Policy Analysis

Cato Institute Policy Analysis No. 228: Medical Savings Accounts: Answering the Critics

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Executive Summary

As the movement for medical savings accounts (MSAs) picks up speed in Congress, critics of consumer-based health care reform are mounting a counterattack. An examination of the evidence shows that their criticisms of MSAs are just plain wrong. For example:

- Critics claim health care has become so complex that consumers are no longer capable of making cost-conscious decisions about their treatment. However, numerous scientific studies show that health care consumers can and do make cost-conscious decisions when given a financial incentive to do so.

- Critics say consumers will forgo necessary or preventive care to save money in their medical savings accounts, but studies show that MSAs do not deter preventive care. Rather, savings result from reduced use of optional services and cost-based selection among competing providers.

- According to critics, MSAs would attract the healthy, leaving the sick with conventional insurance. If so, that "adverse selection" would drive up the cost of traditional insurance. However, companies currently using MSA-style health plans have not had significant problems with adverse selection.

- Critics claim MSAs are regressive, providing benefits primarily to the wealthy. Our current system of providing a tax break only for employer-provided insurance is far more regressive.

MSAs represent a significant step in solving the problems facing our health care system. Supporters of MSAs should not be distracted by flawed and misplaced criticisms.

Introduction

Despite the defeat of the Clinton health care plan, the need for significant health care reform remains. Health care continues to cost too much. Approximately 40 million Americans still don't have health insurance. Millions of working men and women live in fear that if they lose their jobs they will lose their health insurance.

One of the most popular alternatives for health care reform likely to be considered by the 104th Congress is medical savings accounts (MSAs). Support for this concept cuts across party and ideological lines, with Democrats as well as Republicans, liberals as well as conservatives, supporting MSA proposals.

It is easy to see why this idea is so popular. MSAs would allow individuals to save money in a tax-exempt ac- count, in much the same way they can in independent retire- ment accounts (IRAs) now.[1] The person could use that money to pay routine medical expenses. Then, instead of an expen- sive first-dollar insurance policy, he or she could purchase a relatively inexpensive catastrophic insurance policy to protect against major medical expenses.

It costs an employer more than $5,400 to provide health insurance for a typical American worker today, his or her spouse, and two children.[2] Wouldn't it be better if, in- stead, the employer bought a catastrophic policy (with, say, a $3,000 deductible) for approximately $2,400 and paid the worker the $3,000 difference? The employee could then put that money in an MSA. (See Figure 1.) Any money that wasn't spent 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 the 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.

Most proposals for health care reform focus on govern- ment, physicians, hospitals, and insurers. MSAs are unique because they focus on the most important participant in the health care system--the consumer.

MSAs would establish an incentive for consumers to act responsibly in making their health care decisions. Consumer behavior is a key component in controlling health care costs. Our current system discourages cost-oriented deci- sionmaking and encourages overconsumption and overuse of health care services.

Figure 1
How MSAs Work
[Graph Omitted]
Source: Patient Power.

Under our current third-party insurance system, most health care consumers do not pay for their health care. Nearly 95 percent of hospital bills and more than 80 percent of physician fees are paid for by private health insurance. On the average, 76 cents of every dollar used to purchase health care is paid by someone other than the consumer who purchased it.[3] (See Figure 2). As a result, consumers have little incentive to question costs and every incentive to demand more services.

However, with MSAs, patients would be spending more of their own money, giving them an incentive to become cost-conscious consumers.

A second advantage of MSAs is that they would be com- pletely portable. One of the most serious problems of our current health care system is that insurance is so closely linked with employment.[4] That means that if you lose your job or change jobs, you are in danger of losing your insur- ance. Of the estimated 37 million Americans without health insurance at any given time, half are uninsured for four months or fewer, and only 15 percent are uninsured for more

Figure 2
Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990
[Graph Omitted]

than two years.[5] (See Figure 3.) Most of these temporary, short-term spells without insurance happen to individuals between jobs. With an MSA, individuals would have funds available to pay for health care and health insurance during such temporary interruptions.[6]

Moreover, expenses paid out of an MSA would entail no insurance administrative cost. Insurance is a very ineffi- cient way to pay for small or routine health expenses. Significantly more administrative costs are involved in processing a large number of small claims than in processing a few large claims with an equal dollar value. Indeed, premiums generally fall as average claim size increases.[7] MSAs would cut insurance companies out of the vast majority of health care transactions, particularly small claims where insurance is least efficient. That would reduce both the overall cost of health care and the paperwork burden on doctors.

