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Medical Savings Accounts
Progress and Problems under HIPAA

by Victoria Craig Bunce

Executive Summary

Medical savings accounts (MSAs) have shown that they can help health care consumers control costs, exercise greater choice in and control of their own health care, improve access to medical care, and increase personal savings. Early experiments with MSAs achieved modest success by the mid-1990s. The Health Insurance Portability and Accountability Act of 1996 established a five-year MSA demonstration project for a select group of individuals—employees of small firms with 50 or fewer workers and self-employed individuals. MSAs under HIPAA provided federal tax deductions for contributions to multiyear savings accounts established for medical purposes.

HIPAA MSAs were handicapped by rules that limited their availability and growth over the last four years. HIPAA imposed unnecessary complexity, restricted the scope of the MSA project, and created a number of MSA design problems. Last December the HIPAA MSA project was about to sunset when Congress renewed it for another two years, until December 31, 2002. However, Congress failed to fix any of the underlying problems plaguing HIPAA MSAs. It simply renamed them "Archer MSAs" in recognition of the role of Rep. Bill Archer (R-Tex.) in enacting them.

On February 28 President George W. Bush proposed that MSAs be made permanent and liberalized. The Bush administration's budget plan for fiscal year 2002 would remove HIPAA's cap on the number of MSAs and the restriction related to employer size. All employees and individuals covered by a high-deductible health plan would be eligible for MSAs. The Bush MSA reforms would lower the minimum annual deductible amount eligible for tax advantages as a high-deductible health plan, allow annual MSA contributions up to 100 percent of the applicable maximum deductible, and permit employees and employers to combine their MSA contributions to reach that annual limit.

To provide a fairer test of MSAs for all Americans, Congress should peel away the remaining legislative and regulatory restrictions on federally qualified MSAs. Expanding the availability of tax-advantaged MSA plans with high-deductible insurance could allow many Americans to economize on insurance costs, save for future medical and long-term-care expenses, and still remain protected against the risks of catastrophic illness. Potential MSA customers certainly will be interested in purchasing more-flexible and better-structured MSA plans.

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Introduction

The Health Insurance Portability and Accountability Act of 1996 gave employers of 50 or fewer workers (hereinafter "small employers") and the self-employed a new health care coverage option, medical savings accounts (MSAs). Health plans with MSAs can reduce health insurance premiums and enable insured individuals to accumulate their savings in tax-advantaged accounts that can be accessed to cover out-of-pocket medical expenses.

Although various types of MSA insurance products have been available for the past decade or so at the state level,[1] HIPAA authorized the first federal program allowing federal tax breaks on multiyear savings accounts established for medical purposes.[2] Nineteen states also allow state income tax deductions for MSA contributions.[3]

As the original HIPAA MSA demonstration project neared its four-year deadline last December, participation levels remained disappointingly low. The most recent estimate of total HIPAA MSAs, issued by the Internal Revenue Service in October 1999, indicated that there were a few more than 42,000 MSA holders in tax year 1998.[4] Although more recent private industry estimates suggested that as many as 100,000 MSAs had been opened by last year, that figure remained well short of the HIPAA participation limit of 750,000 MSA holders.

The federal MSA program was poorly designed. HIPAA restricted the scope of the demonstration project, imposed unnecessary complexity, and hampered the design of consumer-friendly MSA products.

Several efforts to correct the structural flaws and handicaps that limited the growth of HIPAA MSAs fell short during the 106th Congress. The political fight over MSAs in Congress remained fundamentally about control. MSAs give control to patients and physicians. Expanded use of private MSAs would thwart the goals of advocates of nationalized health care and reduce the market for managed-care insurance.

During last year's presidential campaign, Republican candidate George W. Bush advocated permanent legal status for an expanded version of MSAs that would be available to all Americans.[5] With the HIPAA MSA pilot program set to end on December 31, 2000, Congress voted on December 15 to extend that deadline another two years, but it did not address the underlying problems hampering federally qualified MSAs.[6]

Earlier this year President Bush redeemed his campaign promise when he offered new tax provisions to extend permanently MSAs and make them available to anyone covered by a high-deductible health plan.[7] On April 4 Reps. Bill Thomas (R-Calif.) and William Lipinski (D-Ill.) introduced the Medical Savings Account Availability Act of 2001 (H.R. 1524), which would expand and improve access to MSAs in a similar manner. On June 20 Sens. Charles Grassley (R-Iowa), Robert Torricelli (D-N.J.), and Larry Craig (R-Idaho) introduced nearly identical Senate legislation (S. 1067).

In this paper I explore the concept of MSAs, examine their history, and show how they have worked in practice. Regardless of the federal income tax treatment of MSAs, employers and individuals across the nation already have established and successfully used both federally qualified MSAs under HIPAA and other "nonqualified" MSAs.[8] I then analyze the future of MSAs and outline a number of policy measures that could improve and expand MSAs for everyone.

How a Typical MSA Works

An MSA health plan provides a health care savings account in combination with a high-deductible health insurance policy. The savings account is controlled by the insured person and used to pay routine health care expenses. The accompanying catastrophic insurance policy covers more substantial health care costs.

In most instances (particularly to qualify

for federal tax benefits under HIPAA), MSAs are established by either self-employed workers or employers on behalf of their employees. The cost of an MSA plan's high-deductible health insurance policy is usually significantly less than the cost of a low-deductible policy.[9] The high-deductible policy protects the insured from catastrophic illness, prolonged hospitalization, or a particularly unhealthy year. The money saved by purchasing less-expensive insurance may be used to increase contributions by an individual or his employer to an MSA administered by a designated trustee or custodian—usually a bank or an insurance company.

Funds accumulated in the MSA may be used to pay initial medical expenses incurred by the insured and his family in a given year. When qualified medical expenses for that year exceed the MSA plan's deductible, insurance payments under the high-deductible policy begin to cover most, if not all, medical expenses (depending on the plan's scope of covered services and any other cost-sharing features, such as coinsurance or copayments). In general, once the total out-of-pocket maximum (the "stop-loss" level) is reached under the high-deductible policy, the insurance plan will cover all remaining medical expenses. Unspent MSA funds, including any interest or investment earnings, accumulate from year to year, providing additional money to cover possible medical expenses in the future.

MSAs improve health care financing options and offer a number of advantages. They control costs, improve access to health care, expand consumers' choice in and control of health care, and increase savings.

MSAs Control Costs

MSAs are not the panacea for controlling health care cost increases, but they are a step in the right direction. The tax treatment of insurance premiums for employer-funded MSAs is similar to that already accorded other employer-sponsored health insurance plans.[10] However, MSAs also reallocate some current health care dollars that would normally be spent on insurance premiums and allow them to remain under the direct control of individual workers. Those dollars then may be spent on actual health care services (not just insurance coverage) or saved for future health care needs. By putting individuals back in control of more purchasing decisions, MSAs create incentives for individuals to purchase health care more prudently and reduce their overall health care spending in a given year.[11]

One of the major factors driving health care costs higher has been the increasing share of medical bills paid by third-party payers (private health insurers, employers, and government agencies) in the U.S. health care system. Most health care consumers do not pay directly for their own health care. Nearly 97 percent of hospital bills and more than 84 percent of physicians' fees are paid by private health insurance. On average, 80 cents of every dollar used to purchase health care is paid by someone other than the consumer who receives the care.[12]

Third-party payment of health care bills insulates individual consumers from the real cost of their health care decisions and treatment. With little incentive to control health care costs, consumers have less reason to avoid unnecessary care, question costs, or shop around for the best treatment available at a reasonable price. They do have every incentive to demand more services. Because the degree of third-party payment varies greatly among different types of health services, patients and their doctors also are more likely to choose services with greater insurance coverage even when alternative services with less coverage may be at least as effective and less expensive.[13]

