choose a traditional policy leaving each covered individual subject to a $100 deductible and 20 percent copayment of the next $2,000 in expenses, up to a maximum out-of-pocket expense of $500, for two family members. Additional family members will not be subject to copayments or deductibles.

With MSAs, in contrast, the employer will buy an insurance policy that covers all expenses over a $1,500 annual deductible for individuals and a $2,000 annual deductible for families regardless of size. The employer will then deposit $1,500 in an MSA for each individual and $2,000 in an MSA for each family. Everyone will then be covered for all expenses, through either MSA funds or the catastrophic coverage. Workers can withdraw any unspent MSA funds at the end of the year for any purpose.

The MSA will cost the city a little less than traditional coverage, even though workers with MSAs will avoid the out-of-pocket expenses of traditional coverage and will be able to withdraw up to $2,000 per year in unspent funds. Workers will also be able to use MSA funds for checkups and other preventive care that is either not covered under the traditional policy or subject to the deductible and copayments. The city expects to benefit from reduced health claims in the future and reduced administrative costs of reviewing most medical bills below $2,000.

The United Mine Workers Union

The demonstrated success of MSAs and their appeal to workers led the United Mine Workers to successfully negotiate for them in its most recent contract. Under an agreement with the Bituminous Coal Operators Association, covering about 15,000 employees, coal mine operators now provide workers insurance with a $1,000 deductible replacing a zero deductible under the old health plan. The employees are each provided a $1,000 cash bonus at the beginning of the year that they can use for health care expenses below the deductible. At the end of the year, workers can keep for any use whatsoever any portion of the bonus they do not use for health care.[21]

The mine workers consequently still have first-dollar coverage. But they also have incentives to reduce costs and can gain directly by doing so. This example demonstrates better than any other the strong appeal of MSAs to workers.

Council for Affordable Health Insurance

Leading advocates of MSAs have also gotten into the act. In 1993 the Council for Affordable Health Insurance in the Washington, D.C., area dropped HMO coverage with a $250 deductible and bought insurance with a $1,000 deductible for each employee. The annual premium for the new plan was about $1,000 less for each worker. So the council granted each worker a savings plan with $1,000 for the year, which the worker could use for medical expenses below the deductible. Whatever the employees do not use for health care, they can keep at the end of the year.

The National Center for Policy Analysis in Dallas, Texas, has adopted a similar plan for 1995. That plan includes a deductible and a savings account of $2,000 for families and $1,500 for individuals.

State MSAs

Seven states have now enacted legislation providing for MSAs in their state income tax codes. Although states cannot reverse the federal tax discrimination against MSAs, they can eliminate any state tax discrimination, putting MSAs on an equal paying field under state law with traditional insurance and HMO coverage. The preceding discussion shows that MSAs can still be viable, attractive, and effective even with present federal and state tax discrimination. Given that, removing the state tax discrimination would be effective in advancing MSAs further. The specific legislation adopted by each of the seven states is discussed below.

Arizona

Starting in 1995 workers and employers will receive tax deductions for MSA contributions of up to $2,000 for each worker, plus $1,000 each for as many as two dependents. Those maximum contribution limits are indexed to grow with inflation. Investment returns are tax-free, but all withdrawals, even those for health care, are included in taxable income. Funds deposited in an MSA may not be withdrawn during the year for anything but health care. Funds withdrawn for other purposes are subject to an additional 10 percent penalty, similar to the penalty on premature withdrawals from IRAs. At the end of the year, all funds remaining in an MSA may be withdrawn without any penalty.

Colorado

Starting in 1995 employer contributions to an MSA of up to $3,000 for each employee will be deductible. Investment returns are tax-free, but all withdrawals are fully taxable, even those for health care. Remaining funds at the end of the year may be withdrawn for any use without additional penalty.

Idaho

Starting in 1994 employer and worker contributions of up to $3,000 to an MSA are deductible. The contribution limit is indexed to increase with inflation each year. Investment returns are tax-free, but all withdrawals, including those for health care, are fully taxable. MSAs must be established through an employer, so the uninsured cannot start them on their own to obtain coverage. Remaining funds at the end of the year can be withdrawn for any use without additional penalty.