Figure 3 How Long Do People Go without Health Insurance?

[Graph Omitted]
Uninsured for Fewer Than 6 Months 50%
Uninsured for Less Than 1 Year 72%
Uninsured for Fewer Than 2 Years 82%

Source: "Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," Inquiry 27 (Fall 1990).

However, even as MSAs have gained popularity, those who support a government takeover of the American health care system, supported by large insurance companies who fear a loss of premium income if MSAs become widespread, have mounted a sustained attack on this free-market approach to health care reform. They allege that MSAs would not reduce health care costs, could bankrupt the health care system, and would primarily benefit the wealthy.

Yet an examination of the most common criticisms of MSAs shows that these critiques are either misleading or simply wrong.

Are Consumers Stupid?

From Hillary Rodham Clinton to Alain Enthoven, critics of MSAs have argued that health care has become too complex for average patients to make rational decisions about their treatment. This argument generally takes one of two some- what contradictory tracks: a) consumers will not reduce spending because they will mindlessly accept any treatment proposed by their doctor, and b) consumers will forgo neces- sary and preventive treatment to save money.

Rep. Pete Stark (D-Calif.), for example, has said that patients either "feel they are invincible [if healthy]" or, when sick, are "absolutely brain dead, sniveling, begging and fantasizing ills and pains."[8] Neither is supported by the facts.

Some of the most compelling evidence that consumers can and do make cost-based decisions on health care comes from a study performed by the RAND Corporation in the late 1970s.[9] That study assigned families to four health insurance plans with differing copayment provisions and deductibles. Some families had no copayment or deductible, meaning that the plan paid all their medical bills, while other families had to pay up to 95 percent of the cost of their medical bills, until their bills reached a deductible of $1,000 in 1973 dollars, which is the equivalent of approximately $2,850 in today's dollars.

The RAND researchers observed how the different copay- ment rates influenced the use of medical resources by 2,500 families for three to five years. They concluded that "the data from the Health Insurance Experiment clearly shows that the use of medical services responds to changes in the amount paid out-of-pocket."[10] In particular, families with no copayment used 53 percent more hospital services (mea- sured in dollars) and 63 percent more visits to doctors, drugs, and other services than did the families with the 95 percent copayment. Overall, the total use of medical re- sources was 58 percent greater for the group with no copay- ment, despite virtually identical health outcomes.

Even smaller copayment rates produced savings. The study found that an individual with no copayment spent 18 percent more on health care than an individual with a 25 percent copayment. (For the results of the RAND experiment, see Table 1.)

The RAND study essentially confirms earlier studies by Martin Feldstein and others.[11] In addition, studies of specific health care services such as mental health[12] and prescription drugs[13] have shown that consumers will make cost-conscious decisions if given an incentive to do so.

Table 1 RAND Health Insurance Experiment: Increased Spending over Plans with No Copayment 95% Copayment 25% Copayment Physician visits 167% 137% Outpatient expenses 167% 131% Admissions 129% 122% Inpatient expenses 130% 110% Probability of any use 128% 110% Probability of any inpatient use 130% 123% Total expenses 145% 118% Source: Manning et al. (1987) Note: "95% Copayment" requires out-of-pocket expenditures of 95 cents on the dollar for covered services. "25% Copayment" requires out-of-pocket expenditures of 25 cents on the dollar for covered services.

Several studies have called into question the degree to which physicians are actually able to induce demand.[14] University of Washington economist Michael Morrisey, for example, points out that the inflation-adjusted median income of physicians has declined since 1975, suggesting that physicians are not able to generate an unlimited demand for their services regardless of price.[15] Others suggest that even if physicians are able to induce demand, consumer decisions will still be influenced by their perceived costs as distorted through third-party payments.[16]

Certainly, a person suffering a heart attack or in- volved in an automobile accident is not going to comparison shop for the best price. But fewer than 15 percent of health care expenditures are emergency in nature.[17] For nonemergency services, it is possible for consumers to shop and compare. For example, one study found that the cost for cataract surgery in Illinois ranged from $650 to $5,674 depending on the hospital; hernia surgery ranged from $404 to $4,329; and mammograms ranged from $35 to $178.[18]

MSA critics also warn that consumers lack the informa- tion and expertise necessary to make such decisions. Clear- ly, many patients will have to rely on the advice of a physician that they know and trust. Such patient-physician relationships have long been at the heart of health care, but are not unique to medical goods and services. Few Americans know all the details of automotive repair. When their cars break down, they rely on the advice of mechanics whom they know and trust.