Excessive third-party coverage with low deductibles increases administrative costs. Regardless of the dollar amount of any particular bill submitted to the third-party payer, every bill must be reviewed and checked for accuracy. In addition, the third-party payer must maintain some system for ensuring that the prices charged are reasonable and customary and that the services provided are covered

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benefits under the policy. Processing so many single claims and authorizing their payment require a costly bureaucracy of medical reviewers and claim adjusters.[14]

MSAs provide a different type of cost control mechanism than do the tools used by managed-care insurance plans. Because managed care relies on third-party control of the availability of health care services, it is less effective in curtailing overuse of routine, outpatient medical services. Managed-care plans may be more effective in dealing with high-cost conditions for which there are alternative treatment options.[15]

MSAs are designed to address the fundamental problem of controlling health care costs without resorting to third-party restrictions on access to care. Instead of limiting the *supply* of desired medical services, according to the type of criteria commonly used by managed-care insurers or government bureaucrats, MSAs lower the *demand* for those services by requiring individuals to pay directly and up-front for their discretionary health care choices. MSAs integrate the consumer goals of quality, choice, and cost control by putting the individual consumer back in charge of meeting them. Whereas other health care financing arrangements often frustrate or annoy consumers to various degrees, MSAs empower consumers and increase their satisfaction.

MSAs work best in controlling and reducing the use and costs of low-dollar, routine, discretionary medical care, as illustrated by the RAND Corporation's Health Insurance Experiment. The RAND HIE involved a controlled trial of how the design of insurance benefits might affect medical use, medical expenses, and health status. The HIE was one of the largest and most comprehensive health care research projects ever conducted. It examined health expenditures of 2,500 families from 1974 to 1982. Each family was provided with one of four different insurance plans. The level of out-of-pocket cost sharing under the plans ranged from none at all to 95 percent of the family's first $1,000 in annual health care expenses.[16]

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Families with no deductible (0 percent coinsurance) incurred hospital expenses 30 percent higher and spent 67 percent more for doctors' visits, drugs, and other outpatient health care services than did families with the highest deductibles.[17] Manning et al. concluded that a catastrophic insurance plan reduced expenditures 31 percent relative to insurance with zero out-of-pocket cost sharing.[18] The RAND HIE demonstrated that the more people had to pay for medical care without insurance reimbursement, the less they would spend on total medical care. In comparing patients in "free care" plans with those in plans requiring more sharing of costs, RAND researchers detected no significant effects on their health status and health habits.[19]

MSA plans achieve similar savings by reducing the misincentives of first-dollar and low-deductible health insurance coverage.[20] When provided with comprehensive insurance coverage, patients naturally will seek all the care possible, however unlikely it is that additional services will have a beneficial effect or how slight that effect may be. When physicians and other health care vendors are compensated according to the volume and price of the services they provide, they too have a financial incentive to order or suggest additional or more expensive tests and procedures. On the other hand, consumers with MSAs can increase their savings in personal accounts by reducing their out-of-pocket payments for marginally beneficial, discretionary health care items. Medical providers who wish to retain those customers must adjust their practice styles accordingly.

A high-deductible or catastrophic health insurance arrangement also has fewer administrative costs and complexities than does more comprehensive insurance coverage.[21] Because MSAs cut out the excessive administrative expenses associated with billing and coding at both the physician and the insurer levels for routine or discretionary health care expenses, health care practitioners can charge a fair or "best" price that reflects the level of professional services they

perform. In many cases, the discounted price can be as much as 35 percent to 50 percent lower when patients pay in full at the time they are seen.[22] Although physicians and other health care providers once considered it a common courtesy to offer to bill insurance companies on behalf of their patients, the practice has become an increasingly expensive headache, according to Vern S. Cherewatenko, M.D., medical chairman, president, and CEO of the American Association of Patients and Providers and founder of SimpleCare. However, the ease of the medical savings account payment method appeals to both physicians and patients.[23]

SimpleCare, based in Renton, Washington, offers one example of providers who pledge to offer their best price to patients who pay in full at the time of service.[24] SimpleCare asserts that the high cost of insurance-related administration runs up the cost of medical care, even for cash-paying consumers. The SimpleCare program is a separate medical care payment system with no insurance-related costs. It is available to patients when they pay by cash, check, or credit card at the time of the medical service. The medical provider eliminates all activities related to insurance. In the SimpleCare program, many patients save up to 30 percent or more by paying out of their own pockets.[25] Moreover, without administrative "red tape," health care providers have more time available to focus on the patient's needs rather than the health insurance company's demands.

For example, the SimpleCare program is used in a family practice clinic just south of Seattle, Washington. The clinic's typical "list" office visit charge of $79 (including billing, rebilling, and complying with insurance-related requirements) is reduced to from $35 to $45 when patients pay for services at the time they are rendered. In the case of fully insured coverage, the cost of billing, collections, coding, reporting, and meeting multiple layers of both government and insurance company requirements is included in the overall price. Some of those requirements can prevent the physician from providing the services that he would ordinarily recommend to the patient, because of the multiple parties to whom he has to answer. Insurance companies or government health programs may approve only certain benefits or tests even though the physician would rather choose others. The physician must then take into account possible denial of payment, or simply the amount of paperwork needed to gain approval, before deciding whether to order a different test or recommend another type of service. In the "cash payment" case, the physician supplies the services that the patient needs and charges only for those services. The patient pays the entire bill before leaving the office.

Simply Medicine in Wallingford, Vermont, is an example of an acute care walk-in clinic where patients know what fees they will be charged: $2 per minute for labor, $5 for an ear wash, $30 for a knee splint, $10 for a suture, $2 for a large bandage, and $1 for a small one. Dr. Lisa Grigg accepts only cash, does not accept insurance, and will make house calls. Two-thirds of her patients have health insurance but waive its coverage. Her services are no more expensive than the insurance copayment that patients otherwise would often have to pay. Her patients frequently would rather walk into the Simply Medicine clinic for routine medical care than wait longer to see their regular doctors. Grigg says she wanted a way to return some control to the patient.[26]

In addition to reducing administrative costs, MSAs can lower the overall expense of health care by encouraging consumers to substitute outpatient care for inpatient care, choose health care services that are economical, or seek out the best competitive alternatives on the basis of both service and price. MSA holders may choose more-efficient and lower-cost providers. They may review physician care and question the value of particular medical procedures or decide to reduce the number or intensity of outpatient visits they make. They may negotiate treatment prices or seek discounts for paying their physicians directly. They also may ask for generic

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instead of brand-name drugs when being prescribed medication by a physician.

According to the Council for Affordable Health Insurance, MSAs can lower outpatient costs by at least 25 percent and possibly as much as 50 percent. Inpatient cost savings may be as much as 20 percent. The range depends on a number of factors: type of plan, plan design (e.g., managed-care components), discount, relative differences between cost sharing under a traditional health benefit plan and an MSA plan, demographics, benefits, and geography.[27]

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MSAs Improve Access to Health Care

Even when low- and moderate-income families receive employer-sponsored health coverage, they still may not have sufficient cash on hand to meet their insurance plan's copayments and deductibles. Many other individuals without access to employer-sponsored health coverage may lack the funds to begin purchasing coverage on their own. MSAs can assist those people by providing more financial flexibility. MSA plans reduce fixed monthly costs (health insurance plan premiums) and increase reliance on discretionary and variable payments (monthly MSA contributions). By providing less-expensive insurance coverage, MSAs allow families to address other pressing financial needs yet still maintain protection against more costly health risks that they cannot handle on their own.