Illinois

Starting in 1994 employer and worker MSA contributions of up to $3,000 for each worker are deductible. The contribution limit is again indexed to inflation. All investment returns are tax-free, but all withdrawals are taxable. The MSAs must be established through an employer. Any funds remaining in the MSA at year-end can be withdrawn without additional penalty.

Michigan

Starting in 1994 employers and workers could receive a tax credit for up to $3,000 in contributions to an MSA for each worker. The tax credit is equal to 3.3 percent of contributions, which is the equivalent of a deduction at a 3.3 percent income tax rate. The contribution limit is indexed to inflation. Workers can establish MSAs independent of employers, which helps to expand coverage.

Mississippi

Starting in 1994 Mississippi allowed employers and individuals to establish MSAs. Contributions are tax deductible, and the interest is tax-exempt. The maximum limit on contributions is $2,250 for individuals and $3,500 for families, but contributions may be no higher than the deductible in an accompanying catastrophic health insurance policy. Funds withdrawn for health care are tax-free, but funds withdrawn for any other purpose are subject to the regular income tax. Only funds in excess of the deductible of an accompanying catastrophic health insurance policy may be withdrawn for nonmedical purposes.

Missouri

Employers may establish MSAs for their workers, but individuals may not establish them independently. Contributions are not tax-deductible, but returns on MSA savings are tax-exempt. Withdrawals for medical expenses are also tax-free, but any other withdrawals are subject to regular income tax. MSA funds may be withdrawn for nonmedical expenses to the extent they exceed a minimum balance established each year by state regulations.[22]

Congress Should Act

If MSAs are so successful, why have they not been more widely implemented? The problem is that current federal tax law discriminates heavily against MSAs and in favor of traditional third-party insurance coverage provided by employers. All that is needed is to remove that powerful tax bias and tax MSAs and traditional insurance equally.

If an employer pays for traditional third-party insurance for an employee, the employer receives a full tax deduction for the premiums. None of the premiums are included in employee income. All health insurance benefits are also tax-free to the worker. Moreover, any returns on health insurance reserves are not taxed, unless retained by the insurance company as profit.

In contrast, if an employer contributes to an MSA, although the employer still receives a deduction for the payments, the total of those payments is included in the employee's taxable income. While the funds are in the MSA, any returns are subject to triple taxation--the corporate income tax, the capital gains tax, and the individual income tax. That cripples private savings as an alternative to full third-party insurance coverage. Finally, any withdrawals from an MSA not previously taxed are included in employee income and fully taxed, even if the withdrawals are used for entirely legitimate medical expenses. Moreover, if an individual contributes to an MSA on his own, he receives absolutely no deduction for his contributions.

Because tax rates are so high, tax discrimination makes a big difference. For even a moderate income worker, MSA funds included in taxable income would be subject to a 15 percent income tax, and effectively the full 15.3 percent employer and employee shares of the Social Security and Medicare payroll tax. If the worker is subject to a common 6 percent state and local income tax as well, MSAs are effectively subject to a 36.3 percent tax in comparison with traditional employer-provided insurance, on which the employer pays no tax.

For higher income workers, the tax penalty is even worse. Their MSA funds would be subject to at least a 28 percent federal income tax, a 15.3 percent payroll tax, and, most commonly, at least a 6 percent state income tax, for a tax penalty of nearly 50 percent on MSAs.

If MSAs are ever to be fully effective in reducing costs and providing the other benefits discussed above, the heavy tax discrimination must be removed.[23]

Conclusion

The experience of private companies currently using MSA-type approaches to reducing health care costs shows that MSAs can control rapidly rising health costs, while preserving both quality and patient choice. Policymakers should fully use this tool to control costs throughout our health care system. By ending the tax bias against MSAs, Congress would establish a fully comprehensive cost-control system that would restrain costs without imposing rationing by either the government or insurance bureaucracies. That is because the system would provide the right incentives to weigh costs against benefits and allow patients and consumers to decide on the basis of their own preferences.

MSAs would accomplish that by expanding the freedom and the control of workers, patients, and consumers over their own health and its care. Instead of rationing, MSAs would expand individual choice and control. Instead of granting even more power to government, big insurance companies, and bureaucracies, as last year's health reform proposal would have done, MSAs would do just the opposite. They would shift power and control away from government, insurance companies, and employers to individual consumers, patients, and workers and the doctors and hospitals they choose to serve them.

In short, MSAs would solve the health cost problem by giving power to the people.