Moreover, the market is already generating an increas- ing number of resources to provide consumers with informa- tion on health care prices, quality, and availability. Automated medical information lines offer prerecorded facts and figures, while live lines such as Ask a Nurse, Doctors by Phone, and Pharmacy Question? offer person-to-person contacts with health care professionals.[19] As more and more consumers take control of their health care decisions, such information resources can be expected to proliferate.

Academic studies of consumer ability to make cost- conscious health care decisions are confirmed by real-world experience. Several companies have established MSA-style insurance plans and have realized significant savings as a result of changed consumer behavior by their workers. Among these are Golden Rule Insurance Company, Dominion Resources, Forbes Inc., Quaker Oats, and Indresco Corporation.[20]

If it is shown that consumers do change behavior ac- cording to financial incentives, MSA critics then move on to part (b) of their argument: consumers will forgo necessary or preventive care to save money. As a result, they will end up sicker and cost the system more money in the future.

However, once again the facts dispute the critics' contention. Analysts studying the RAND Health Insurance Experiment concluded, "We reject the hypothesis that less favorable coverage of outpatient services increases total expenditure . . . by deterring preventive care."[21]

The RAND experiment found that the reduced expenditures are not caused by individuals forgoing truly necessary health care. Health outcomes were virtually identical.[22] Rather, the savings resulted from a reduced use of optional services and cost-based selection between competing provid- ers.

There is even evidence that MSAs will increase the likelihood of seeking preventive care, particularly among low-wage earners. Under conventional insurance, individuals receive no reimbursement until they have met the deductible. That places all the spending disincentive on the first expenditures of the year, expenditures that are most likely to involve preventive care. For low-wage earners, who may lack the resources to pay for these expenses out of pocket, that disincentive creates a strong likelihood that they will forgo preventive care.

MSAs, in contrast, flatten the spending curve, spread- ing the spending disincentive over the entire $3,000 rather than focusing it on the first expenditure.

Indeed, MSAs would actually provide low-wage earners with a pool of money that they could use to pay for preven- tive care. A survey of Golden Rule employees with MSAs found that 20 percent used their MSAs for medical services that they would not have purchased with traditional plans. Yet, overall health spending declined.[23]

MSAs and Health Care Costs

Critics of MSAs also claim that even if consumer behav- ior changed it would have little impact on overall health care costs because the majority of costs occur at a level above the $3,000 deductible envisioned by MSA supporters. As Alain Enthoven puts it, "The $3,000 deductible does nothing to motivate reduction of expenditures on high-cost treatments.... Once someone is told she is pregnant, or has cancer, or must be admitted to a hospital, she might as well write off the $3,000 and say 'bring on more technology.'"[24]

It is clearly true that the vast majority of health care expenditures are made by only a tiny fraction of the population. The evidence suggests that the spending curve steepens sharply after $3,000. In a typical insurance pool about 4 percent of the people spend approximately 50 percent of the health care dollars. (See Figure 4.)

Even so, a substantial portion of health care expendi- tures, between one-third and one-half of all health care spending, is on bills below $3,000.[25] If spending were reduced on just this portion of health care expenditures, overall costs would be significantly affected.

Second, the incentive structure created by MSAs could prevent some expenditures from ever reaching the $3,000 level. For example, if an individual seeking to preserve the $3,000 in an MSA avoids an unnecessary $6,000 operation, she or he reduces spending above the $3,000 level as well as below.[26]

Figure 4
Distribution of Medical Expenses among 50 People
[Graph Omitted]

Source: Patient Power.
Note: Assumes a $250 deductible and a 20 percent copayment on the next $5,000 of expenses. Period of coverage is one year.