For example, if a worker gets occasional overtime pay, he can use that money to fund the savings component of his MSA plan. At other times, he can continue making the fixed monthly premium payment for the health insurance component (which is lower than premiums for more comprehensive low-deductible insurance) and delay the MSA contribution. As other periodic demands (back-to-school expenses, emergency car repairs, and the like) on family income arise, a family can delay its MSA contribution for a brief period and then catch up when the crisis passes. Without this flexibility, the family might not be able to make its monthly premium payment and would have to drop its health insurance coverage. An MSA plan allows a family to remain covered by health insurance in case a serious medical need arises, while *delaying* contributions to the MSA. If funds in the MSA have accumulated over time, the family may withdraw them to pay for medical needs as they arise.

Because MSA plans are linked to high-deductible insurance that covers health claims that are more catastrophic in nature, they make the cost of insurance coverage more affordable for most Americans. In particular, less-comprehensive coverage will mean lower insurance premiums for a larger fraction of people with low incomes. Those lower premiums also will be more attractive to low-risk people who may want less than full coverage and therefore may not decide to purchase higher-priced, standardized insurance policies.[28]

Because MSAs are individually owned, they are fully portable and remain available to an individual consumer when employment opportunities change. Because the amount of built-up savings in MSAs is likely to increase over time, account holders will have access to those financial resources in the event that they become unemployed or cannot count on continued access to employer-provided health coverage. They can use MSA funds to help maintain existing health insurance coverage or buy new coverage on their own. MSA balances will help provide individuals greater freedom to change jobs and worry less about jeopardizing their health insurance coverage.[29]

Unlike other federal and state requirements for preserving access to insurance coverage (continued health care coverage mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, HIPAA portability protections, state health insurance continuation and conversion laws), MSAs in many cases provide up-front the funds that enable workers and their families to pay for health insurance premiums at the very time that it is most difficult for them to do so.[30] Most federal and state options for

preserving health insurance coverage are generally available only when people are financially least able to exercise them. Premiums under those additional sources of coverage must be paid out of pocket, without any tax assistance or "contributions" by an employer.

MSAs also might improve access to insurance by encouraging health insurers to relax their administrative rules, engage in less underwriting, and enroll higher-risk individuals—because insurers face less health cost exposure and reduce their administrative costs with high-deductible policies.

MSA plan coverage under the HIPAA pilot program already has provided increased access to health insurance for previously uninsured individuals. For example, the U.S. General Accounting Office found that almost 4 of every 10 people who set up tax-qualified MSAs during 1997 were previously uninsured.[31]

MSAs Expand Consumers' Choice and Control of Their Health Care

Much of the backlash against employer-sponsored managed-care health plans is founded on resentment of their third-party restrictions on workers' choice of health plans, doctors, and benefits. Even as choice is increasing in many other areas of our lives (cable and satellite options for television, vouchers and charter school alternatives in education, new competitive challenges to classic monopolies like electricity and local telephone service), choice in health care is being curtailed.

As long as employers, insurers, and governments handle most of the financing of health care coverage, they will try to hold down rising costs by intervening in the health care decisionmaking process. Their primary tool for containing costs has been managed care, which largely removes the individual patient from negotiations over the scope of benefits, levels of payment, and course of medical treatments. Providers have learned that, in order to get paid, they have to satisfy third-party payers, not just their patients.

Unlike managed-care plans, MSAs provide people the opportunity to spend their own funds for health care however they choose. MSAs allow individuals to go directly to a specialist rather than through a "gatekeeper." At the same time, they empower individuals to hold down health costs by self-managing their routine medical care decisions.

Managed-care plans assemble a large number of customers to amass bargaining power and seek volume discounts on routine medical services. MSAs empower individuals to target their personal bargaining power to maximize the quality of the service they receive for the price they agree to pay. Individuals can push medical prices downward by selecting the most competitive health care providers, reducing their use of overpriced or unnecessary services, and negotiating prices for routine medical care. For example, syndicated columnist Betsy Hart wrote about her MSA experience. Her pediatrician, internist, and allergist all agreed to cut their charges by 30 percent or more when she told them she would pay the bills herself at the time of service. In fact, the hospital where she delivered her last baby dropped its all-inclusive fee from almost $6,000 to $3,000.[32]

Under many third-party health benefit arrangements, consumers have little incentive or ability to become more knowledgeable about health care. With little economic responsibility and decisionmaking left in the hands of the consumer, there is little reason to become informed about the alternatives. On the other hand, MSAs stimulate consumer demand for information about the quality and price of care.

The Federal Employees Health Benefits Program provides a powerful example of how the level of demand for information rises dramatically when health care consumers face choices and financial incentives to choose wisely. The FEHBP is the largest employer-sponsored health benefits program. It began covering federal employees in 1960 and now provides benefits to some 9 million federal enrollees and dependents through contracts

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with about 300 carriers.[33] Federal employees have a wide range of options when they choose a health plan each year, but they have to contribute more of their own money to purchase more expensive plans. Each year the U.S. Office of Personnel Management publishes a handbook containing reams of information about the costs and benefits of available plans. A private publication, *Washington Consumer Checkbook,* provides even more extensive information and advises federal employees about how the FEHBP system works and which health plans offer the best deals.

MSAs provide flexibility so that individuals can spend their funds on services that may not traditionally be covered by health insurance, such as acupuncture, holistic healing, and chiropractic care. Even with more than 1,200 state-mandated health insurance benefits,[34] there is no guarantee that a particular unique or less-popular benefit will be covered by one's insurance policy. Indeed, the cost of unnecessary mandated benefits may crowd out the ability to include other benefits in an affordable health plan. On the other hand, tax-qualified MSA funds may be withdrawn without tax consequences or additional penalties for any kind of medical care, as defined quite broadly by section 213(d) of the Internal Revenue Code.[35] Once an MSA holder decides what medical treatment would work best for him, he can pay for it out of MSA savings, instead of submitting a claim to his insurer and running the risk of learning later that the treatment is not considered a covered benefit.

Thus, by helping to place consumers back in a central role in the health care decision-making process, MSAs expand consumer choice, restore accountability in the health care system, and strengthen the patient-physician relationship.

MSAs Increase Saving

MSAs reward consumers who decide to spend less on discretionary health care and instead retain a larger balance of funds in their MSAs to accumulate over time. In the case of most tax-advantaged MSAs, the interest earnings on those funds also are not taxed, as long as they are not withdrawn for nonmedical purposes. After several years of moderate health care spending, a sizable nest egg could be available for future medical or long-term-care expenses.[36]

MSAs are different from flexible spending accounts (FSAs) for health care. Under FSAs, which may be offered as cafeteria-style options under many employee benefits plans, the employee must declare how much money he is going to spend on medical care for the upcoming year. At the end of the year, any remaining money not spent on health care reverts back to the employer and the employee loses it.[37] On the other hand, MSAs provide incentives for long-term saving, because MSA funds that are not withdrawn can be rolled over at the end of each year and remain available for the employee's future use.

MSAs Are Not New

Since the mid-1970s, the vision of empowering consumers to become more involved in financing and purchasing their own health care has prompted great interest in both the private sector and the public sector. Medical savings accounts were first known as individual accounts within a "health bank." They have been referred to as "medical IRAs," "medical care savings accounts," and, more recently, "medical savings accounts."

How the MSA Concept Evolved

Health policy experts often refer to Jesse Hixson, principal economist for the American Medical Association, as "the Father of MSAs." Others may associate MSAs closely with Pat Rooney, chairman of Golden Rule Insurance Company.[38] During the last year of the Nixon administration (1974), Hixson and Paul Worthington (who were both working in a department of the Social Security Administration that later became the Health Care Financing Administration) developed the idea of health banks. Employer health care contributions would be deposited in

employees' individual savings accounts within a financial institution given a special charter to handle health loans. By pooling multiple deposits, health banks would be able to provide loans for major medical needs if sufficient money was not available in an employee's individual account.