Notes

[1] For a detailed discussion of medical savings accounts, see John C. Goodman and Gerald L. Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato In stitute, 1992).

[2] For a more detailed discussion of the third-party pay ment problem, see Stan Liebowitz, "Why Health Care Costs

Too Much," Cato Institute Policy Analysis no. 211, June 23, 1994.

[3] John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, Dallas, Texas, Policy Report no. 168, January, 1992, pp. 2-3; John C. Goodman and Gerald C. Musgrave, "Personal Medical Savings Accounts (Medical IRAs): An Idea Whose Time Has Come," National Center for Policy Analysis, Dallas, Texas, Policy Backgrounder no. 128, July 22, 1993, p. 11.

[4] Liebowitz, pp. 13-15.

[5] Goodman and Musgrave, "Personal Medical Savings Ac counts," p. 10.

[6] Robert Brook et al., The Effect of Co-Insurance on the Health of Adults (Santa Monica, Calif.: RAND Corporation, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experi ment," American Economic Review, June 1987.

[7] See, for example, Paul Feldstein, Healthcare Economics (New York: Wiley, 1988); and Alan Sorkin, Health Economics (New York, Lexington Books, 1992), p. 31.

[8] Liebowitz, pp. 16-17.

[9] Gary Robbins, Aldona Robbins, and John C. Goodman, "In efficiency in the U.S. Health Care System: What Can We Do?" National Center for Policy Analysis, Dallas, Texas, Policy Report no. 182, April 1994.

[10] Liebowitz, pp. 20-21.

[11] The Golden Rule experience with MSAs is discussed in Peter J. Ferrara, "The Health Policy Debate: Options for Reform," National Center for Policy Analysis, Dallas, Texas, Policy Backgrounder no. 132, July 7, 1994, pp. 29-30; and idem, "Medical Savings Accounts: The Private Sector Already Has Them," National Center for Policy Analysis, Dallas, Texas, Brief Analysis no. 105, April 20, 1994.

[12] See Peter L. Spencer, "New Plan Cuts Health Care Costs in Half," Consumer's Research, October 1993, pp. 16-19; Nancy P. Johnson, "Utility Rebates $800 to Employees with Lower Health Costs," Business Insurance, May 14, 1993, pp. 1, 16-17; Ferrara, "The Health Policy Debate," p. 29; and John Merline, "Employees as Health Reformers: Medical Savings Accounts Curbing Premium Costs, Investors Business Daily, March 18, 1994, pp. 1-2.

[13] These examples are provided by Golden Rule Insurance, Indianapolis, Indiana.

[14] Ron Thompson, "Employer Benefits: A Tale of Success," Thompson and Associates, Council Grove, Kansas, 1992.

[15] The information on Plan 3 was provided by Dennis Kelly, president of Plan 3, Bethesda, Maryland.

[16] The experience of Windham Hospital is discussed in Vera Tweed, "Medical Savings Accounts," Business and Health Maga zine, October 1994, p. 44.

[17] The experience of the Health Wealth plan is discussed in Merline, p. 2; and Tweed, pp. 44-45.

[18] The Quaker Oats plan is discussed in Ferrara, "Medical Savings Accounts," p. 30.

[19] The Forbes plan is discussed in ibid., p. 29; and Tweed, p. 45.

[20] The Indresco plan is discussed in John C. Goodman and Gerald L. Musgrave, "The Economic Case for Medical Savings Accounts" (paper presented at American Enterprise Institute Conference on Reforming Health Care, Washington, April 18, 1994).

[21] The United Mine Workers example is discussed in Ferrara, "Medical Savings Accounts," p. 30; Merline, p. 2; and

Tweed, p. 45.

[22] For additional information on state-level MSAs, see Council for Affordable Health Insurance, "Health Care Reform in the States," Alexandria, Virginia, August 1994, pp. 19-24.

[23] Interestingly, current tax treatment of health care is not the result of deliberate policy decisions; it is largely a historical accident. During World War II American busi nesses simultaneously faced a labor shortage and wage-price controls. As a result they began to offer health insurance benefits as a way to lure workers. After the war the prac tice was sufficiently widespread that it became ensconced in the tax code. For a detailed look at how that policy devel oped, see Stuart Butler and Edmund Haislmaier, A National Health System for America (Washington: Heritage Foundation, 1989).