Perhaps most important, this argument ignores the impact that reduced prices will have throughout the health care system. If the price of an x-ray is reduced, it will be reduced for people who spend more than $3,000 in a year as well as for those who don't. There is overwhelming evidence that prices will be reduced in response to cost- sensitive purchasing by consumers. For example, a study by Joseph Newhouse and Charles Phelps found that a 10 percent- age point increase in out-of-pocket expenditures resulted in a 2 percent reduction in the price of physician services.[27] Likewise, several studies have found that increased third- party payments have led to price increases, making it likely that decreased third-party payments would lead to price decreases.[28]

That criticism also ignores the tremendous potential for administrative savings with MSAs. Administrative costs amount to between 19.3 and 24.1 percent of total American health spending.[29] Considerably more claims are submitted for expenses below $3,000 than above $3,000. Thus adminis- trative expenses are disproportionately concentrated in low dollar claims. By eliminating much of the paperwork and other administrative costs associated with third-party payment of these claims, overall health care spending could be reduced significantly. Some estimates indicate that MSAs could save as much as $33 billion per year in reduced admin- istrative costs.[30]

Will MSAs Bankrupt the System?

One of the most widely circulated recent criticisms of MSAs has been leveled by John Burry, CEO of Blue Cross and Blue Shield of Ohio.[31] Burry claims that MSAs "would create a large financial shortfall that would bankrupt our health care system."[32] Because Burry's criticism of MSAs appears more scientific than others, it is worth examining his claims in detail.

Burry bases his argument on his analysis of the claims experience of 38,729 families currently insured by Blue Cross and Blue Shield of Ohio. According to Burry, total claims by this group were $159 million, or an average of $4,113 per family. Approximately 10 percent of the families were responsible for 55 percent of this total, or approxi- mately $88 million, with the remaining 90 percent of fami- lies incurring claims of approximately $71 million. For the 10 percent incurring the highest claims, the average charges were $22,747, compared with an average of $2,045 for the remaining 90 percent.[33]

Burry then assumes that a catastrophic insurance policy purchased in conjunction with an MSA would cost $1,200. His assumption is based on the Clinton administration's claims that the cost of health care for the average American family is $4,200 (very close to the $4,113 in charges for Ohio). Burry suggests that if the family subtracts $3,000 for deposit in an MSA, there remains $1,200 to purchase a cata- strophic policy. That would result in a total premium payment of $46.5 million.[34]

Next, Burry estimates that 68 percent of the families would spend less than the $3,000 in their MSAs. These families would average spending $961 from their MSAs, a total of $25.3 million. The remaining 32 percent of fami- lies would spend all $3,000 in their MSA, totaling $37.2 million.[35] Thus, the total spending from MSA funds would be approximately $62.5 million. Adding the $62.5 million in MSA spending to the $46.5 million in catastrophic insurance premiums yields total health care spending of $109 million. But, since claims totaled $159.3 million, this results in a $50.3 million deficit.[36] Projecting this deficit over the entire U.S. health care system leads to a potential short- fall of $83.6 billion.[37]

However, Burry's analysis is far from accurate. For example, Burry confuses "billed charges" with insurance premiums. Under Burry's example, the families had average charges of $4,113. However, assuming an industry standard loss ratio of 75 percent, the families would pay an average premium of $5,484.[38] That means that after putting $3,000 in an MSA, the family would have $2,484 left over, more than enough to pay for a catastrophic policy. This would yield total premiums of $96.2 million. Adding this revised premi- um total to the $62.5 million in MSA expenditures equals total expenditures of $158.7 million. If total charges in the system were $159.3 million, the results are a statisti- cally meaningless deficit of only $600,000.

Second, Burry assumes that the family currently has no out-of-pocket exposure. But that is highly unlikely. Nearly all policies sold by Blue Cross and Blue Shield of Ohio require both copayments and deductibles. If the fami- lies in question averaged only $500 in out-of-pocket expens- es, there would be an additional $19.4 million in the sys- tem, providing an actual surplus of nearly $19 million.

Most important, all of this assumes no change in behav- ior among health care consumers and therefore no reduction in health care expenditures. But the entire concept of MSAs is that it would change consumer behavior.

Similar flaws can be found in a discussion of MSA distributions by the Medical Savings Account Working Group of the American Academy of Actuaries. The actuaries con- clude that "the savings to employers of replacing low-deductible plans with very high-deductible plans would be substantially less than the change in the deductible that the workers would have to pay."[39] Their logic is very simi- lar to Burry's. Because "10 percent of covered individuals account for between 70 and 80 percent of all health insur- ance claims" subsidies by nonconsuming insured individuals are required to hold down premium costs for the catastrophic policies.[40]

However the actuaries also repeat Burry's errors. "For simplicity," the actuaries made three very flawed assump- tions:

1. Current plans "pay all claims (i.e., that the de- ductible amount and coinsurance are all zero)."

2. "There are no administrative costs or profits asso- ciated with the (traditional) plan."