The underlying theory was that most major health care expenses augment one's health status, but they should be financed over time. Particularly for routine, discretionary health care items, people would spend their own money more wisely than someone else's money.[39]

In the early 1980s, Hixson enlisted the involvement of John Goodman at the National Center for Policy Analysis in Dallas, Texas. At the same time, other groups such as the Louisiana State Medical Society and the American Medical Association started thinking independently about similar concepts. The AMA encouraged businesses to develop the concept into a health benefit option for employees.[40]

In 1984 John Goodman and Richard Rahn, then chief economist for the U.S. Chamber of Commerce, published a *Wall Street Journal* article that outlined a plan to privatize Medicare with medical individual retirement accounts (IRAs).[41] In 1990 NCPA organized a task force to develop a free-enterprise approach to health policy issues. The group, comprised of representatives of more than 40 think tanks, universities, and other organizations, proceeded to carefully consider the medical IRA concept and encouraged NCPA to advocate development of medical savings accounts. In 1992 NCPA president Goodman and senior fellow Gerald Musgrave built the popular case for MSAs in *Patient Power*.[42]

Private-Sector Initiatives

Private-sector MSA prototype plans began to emerge in the late 1980s and early 1990s. The two leading examples involved Dominion Resources and Golden Rule Insurance Company.

In 1989 Dominion Resources, a utility company in Virginia with 200 employees, offered its workers a choice of health coverage that included insurance with an annual deductible of $3,000 for families and $1,500 for individuals. Workers who chose the high-deductible option could save almost $1,100 in premiums per year for family coverage and $500 for individual coverage. They could retain those savings in personal MSAs or use the money to pay health care expenses below the deductible. Dominion Resources instituted another program in 1992 that offered an $800 bonus to workers whose expenses stayed below the deductible level, as well as an annual $600 wellness rebate based on five key health factors: blood pressure, weight, smoking, cholesterol, and seat belt use. Both kinds of payments also could be saved in an employee's MSA. Approximately 80 percent of Dominion Resources' employees chose the high-deductible option. The company reported that, during the program's early years of operation, Dominion Resources' health care costs rose less than 1 percent per year, compared to 20 percent per year for other Virginia companies.[43]

In 1993 Golden Rule Insurance Company, based in Lawrenceville, Illinois, offered its employees the option of choosing an MSA plan or traditional insurance coverage. The company-sponsored traditional insurance plan included a $500 annual deductible with a 20 percent copayment on the next $5,000 in health expenses, for a maximum out-of-pocket exposure to individual policyholders of $1,500 per year.[44] Golden Rule's MSA option included a $2,000 high-deductible health benefit plan for individual policyholders, with an additional contribution of $1,000 to the MSA (deposited in prorated amounts over 24 pay periods). For family coverage, Golden Rule offered its employees a $3,000 family deductible and deposited $2,000 in the MSA account (prorated over 24 pay periods). In either case, the MSA option limited maximum annual out-of-pocket expenses to $1,000. Approximately 80 percent of Golden Rule's employees chose the MSA option that year.

At the end of 1993 workers covered under

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the MSA option had an average of $600 in their "unspent" MSAs that they then could use for any purpose (including saving it for future health care needs). In 1994 approximately 90 percent of Golden Rule's employees chose the MSA option. Health care costs dropped considerably for the company and its workers. In addition to the savings retained in each worker's MSA, health care spending above the $3,000 deductible for family coverage in the accompanying catastrophic insurance policy fell 40 percent below 1993 projections. At the same time, about 20 percent of Golden Rule's participating employees reported that they used their MSA funds to pay for a medical service, such as preventive care, that they would not have pursued under the traditional health insurance policy. Even the sickest employees faced lower maximum out-of-pocket costs under the MSA plan ($1,000 per year) than under the traditional insurance plan ($1,500 for individual coverage).[45]

Early Legislative Proposals

By the early 1990s consideration of MSAs moved beyond the business community to the legislative arena. Pat Rooney of Golden Rule Insurance Company refined the concept and promoted it in Washington and in most states.[46] The Council for Affordable Health Insurance and the Business Coalition for Affordable Health Care were formed to promote free-market reforms, including MSAs.

State-Level MSA Laws

In 1993 Missouri enacted the first state-level version of employer-sponsored MSAs.[47] By the end of the decade, at least 39 states had considered proposals to allow MSAs for their citizens. Additional states are developing more limited MSA proposals that would cover only their state employees or Medicaid populations.

As noted earlier, nineteen states have enacted MSA-enabling laws.[48] Those laws allow employers and, in some cases, individuals to establish MSAs and make contributions to them that are exempt from state income taxation.[49]

Nineteen states have enacted MSA-enabling laws. Fourteen states have adopted resolutions calling on Congress to enact full MSAs at the federal level.

Seven other states (Arkansas, Florida, Maryland, Nebraska, New Jersey, Oregon, and Wyoming) approved more narrow MSA laws that accommodated participants in the HIPAA MSA program by providing them state income tax deductions for their MSA contributions. However, those states did not enact statewide MSA tax advantages for people owning other types of MSAs. Three additional states (Louisiana, Montana, and Texas) have approved only Medicaid MSA demonstration projects.

Two other states, Virginia and Wisconsin, provided new advantages for MSAs under state tax law that remained contingent on passage of a full federal MSA law (the federal MSA demonstration project enacted in 1996 did not trigger this provision). In addition, as of December 2000, 14 states (including Virginia and Wisconsin) had adopted resolutions calling on Congress to enact full MSAs at the federal level.[50]

Congress Considers MSA Proposals

Early congressional efforts to enact federal MSA legislation paralleled state-level MSA developments. In May 1992 the first federal legislation to establish MSAs, H.R. 5250, was introduced by Reps. Andy Jacobs (D-Ind.) and Bill Archer (R-Tex.). During the 102nd Congress, nine MSA bills with more than 178 separate cosponsors were introduced.[51] In the next Congress, 16 MSA bills were introduced with more than 205 cosponsors from both sides of the aisle.[52] MSAs achieved their first real legislative success at the congressional committee level on June 8, 1994, when the Senate Labor and Human Resources Committee passed S. 2296, which included language stating that MSAs should be included in any health care reform package.

In 1996 Congress considered new legislation to make it easier for insured Americans to keep their health insurance coverage when they changed jobs or encountered serious medical problems. The House version of proposed "portability" legislation also provided for the creation of tax-advantaged MSAs. On March 18, 1996, Archer introduced H.R.

3103, the Health Coverage Availability and Affordability Act of 1996, which aimed at improving portability and continuity of health insurance coverage in the group and individual markets; combating waste, fraud, and abuse in health insurance and health care delivery; promoting the use of MSAs to improve access to long-term-care services and coverage; and simplifying the administration of health insurance. Previously, Sen. Nancy Kassebaum (R-Kans.) had introduced S. 1028, the Health Insurance Reform Act, on July 13, 1995. The Senate bill sought to provide increased access to health care benefits and to increase the purchasing power of individuals and small employers. By the end of April 1996 both the House and Senate had passed their respective versions of health insurance legislation. However, the Senate on April 18 had voted to reject an MSA provision before approving the Kassebaum bill.

RAND Research Advances the Case for MSAs

As Congress considered whether to improve the federal income tax treatment of MSA contributions, the RAND Corporation revisited and reinforced its earlier work on the benefits of high-deductible health insurance and greater individual cost sharing. RAND researchers used an updated simulation model to calculate the impact of proposed MSA legislation on health care spending and plan choice. The RAND findings, "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" were published on June 5, 1996, at a critical time during the MSA debate on Capitol Hill.[53] Whereas the original RAND HIE demonstrated that the more people had to pay for health care out of pocket, the less they would use, the latest RAND research also found that MSAs would be attractive to both the sick and the healthy, as well as the rich and the poor.