3. There is "no change in behavior" for people with a medical savings account.[41]

Every one of these assumptions is incorrect. As noted above, nearly all current insurance policies require copay- ments and deductibles. Heavy administrative costs are associated with traditional insurance plans, as much as 33.5 cents of every premium dollar, according to some esti- mates.[42] And, as stated above, the purpose of MSAs is to change behavior. Indeed, elsewhere in their report the actuaries themselves propose that MSAs will make Americans "more conscious of their health care and more thoughtful about the casual utilization of care" providing "a substan- tial role in reducing health care inflation."[43]

The actuaries do not agree with Burry that MSAs would bankrupt the health care system, but merely contend that the cost of catastrophic insurance would increase, leaving a gap between the savings an employee would have to deposit in the MSA and the deductible. However, even if this did occur, the vast majority of individuals with low medical

expenses would be unaffected. Those few who did face out-of-pocket expenses would be likely to have less exposure than under traditional deductibles and copayments. Finally, because there would be additional contributions to the MSAs each year, any shortfall is likely to be a one-time occurrence.

Are MSAs Regressive?

According to critics, MSAs would primarily benefit "the rich, because they get the biggest benefit from tax-free investments."[44] They argue that MSAs, like the IRAs they resemble, disproportionately benefit taxpayers in the high- est tax brackets, because all tax deductions are worth more to those individuals.[45]

However, it is today's system of tax breaks only for employer-provided insurance that really favors the wealthy. In this country we give American workers and their families very generous tax relief on their medical expenses, but only on two conditions. First, they must obtain their medical care through health insurance. And second, they must obtain their health insurance through their employers.

As a result, if one works for a Fortune 500 corporation that provides an all-inclusive first-dollar insurance plan, the worker receives it tax free. But a small business owner, waitress, or truck driver has to pay for health care out of pocket or purchase insurance, and receives no tax break at all. MSAs would help to level this playing field, giving these workers a chance to save on a tax-free basis for the health care.

A study by the Congressional Budget Office noted how regressive the current tax structure for health care is. The CBO points out:

> The tax exclusion provides a subsidy for employ- ment-based health insurance premiums that increas- es with the size of premiums, the share of the premiums paid by the employers, and the marginal tax rate. These factors all increase with in- come.... Moreover, families with higher incomes are much more likely to have employment-based health insurance than families with lower in- comes.[46]

A study conducted by Lewin-VHI in 1994 for the Heritage Foundation found that households with incomes greater than $50,000 per year received $35 billion in tax relief, while households with incomes under $20,000 received only $2.7 billion in tax relief.[47] Urban Institute economist Eugene Steurle concludes that the current tax treatment of health care provides a family in the top fifth of income earners almost six times as much benefit as a family in the lowest quintile.[48] (See Figure 5.)

All tax deductions are by nature regressive. MSAs are certainly no more so than the current system. Indeed, the fact that contributions are limited to $3,000 makes them slightly less regressive than the current open-ended tax exclusion. Congress can take steps to replace the current tax exclusion with a universal health care tax credit. Such a credit could even be made refundable. However, such actions are independent of support for MSAs.

Figure 5
Estimated Average Value per Recipient Household of Federal Tax Exclusions for Employer Health Insurance, Fiscal Year 1992
[Graph Omitted]

Quintile of Household Income	
Lowest	$270
Second	$525
Third	$690
Fourth	$1,025
Highest	$1,500

Source: C. Eugene Steurle, "The Search for Adaptable Health Policy through Finance-Based Reform," in American Health Policy: Critical Issues for Reform, ed. Robert Helms (Washington: American Enterprise Institute, 1993).

A corollary of the argument over regressiveness is the assertion by some critics that the poor would lack the money to contribute to MSAs. The Center for Budget and Policy Priorities notes that pre-1986 IRAs were used primarily by those with higher incomes. In 1986, for example, 66 percent of individuals with incomes in the top 4 percent of taxpay- ers took IRA deductions, while only 4 percent of workers with incomes below $15,000 did so. They contend that MSAs would work the same way.[49]

However, contributing to an IRA required an individual to divert income that could have been used for another purpose. It was, in effect, an additional expenditure. For the vast majority of Americans who receive their insurance through their employer, MSAs merely represent a different way of receiving their insurance benefits. No additional expenditure would be required.

Those individuals who do not receive employer-provided insurance would have to make an additional expenditure. However, at least they would receive a tax break for that expenditure, which is more than they receive under the current unfair system. The question of whether and to what degree there should be subsidies to assist these individuals to buy insurance is independent of MSAs.

Finally, it should be noted that if one is concerned about the impact of health care reform on the poor, no one would benefit more than the poor from the lower health care prices that MSAs are designed to bring about.

The Adverse Selection Problem

The final criticism leveled by critics of MSAs is that such a plan would appeal primarily to the young and healthy, leading to adverse selection that will drive up the cost of traditional first-dollar coverage.

In analyzing MSAs in 1994, the Congressional Budget Office warned that "the availability of the catastrophic- plus-MSA option would exacerbate the problem of adverse selection."[50] According to the CBO, as healthy people in- creasingly choose MSAs combined with catastrophic insurance, the pool of people purchasing traditional low-deductible insurance will become steadily sicker. To compensate, insurers will have to increase the cost of such insurance. Eventually, low-deductible insurance will become so expen- sive as to "threaten the existence of standard health insur- ance."[51]

The problem of adverse selection becomes even worse if individuals can move freely from one insurance policy to another. As the Center for Budget and Policy Priorities warns, "There would be strong incentives to accumulate tax-advantaged savings [in medical savings accounts] at times when few health care expenses are anticipated.... When medi- cal expenses became more probable, the individual could simply switch to comprehensive coverage and keep the MSA accumulation as savings."[52]

The experience of companies currently using MSA-style health plans has not shown significant problems with adverse selection. At companies such as Golden Rule, employees with chronic illnesses have chosen MSAs nearly as frequently as have healthy workers. The reason is that the copayments and deductibles under traditional insurance leave those workers with chronic conditions facing significant expenses every year. Under such a traditional policy, a worker with a $250 deductible and a 20 percent copayment up to $3,000 and a chronic condition costing more than $15,000 per year can anticipate paying $3,250 out of pocket every year. With an MSA, the worker would have little or no out-of-pocket ex- pense.

In addition, the likely alternative to MSAs, managed care with its limits on the choice of physician and treat- ment and restrictions on access to specialists, can be unpopular with the chronically ill. Indeed, a study from the National Center for Policy Analysis demonstrates that it is the chronically ill who are most likely to be short- changed under managed care.[53] Therefore, MSAs may well be a popular alternative for this group.

However, if adverse selection did occur and increase the cost of low-deductible policies, that would not neces- sarily be a bad thing. It is traditional, low-deductible insurance that is driving up the cost of health care. If such policies become unsustainable and most Americans move to an MSA plus catastrophic coverage, the result will be lower health care costs. The market will merely have pro- vided an incentive for a socially beneficial change in behavior.

The issue of individuals using MSAs when healthy and shifting to traditional insurance when they become sick would exist primarily in an environment where insurance was not properly risk rated. If insurers are permitted to base premiums on an individual's health status and to refuse coverage to individuals with preexisting conditions, it would not be possible to "game" the system in this manner. Therefore, this critique becomes an argument against community rating and "guaranteed issue," not against MSAs.

Conclusion

MSAs are not a "magic bullet" that will solve all our health care problems. However, they will have a significant impact on reducing health care costs, while expanding access to care and preserving consumer choice and the quality of our health care system.

Ultimately, only three entities can control health care costs: government, through rationing; insurance companies, through managed care (another form of rationing); or indi- vidual consumers. MSAs provide the incentive for individual consumers to make cost-conscious decisions. Recent criti- cisms of MSAs are not accurate.

1. Consumers are capable of making cost-conscious decisions about health care purchases.

2. In making cost-conscious decisions, consumers do not forgo necessary or preventive care.

3. MSAs will reduce costs throughout the health care system, not just on spending below $3,000.

4. MSAs will not bankrupt the health care system.

5. MSAs are no more regressive than the current health care system.

6. The adverse selection problem has been over- stated.

Medical savings accounts may not be perfect, but they represent a significant step in solving the problems facing our health care system. Supporters of MSAs should not be distracted by flawed and misplaced criticisms.