To understand the changes that might occur in response to MSA legislation, the RAND researchers modeled a health insurance market in which three types of plans were offered (all plans covered the same set of services; they differed only in terms of the cost-sharing provisions and the degree to which care was managed). The first plan was a typical fee-for-service plan for that time. It included a $250 deductible, a 20 percent coinsurance rate above the deductible, and a stop-loss cap of $1,500. The second plan was an MSA–catastrophic insurance option with two deductible alternatives—a low-deductible package of $1,500 for individual coverage and $3,000 for family coverage and a high-deductible package of $2,500 for individual coverage and $5,000 for family coverage. The third plan was a typical staff-model HMO. RAND evaluated both employer-funded and employee-funded versions of the model MSAs.[54]

The RAND researchers noted that the method of funding MSAs has important effects on the incentive to use care. If the MSA is funded by the employer with only a modest annual amount, the employee's incentives to consume health care are limited until the insurance deductible is met and the insurer begins to cover all remaining costs. However, when the employee funds the MSA, that arrangement provides a broader tax subsidy for out-of-pocket medical expenses.[55]

Depending on MSA plan design and availability, the RAND researchers predicted that, if all insured nonelderly Americans switched to MSAs, their health care expenditures would decline by as much as 13 percent. However, the researchers concluded that overall health spending would change much less—either dropping by as much as 2 percent or increasing by as much as 1 percent—because not everyone would choose MSAs. Taking into account both the level of deductibles and the selection patterns for choice of plans, the RAND researchers concluded that proposed MSA legislation would have little impact on health care costs of Americans with employer-sponsored health insurance.[56]

However, waste from the excessive use of generously insured health care could be reduced, depending on the catastrophic limit. The larger the deductible, the less waste from buying care of low value after the deductible is

RAND research found that MSAs would be attractive to both the sick and the healthy, the rich and the poor.

exceeded, but the higher the financial risk of out-of-pocket payments. Higher deductibles make the MSA option less expensive and more attractive to healthy people. The researchers concluded that mandating an intermediate MSA plan deductible, for example, a $2,000 deductible for individuals and a $4,000 deductible for families, might be best. Such a plan would retain much of the cost discipline of the high-deductible option without imposing excessive risks on families using employer-funded MSAs, or making MSAs attractive mainly to healthy people.[57]

On balance, the researchers found that the MSA approach of increasing tax subsidies for spending is not likely to reduce health care use to any great degree, because it fails to solve the problem of overinsurance that is caused by *unlimited tax subsidies* of employer-provided insurance. Solving that problem would require restrictions on the tax advantages provided for such insurance arrangements, for example, a limit on the amount of employer-paid premiums that can be excluded from income or replacement of the tax exclusion for employer-paid premiums with a tax credit that is offered to each person with an adequate insurance policy.[58]

HIPAA created a limited federal MSA demonstration project that permitted small employers and the self-employed to establish tax-free MSAs.

Federal MSAs under HIPAA

By mid-June 1996 a conference committee had begun revising and merging the Senate-approved Kassebaum bill and the House-passed Archer bill. Many Democrats opposed MSA provisions because they felt that new MSA options would segment the marketplace and leave only sicker individuals in health insurance pools for traditional indemnity or managed-care insurance. Some Republicans, on the other hand, objected to portability provisions that required guaranteed issue of health insurance for small groups. Nevertheless, a broad consensus was reached by the end of July, and the final version of the legislation, the Health Insurance Portability and Accountability Act of 1996, was ready for passage. The House approved the conference report by a vote of 421 to 2 on August 1, 1996. The Senate passed the measure unanimously on August 2, 1996. The conference report was presented to President Clinton on August 9, 1996, and H.R. 3103 was signed into law on August 21, 1996.[59]

Most notably, HIPAA created a limited federal MSA demonstration project that permitted small employers and the self-employed to establish tax-free MSAs.

HIPAA established an overall participation limit of 750,000 MSA holders. The limit would not apply to qualified previously uninsured individuals until the participation cap of 750,000 was met.[60] MSAs were available to small employer groups of 50 or fewer and the self-employed.

Participants in the demonstration project must be covered under a qualified high-deductible health plan. For individuals, deductibles may be no less than $1,500 and no greater than $2,250 (with a total out-of-pocket expense maximum of $3,000). For family coverage under an MSA plan, deductibles may be no less than $3,000 and no greater than $4,500 (with a total out-of-pocket expense maximum of $5,500). Cost-of-living adjustments to deductibles and out-of-pocket expense levels may be allowed.[61]

Either the employer or the employee can make contributions, but they cannot both contribute in the same year. For individual coverage, contributions cannot exceed 65 percent of the deductible amount. For family coverage, contributions cannot exceed 75 percent of the deductible.

"Qualified" medical withdrawals of funds from HIPAA MSAs include medical expenses as specified in the Internal Revenue Code, sec. 213(d).[62] They do not include insurance premium expenses, except payments for COBRA continuation coverage,[63] long-term-care insurance (or services), and health insurance coverage while receiving unemployment compensation. Nonqualified withdrawals are subject to a 15 percent penalty, and they also are included in gross income for federal tax purposes. However, any such withdrawals after the MSA holder turns 65, becomes disabled, or dies are exempt from that 15 percent penalty.[64]

The federal MSA demonstration project was limited to four years, from January 1, 1997, to December 31, 2000, unless any of the numerical caps on eligible individuals for various interim time periods were reached before then, at which point the Internal Revenue Service would have issued guidance. Eligible individuals who established MSAs before the end of the four-year time period would be able to keep the MSA after the year 2000, even if the demonstration project's authority was not extended.[65]

HIPAA Provisions Handicapped the Growth of MSAs

Participation in the HIPAA MSA demonstration project did not grow as rapidly as expected by many policy analysts and industry representatives. In December 1998 the U.S. General Accounting Office reported that, although the insurance industry responded to the HIPAA demonstration project rapidly (more than 50 companies offered qualifying products by the summer of 1997), the total number of companies offering qualifying products had declined slightly by the end of 1998. Consumer demand in the first two years of the MSA pilot program was lower than many people in the industry anticipated. Lower demand reflected, in large part, the complexity of the qualifying insurance plan–MSA product for both agents and consumers. A minority of insurers offering qualifying plans were marketing them aggressively and remained optimistic that MSAs would be an important option in the market. Other insurers took a more passive approach and adopted more of a "wait-and-see" view of MSAs. GAO suggested that many insurers entered the MSA demonstration primarily to protect market share or for similar defensive reasons. The GAO report also concluded that there was little evidence that new insurers would enter the market unless demand for MSAs increased or features of the demonstration design were changed, or both.[66]

The Council for Affordable Health Insurance also tracked companies that offered MSA-qualified high-deductible insurance or administered MSAs, or both. As of January 2001, CAHI estimated that there were 32 companies offering either MSAs or high-deductible health plans, 20 companies operating as MSA insurance administrators, and 24 banks or financial institutions administering MSAs.[67] The Internal Revenue Service has published several estimates of total MSAs at various points in time.[68] The most recent one, issued on September 30, 1999, indicated that for tax year 1998 there were 42,477 MSA holders. Of those account holders, 10,176 (almost one in four) were previously uninsured.[69]

A number of MSA experts interviewed by *Lawyers Weekly* indicated that their companies reported higher numbers of MSA accounts to the IRS. For example, Jo Ann Robinson of Golden Rule Insurance Company indicated that her company reported 31,000 MSA accounts to the IRS for tax year 1998. Scott Krienke of Fortis Health said his company reported more than 20,000 MSA holders. Those two companies alone reported more MSA holders than did the IRS.[70]

The original design of the MSA demonstration project clearly limited its potential for success. HIPAA imposed unnecessary complexity, restricted the scope of the project, and created a number of MSA design problems.