Notes

[1] For a full discussion of MSAs see John C. Goodman and Gerald Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato Institute, 1992).

[2] KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits, 1994.

[3] Goodman and Musgrave, p. 77.

[4] The link between employment and insurance is largely a historic accident. During World War II, American businesses simultaneously faced a labor shortage and wage-price con- trols. As a result they began to offer health insurance benefits as a way to lure workers. After the war, the practice was sufficiently widespread that it became ensconced in the tax code, making employer-provided health insurance a tax-free benefit, while individually purchased insurance received no tax break. Today, nearly 85 percent of people with health insurance receive it through their employers. For a detailed look at how this policy devel- oped, see Goodman and Musgrave, pp. 137-63.

[5] Katherine Swartz and Timothy McBride, "Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," Inquiry 27 (Fall 1990).

[6] Under current law, individuals who leave an employer who employs more than 25 workers and provides health insurance are entitled to pay the premiums and extend their coverage for up to 18 months. However, most newly unemployed persons are not able to pay the premiums and allow their insurance to lapse. An MSA would provide a pool of funds that could be used to pay the premium during this period of unemploy- ment.

[7] See, for example, Alan Sorkin, Health Economics: An Introduction (New York: Lexington Books, 1992), pp. 168, 182.

[8] Remarks by Congressman Fortney "Pete" Stark to a confer- ence on "Prospects for Health Care Reform Under Clinton," Washington, D.C., January 14, 1993.

[9] Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine (December 17, 1981): 95-112. See also Willard G. Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," American Economic Review (June 1987): 251-73. [10] Manning et al., p. 258.

[11] See, for example, Martin Feldstein, "Econometric Studies of Health Economics," in Frontiers of Quantitative Econom- ics, ed. D. Kendrick and M. Intrilligator (Amsterdam: North Holland Press, 1974); Richard Eichhorn and Lu Ann Aday, The Utilization of Health Services: Indices and Correlates: A Research Bibliography, NTIS No. PB-211 720 (1972); Avedis Donabedian, Benefits in Medical Care Programs (Cambridge: Harvard University Press, 1974).

[12] Richard Frank, "Pricing and Location of Physician Ser- vices in Mental Health," Economic Inquiry (1985): 115-33; John Wallen, Paul Roddy, and Michael Fahs, "Cost Sharing, Mental Health Benefits, and Physical Complaints in Retired Miners and Their Families" (Washington: American Public Health Association, 1982).

[13] Alan Liebowitz, Willard Manning, and Joseph Newhouse, "The Demand for Prescription Drugs as a Function of Cost- Sharing," Social Science and Medicine (1985): 1063-69.

[14] See, for example, David Kenkel, "Consumer Health Infor- mation and the Demand for Medical Care," Review of Economics and Statistics (1990): 587-95; Roger Feldman and Frank Sloan, "Competition Among Physicians Revisited," Journal of Health Politics, Policy, and Law (1988): 239-62.

[15] Michael Morrisey, Price Sensitivity in Health Care: Implications for Health Care Policy (Washington: NFIB Foun- dation, 1992).

[16] David Dranove, "The Five W's of Utilization Review," in American Health Policy: Critical Issues for Reform, ed. Robert Helms (Washington: American Enterprise Institute, 1993), pp. 239-55.

[17] Rita Ricardo-Campbell, The Economics and Politics of Health Care (Chapel Hill: University of North Carolina Press, 1991).

[18] Joseph Bast, Richard Rue, and Stuart Wesbury, Why We Spend So Much on Health Care (Chicago: Heartland Institute, 1992).

[19] "Hold the Phone," Harvard Health Letter, November 25, 1992.

[20] For a complete discussion of private-sector experience with MSAs, see Peter Ferrara, "More Than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis no. 220, March 14, 1995.

[21] Manning et al., p. 262.

[22] There were three exceptions: hypertension, myopia, and dental care. However, researchers suggest that "programs targeted specifically at these problems would be much more cost-effective in achieving these gains." Ibid.

[23] "Answering the Critics of Medical Savings Accounts: Part II," National Center for Policy Analysis Brief Analysis, no. 133, September 16, 1994.

[24] Alain Enthoven, letter to the editor, Wall Street Jour- nal, July 22, 1994.

[25] "Answering the Critics of Medical Savings Accounts: Part I," National Center for Policy Analysis Brief Analysis no. 132, September 16, 1994.

[26] "Unnecessary" in this context does not mean the opera- tion has no value, but that the value is insufficient to justify the expense.

[27] Joseph Newhouse and Charles Phelps, "New Estimates of Price and Income Elasticities," in The Role of Health Insurance in Health Sector Services, ed. Robert Rosset (New York, National Bureau of Economic Research, 1976).

[28] See, for example, Frank Sloan, "Effects of Health Insur- ance on Physician Fees," Journal of Human Resources (1982): 331-57.

[29] Steffie Woolhandler and David Himmelstein, "The Deterio- rating Administrative Efficiency of the U.S. Health Care System," New England Journal of Medicine 324, no. 18 (May 2, 1991): 1253-58.

[30] Stan Liebowitz, "Why Health Care Costs Too Much," Cato Institute Policy Analysis no. 211, June 23, 1994, pp. 20-21.

[31] John Burry Jr., Medical Savings Accounts: Bad Medicine for the U.S. Healthcare System (Columbus: Blue Cross and Blue Shield of Ohio, 1994). Burry makes essentially the same argument in a second monograph, A Windfall for the Healthy: How Medical Savings Accounts Will Hurt Americans and Hurt Business (Columbus: Blue Cross and Blue Shield of Ohio, 1994).

[32] Burry, Medical Savings Accounts, p. 4.

[33] Ibid., p. 7.

[34] Ibid., pp. 7-10.

[35] This assumption is contrary to the usual distribution of medical expenses. Generally, only 10 percent of Americans spend more than $3,000 per year on health care. See, for example, Blue Cross and Blue Shield Association, Reforming the Small Group Health Insurance Market, March 1991, p. 6. An Ohio think tank, the Buckeye Center for Public Policy Solutions, which examined Burry's numbers, concluded that Burry's inflation of the number of Americans spending more than $3,000 per year overstates the drain on the health care system by at least $3.5 million (Bradley Smith and Samuel Staley, "Medical Savings Accounts and 'Real World' Health Care Economics in Ohio," Buckeye Center Policy Brief, June 29, 1994). However, for the sake of discussion, this paper accepts Burry's projection.

[36] Burry, Medical Savings Accounts, pp. 9-10.

[37] Ibid., p. 12. To obtain this total, Burry divides his $50.2 billion shortfall for Ohio by the 38,729 in his study for an average per family shortfall of $12,967. He then multiplies that by 6.45 million American high-use families, representing 10 percent of the 64.5 million American fami- lies.

[38] Burry subsequently claimed that Blue Cross and Blue Shield of Ohio has overhead costs of only 10 percent (letter to the editor, Cleveland Plain Dealer, September 17, 1994). However, other industry professionals dispute this claim.

[39] Letter from the American Academy of Actuaries, Medical Savings Account Working Group, to the United States Senate, August 29, 1994.

[40] Ibid.

[41] Ibid.

[42] Richard Koenig, "Insurers' Overhead Dwarfs Medicare," Wall Street Journal, November 15, 1990.

[43] Letter from the American Academy of Actuaries, p. 4.

[44] "Don't Be Seduced by Medisave," New York Times, August 16, 1994, p. A26.

[45] Iris Lav, "Medical Savings Accounts Impede Universal Coverage," Center on Budget and Policy Priorities, August 17, 1994.

[46] Congressional Budget Office, "The Tax Treatment of Employment-Based Health Insurance," March 1994.

[47] See Stuart Butler, "A Policy Maker's Guide to the Health Care Crisis: Part II: The Heritage Consumer Choice Health Plan," Heritage Talking Points, March 5, 1992.

[48] C. Eugene Steurle, "The Search for Adaptable Health Policy Through Finance-Based Reform," in American Health Policy: Critical Issues for Reform, ed. Robert Helms (Wash- ington:American Enterprise Institute, 1993), pp. 334-61.

[49] Lav.

[50] Congressional Budget Office, "An Analysis of Congressman Michel's Health Proposal," August 29, 1994, pp. 5-7.

[51] Ibid.

[52] Lav, p. 4.

[53] John Goodman and Gerald Musgrave, "A Primer on Managed Competition," NCPA Policy Report no. 183, April 19, 1994.