Complexity

The federal MSA law took a simple health insurance idea and turned it into a marketer's nightmare. Explaining the fundamental MSA concept is rather easy, but insurance agents have complained that it takes too long to outline to clients the deductible limits and other restrictions on HIPAA MSAs. With lower commissions available to agents selling MSAs compared with other insurance products, are detailed explanations really worth the time and extra effort?[71]

Over the years, longtime MSA advocate Greg Scandlen has presented the complexity of selling the HIPAA MSA product in a nutshell:

> Imagine a presentation that goes something like this: An MSA is a tax-

The federal MSA law took a simple health insurance idea and turned it into a marketer's nightmare.

The MSA plan design imposed by HIPAA hampered the ability of MSA marketers to customize features of their products to the needs of individual employers.

> free savings account with a high-deductible health insurance plan. In order to qualify, the high-deductible plan must have a deductible of between $1,500 and $2,250 for an individual and between $3,000 and $4,500 for a family, with an out-of-pocket limit of $3,000 for an individual and $5,500 for a family. Once you have a plan like that, you can open a medical savings account and contribute 65 percent of your deductible if you are an individual or 75 percent of your deductible if you are a family. Only the self-employed or companies with 50 or fewer employees may participate. If you get the MSA from your employer, only you or your employer, but not both, can contribute to the MSA in a single year.[72]

Scandlen notes that even a knowledgeable health policy analyst's eyes would glaze over in reading that detailed explanation, which does not include the penalty for nonmedical withdrawals or the prohibition on other coverages.

Limited Scope and Duration

The HIPAA provisions allowed MSAs for only a limited number of individuals (750,000 enrollees, at most), a narrowly defined population (small groups of 50 employees or fewer, plus the self-employed), and a relatively short period of time (a sunset provision of December 31, 2000). Confronting a market of limited scope and duration, many potential MSA players—health insurance companies, benefit managers, and financial institutions—were reluctant to invest the substantial resources needed to develop an effective MSA program, train their agents and brokers, and market the product to the general public.

Furthermore, the health insurance markets for small employer groups and for individuals are the two most volatile markets in the health insurance business. Small employers are particularly cautious in purchasing health benefits because they generally lack adequate funds, time, and staff to explore ways to make their benefits more efficient or investigate the merits of new health insurance programs.

The uncertain future of federal MSAs beyond December 31, 2000, further discouraged potential consumers and MSA marketers from committing to a product that might no longer be available after less than four years.

Design Problems

MSA plan design is critical. An MSA program must provide attractive benefits to employees to encourage them to engage more actively in controlling their health care use and costs. An effective MSA plan also will appeal to employers when it helps control their overall benefit costs. However, the tight restrictions on MSA plan design imposed by HIPAA hampered the ability of MSA marketers to customize such features as deductible levels, total cost-sharing limits, MSA contribution levels, and withdrawal options of their MSA products to the unique needs of individual employers.

The permissible range for high-deductibles in HIPAA MSAs was narrow. As noted above by Scandlen, deductibles for individual coverage in 1998, for example, could be no less than $1,500 and no greater than $2,250. Family deductibles could be no less than $3,000 and no greater than $4,500.[73] The limits imposed by HIPAA were much more restrictive than the variety of high-deductible amounts already being offered in the health insurance market at the time. Furthermore, the HIPAA-required deductible levels permitted no variation for geographic differences in medical costs.[74]

In response, insurers that previously offered a choice of high-deductible levels for pre-HIPAA (nonqualified) MSAs often decided they could offer only a single high-deductible insurance benefit under HIPAA MSAs. HIPAA's narrow range for permissible cost-sharing arrangements and total out-of-pocket expense maximums, or stop-loss limits, did not include the much higher stop-loss

limits that already were being offered in other parts of the high-deductible health insurance market at the time.

Given HIPAA's tight restrictions on cost sharing, switching from a lower deductible under conventional insurance coverage to a federally qualified MSA plan with a somewhat higher deductible or greater cost sharing did not produce enough insurance premium savings in some cases to warrant a switch.[75]

HIPAA's limits on MSA contributions were arbitrary, unnecessarily complex, difficult to explain and comprehend, and unresponsive to market demands. For example, based on the original HIPAA deductibles and out-of-pocket maximums (before inflation adjustments for the year 2000), the maximum contribution allowed for an individual or his employer was $1,462.50 (65 percent of the maximum deductible limit of $2,250), leaving a corridor of $787.50 as an unfunded out-of-pocket cost exposure under the deductible. For family coverage, contributions could not exceed $3,375 (75 percent of the maximum deductible limit of $4,500), leaving the family at risk for as much as $1,125 in the unfunded portion of the annual deductible.

No other health insurance benefit program faces similar congressional mandates that set such minimum and maximum cost-sharing levels. In fact, some health benefit plans such as HMOs eliminate deductibles entirely and impose modest copayments instead. HIPAA severely hampered the ability of many potential MSA plans to adequately fund the MSA savings component in the initial years of the plan. Although MSAs might accumulate a substantial balance over a number of years, the initial at-risk corridor (the unfunded portion of the high-deductible insurance plan) would deter potential customers from starting out with a federally qualified MSA plan.

HIPAA allows either an employer or his employee to make MSA contributions, but both parties cannot contribute in the same year. Again, no other health benefit plan arrangement faces such legal restrictions on how employers and employees may decide to combine their contributions to finance benefits. Indeed, most employers and employees today share in paying portions of the cost of health insurance. Advocates of MSAs believe that the rationales for not allowing both employers and employees to contribute to the same MSA account were to (1) limit the amount of tax-advantaged income that an account holder could deposit in his MSA and (2) reduce the IRS's administrative burden of tracking who made the deposits. In any event, the prohibion on dual-source MSA contributions made MSAs difficult to fund fully. For example, some small employers wanted to provide the high-deductible health plan for employees, but they could contribute only a small amount to the MSAs. Employees who may have become accustomed to sharing the costs of their insurance premiums with their employer under their previous employer-sponsored plan were unable to make similar arrangements for the savings component of MSA plans.

Workers and their families choosing to open MSAs after the start of a calendar year still are subject to the entire high-deductible amount if they need to make medical claims under their insurance policy. But HIPAA allows only limited contributions to partial-year MSAs. Maximum contribution limits are prorated on a monthly basis to reflect the number of months that an MSA holder participated in the HIPAA demonstration project during that year. This provision makes selling new MSAs that begin in the second half of a calendar year virtually impossible. For example, if someone purchases an MSA in July, he remains subject to out-of-pocket costs up to the full-year deductible amount (assuming a maximum individual coverage deductible of $2,250), but his part-year contributions may not exceed $731.25, leaving a much higher corridor of $1,518.75 in out-of-pocket cost exposure.[76]

HIPAA complements its "entry" restrictions on contributions to MSAs by imposing "exit" barriers for withdrawals. MSA fund withdrawals for purposes other than qualified medical health care are subject to a 15

HIPAA severely hampered the ability of many potential MSA plans to adequately fund the MSA savings component in the initial years of the plan.

percent penalty and also taxed as current-year income. Penalties for MSA withdrawals for nonmedical purposes end at age 65. Both the age and withdrawal restrictions for MSAs are harsher than those imposed on IRAs. Cash withdrawals from IRAs are subject to a 10 percent penalty (in addition to income taxes), and penalty-free withdrawals can be made after one reaches age 59½.

Regulatory Uncertainty and State Government Resistance Undercut the Market for MSAs

Months after the HIPAA MSA program was legally in effect, the IRS was still issuing implementing regulations.[77] Facing delay and uncertainty, many companies decided not to participate in the MSA program rather than later have to recall their marketing materials, reprogram computers, and retrain agents and other company personnel. The slow finalization of implementing regulations hampered efforts of MSA vendors to project how adequately consumers could fund their MSAs during a partial year. Lacking final IRS regulations, state insurance departments also had to delay their approval of the high-deductible insurance plan components of federally qualified MSAs. General lack of knowledge about the rules for the demonstration project launched the federal MSA experiment on a fitful and uneven start.

Many health insurance agents were reluctant to recommend MSAs in the face of limited understanding of the federal program and the short lifespan of the HIPAA demonstration project.

In a number of states, the regulatory environment already was particularly onerous for the two segments of the health insurance market targeted for the HIPAA MSA experiment—the small-group and individual markets. Beginning in the early 1990s, the National Association of Insurance Commissioners helped to enact changes in state laws governing the individual and small-group health insurance markets, including reforms such as guaranteed issue, open enrollment, and community rating.[78] However, those provisions increased the cost of insurance coverage in those markets over time. Many insurers exited markets in those states because they could not afford to sell insurance under such regulatory conditions. More recently, some states have started to repeal or modify those reforms in an attempt to lure health insurers back to their markets.[79]

State-mandated health benefits, which require first-dollar insurance coverage for particular services, came into direct conflict with the high-deductible insurance structure required for HIPAA-eligible MSAs.[80] Shortly after HIPAA was effective, CAHI reported that as many as nine states plus the District of Columbia imposed mandated benefits that disqualified the type of high-deductible insurance plans required for federally qualified MSAs.[81] Even four years later, CAHI reports that five states, plus the District of Columbia, still prohibit the establishment of federally qualified MSAs.[82]

Insurance Industry Resistance to HIPAA MSAs

Reactions to federally qualified MSA products were mixed within the insurance industry. Many health insurance agents were reluctant to recommend MSAs in the face of limited understanding of the federal program, lower commissions for agents selling high-deductible insurance, and the short lifespan of the HIPAA demonstration project. Insurance carriers that did not want to invest the necessary capital for a limited demonstration project not surprisingly ended up doing a poor job of marketing MSA plans. Purchasers faced a shortage of knowledgeable insurance agents motivated to sell MSAs, and they also found it difficult to locate an insurer that offered MSAs. In December 1998, the General Accounting Office reported that only 48 carriers were offering MSA-qualifying health plans.[83] According to the GAO, the most common reason mentioned by HMO insurers for not entering the MSA market was that a high-deductible health plan was inconsistent with the concept of the HMO.

Initial Congressional Efforts to Modify HIPAA MSA Rules

After HIPAA established MSAs for the under-age-65 health insurance market, mem-

bers of Congress continued efforts to expand the MSA demonstration project. Various proposals would have

- allowed MSA policyholders to fully fund their accounts up to the deductible level,
- made the demonstration project permanent and more widespread (by removing its numerical cap on participants and its four-year time limit),
- permitted contributions by both employees and their employers in the same year,
- lowered the minimum requirements for insurance deductibles on individual plans to $1,000 and on family plans to $2,000, and
- removed the 50-employee size limitation on eligible employers.

While none of the proposed MSA expansion bills became law, the Balanced Budget Act of 1997 included an MSA demonstration project as an option for a limited number of Medicare beneficiaries. Under the law's Medicare+Choice provisions, as many as 390,000 seniors could choose an MSA. This Medicare MSA demonstration project is set to expire December 31, 2002.[84]

At least 10 bills before the 106th Congress proposed expansions and permanent extensions of the HIPAA MSA demonstration project. The Taxpayer Refund and Relief Act of 1999, H.R. 2488, was passed by both houses of Congress on August 5, 1999, but President Clinton vetoed the bill on September 23, 1999. The legislation addressed many of the flaws in the HIPAA-designed MSAs by

- repealing the cap on the number of individuals eligible to establish them;
- allowing employees of any size employer to establish them, including the self-employed;
- changing the annual MSA contribution limit to 100 percent of the deductible;
- lowering the individual minimum deductible to $1,000 and the family minimum deductible to $2,000, but keeping the maximum deductible amount the same; and
- permitting the establishment of MSAs under cafeteria plans.

A number of other efforts to fix the structural flaws and handicaps restricting HIPAA MSAs also fell short. Most Republican members of Congress were enthusiastic proponents of MSAs. They wanted to make the MSA program permanent because it gives consumers more freedom to choose their own physicians and health benefits and also provides low-cost coverage for as many uninsured Americans as possible. Many Democratic critics of MSAs in Congress and several consumer groups claimed that MSAs mostly benefit the wealthy, siphon off the healthiest people from traditional health plans, force insurers to raise premiums, and ultimately would make insurance less affordable for those people most likely to file substantial health insurance claims.

For example, provisions to extend and expand the current MSA demonstration project were included within the House- and Senate-passed versions of patients' bill of rights legislation that each chamber approved separately in 1999. On July 20, 2000, Treasury Secretary Lawrence Summers sent a letter to the House Ways and Means Committee's ranking Democrat, Charles Rangel (D-N.Y.), in which Summers indicated he would urge President Clinton to veto any patients' bill of rights legislation that included tax provisions that expanded MSAs. Summers wrote that if conference report provisions extended the current MSA pilot project indefinitely, expanded access to MSAs to workers in large companies, and reduced required deductibles for HIPAA MSAs, those policies would encourage adverse selection in the health insurance market. They would not expand coverage significantly, could substantially increase premiums for some Americans with traditional health insurance coverage, and would dispro-

A number of efforts to fix the structural flaws and handicaps restricting HIPAA MSAs fell short.

portionately favor wealthy taxpayers.[85]

The veto threat proved unnecessary, because the final legislation remained tied up in conference committee as the future of federally qualified MSAs remained contentious throughout the last Congress.

Nevertheless, congressional support for MSAs remained bipartisan. For example, Senator Torricelli, chairman of the Democratic Senatorial Campaign Committee, urged that the federal MSA program be made permanent and some of its deficiencies (the enrollment cap, unnecessarily high minimum deductibles) be corrected.[86] Rep. Peter Deutsch (D-Fla.) advocated similar changes.[87]

MSAs improve health plan options for all Americans. MSAs should appeal to workers in both small businesses and large companies.

Despite HIPAA Problems, MSAs Remain Attractive

Before HIPAA, as many as 2,000 employers may have adopted some form of a health plan that was either similar to the MSA concept or contained incentives that mirrored the MSA.[88] Even after HIPAA MSAs became available, many MSA customers—particularly those who were not eligible for HIPAA MSAs—looked to the continued availability and attractiveness of "nonqualified" MSAs. Although HIPAA has provided a particular type of MSA option to small employers and the self-employed since 1997, other types of MSA products have been on the market for the past decade or so, and they remain available to most of the general population.

Many of the nonqualified, MSA-type insurance arrangements are eligible to receive state income tax deductions for their savings component. Non-HIPAA MSAs can offer other attractive benefit features not available with federally qualified MSAs. They are not restricted to offering relatively high-deductible health plans with only limited coinsurance and ceilings on MSA contributions that prevent greater funding of out-of-pocket cost exposure. Non-HIPAA MSA alternatives allow withdrawals for nonmedical purposes with no statutory age limits or additional penalties. Because they do not receive federal income tax advantages, non-HIPPA MSA plans are neutral on the choice of using funds for either additional health care spending or other spending. Non-HIPAA MSA plans also provide consumers a sense of permanence that is not provided by the time-limited federal MSA experiment.

In recent years, estimates of the number of non-HIPAA MSAs have fluctuated, depending on their source. There is no formal system for tracking how many MSA-type arrangements remain active. Greg Corie of American Health Value, a Boise, Idaho, administrative benefits company that handles both HIPAA and nonqualified MSAs, explains it best: "The industry numbers [for all MSA arrangements] are probably 10 to 20 percent higher than what was estimated pre-HIPAA for MSA-type arrangements. The most important factor to note is that every hybrid MSA-type arrangement out there is technically a 'non-qualified' MSA arrangement—it is what best suits the employer and its employees. If HIPAA MSAs are not extended beyond the sunset date, I am not worried because there is still a market for these type of plans."[89]

Evidence That MSA Benefits Are Widespread

A number of studies illustrate that MSAs improve health plan options not just for affluent and healthy individuals but for all Americans. MSAs should appeal to workers in both small businesses and large companies.

Large Employers

When presented with a specific example of an MSA health benefits package, larger employers are interested in MSA options. A recent survey of 500 company benefit specialists summarized the advice those experts would give to medium- to large-sized employers regarding a tax-advantaged MSA.[90] Forty-two percent of benefit specialists would recommend an MSA to a typical medium- to large-sized firm. Thirty-nine percent would recommend an MSA to their own firm. Eighty-one percent would recommend

adding the MSA option to existing managed-care plans of medium- to large-sized firms. However, a number of the benefit specialists surveyed remain concerned about the complexity of the HIPAA MSA program, the difficulty of educating insured beneficiaries, and the increased administrative costs of such a system.

Small Business

The RAND Corporation recently examined whether allowing small businesses to offer employer-funded MSAs would change the amount or type of insurance coverage the employers provided. RAND's behavioral simulation model predicted the effect of MSAs on the insurance choices of employees of small businesses and their families. The model assumed that small businesses would offer at most one of four insurance choices: (1) a typical fee-for-service plan, (2) a typical staff-model HMO plan, (3) an MSA plan, and (4) no insurance at all.[91]

The RAND researchers concluded that, in the long run, tax-advantaged MSAs could attract 56 percent of all employees offered a health plan by small businesses. However, the fraction of small business employees actually offered any health insurance would increase only from 41 percent to 43 percent once MSAs became an option. Most of the additional customers for MSA plans would be employees who, already covered under a fee-for-service health insurance plan, would switch to MSAs if they were universally available. On average, MSAs provide the most value to families and society, according to RAND.

RAND rejected the assumption that MSAs appeal most to the wealthiest and healthiest workers. It found that HMOs remain more attractive to higher-income workers, primarily for tax reasons. Exceptionally good health risks are more likely to decline any insurance at all than to select the MSA option.

The RAND study concluded that MSAs would provide only a limited impetus to businesses that do not currently offer insurance coverage to their employees but that MSAs would be particularly attractive to workers in firms that already offer HMOs or standard fee-for-service plans. Expanding MSA availability could make it a major form of insurance for covered workers in small businesses, and overall welfare would improve slightly.[92]

Net Savings for Most Workers

According to a 1996 study published by the National Bureau of Economic Research, most workers would end up retaining a substantial portion of the contributions they made to MSAs by the time they retired. Matthew Eichner, Mark McClellan, and David Wise examined health care spending patterns of 300,000 employees and their dependents covered by a Fortune 500 company's two fee-for-service health plans over the three-year period 1989 through 1991. Given that historical distribution of expenditures, they then modeled what would happen if those employees were covered by a different type of health plan that included "individual health accounts" (IHAs). They assumed that the employer would pay the premium on catastrophic health insurance coverage with maximum annual deductibles of $4,000 for families and make deposits of $2,000 in each employee's IHA at the beginning of each year. The study found that, with a health plan with this kind of MSA, approximately 80 percent of the employees would have retained over 50 percent of their IHA/MSA contributions by the time of retirement, and only 5 percent of the workers would have saved less than 20 percent of their contributions. At age 60 about 90 percent of the workers would have saved more than $25,000 (nominal dollars) in their IHAs, and 50 percent of them would have more than $50,000.[93]

The NBER researchers noted that, although workers with high health care expenses in one year tend to have lower but still higher than average expenses in the next few years, the concentration of annual expenditures declines continuously as more and more years of expenditures are cumulated. High expenditure levels typically do not last

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for many years.[94] Even the small fraction of workers with high expenses would face limited financial risk in the long run under such IHA/MSA plans, because, when their medical costs exceeded the deductible, their health insurance plan would pay the remainder of the bills.

A 1996 study of 27 Ohio-based firms that offered (pre-HIPAA, nonqualified) MSAs to their employees concluded that employees with single coverage in the representative firms on average would be $317 better off with the MSA/high-deductible plan under the worst-case (maximum out-of-pocket liability) scenario. The average advantage amounted to $1,355 for employees with family coverage. Michael Bond, Mary Hrivank, and Brian Heshizer determined that the employer's total cost for family coverage under those MSA plans averaged 23 percent less than traditional family coverage.[95] The unweighted average cost of MSA plans for all the firms studied was about 12 percent less than the cost of traditional plans. If plan designs were altered to lower MSA deposit levels so that MSA plans and traditional plans had the same maximum out-of-pocket liability, employer costs for MSA plans would be 34 percent less than the cost of traditional plans for total employee coverage. Bond and his colleagues concluded that MSA plans saved employers 10 percent on average compared with traditional health insurance and that employees had an average of about $700 remaining in their MSA accounts.[96]

MSA Case Studies

Recent information about the experience of individual insurers, employers, and consumers with HIPAA MSAs is very limited. Because of the restricted scope of the federal demonstration project, many insurance companies opted not to invest the hundreds of thousands of dollars needed to track the data that policymakers and analysts desire. A number of insurers contacted for this study indicated that their block of MSA/high-deductible insurance business was too small to justify the investment of time and money needed to create a new system to track data and equip employees to handle it. Those companies indicated that, if the federal demonstration project were expanded and made permanent, they would reconsider implementing such information systems. In the interim, they would continue to track and report only the limited data required by HIPAA's MSA demonstration project—the number of MSAs opened, how many account holders were previously uninsured, and the amount of money deposited in MSAs.

However, a handful of companies have tracked some additional information beyond what is required by the HIPAA law, for both qualified and nonqualified MSA plans, and they provide some valuable illustrations.

Federally Qualified (HIPAA) MSA Plans

American Health Value. American Health Value, based in Boise, Idaho, became the first MSA administrator to offer its customers convenient and immediate access to their MSA funds with a Visa Check Card.[97] This company operates in 49 states for state and federally qualified MSAs and all 50 states for nonqualified MSAs.[98] As of June 2001, American Health Value had more than 30,000 MSA accounts, managed $60 million in trust, and had paid out $35 million in direct payments to medical providers and others.[99] A profile of American Health Value MSA holders indicates that 28 percent have single coverage and 72 percent have family MSA coverage. Ten percent of account holders are single parents with at least one child. Almost 50 percent were previously uninsured. The average age of the primary insured (MSA holder) is 42 years.[100]

The MSA funds administered by American Health Value are deposited with the Home Federal Savings and Loan Association of Idaho in an interest-bearing, FDIC-insured account. The company offers other investment options through Delaware Investments,[101] which allows an MSA holder to choose among more than 30 mutual

funds. In order to make mutual fund investments, an account holder must have a $1,250 MSA balance. The minimum initial investment in a mutual fund is set at $1,000, and subsequent investments may be made in $250 increments. (As long as a $250 balance is retained in one's regular interest-bearing American Health Value MSA to cover any medical expenses, mutual fund deposits are permitted.) The company recommends that account holders keep at least the amount of their insurance policy's deductible plus other likely out-of-pocket medical expenses in their regular MSA. The company currently works with several insurance companies to offer high-deductible health insurance coverage.

In addition to a Visa Check Card for convenience in purchasing health care services, American Health Value offers a wide range of MSA administrative services such as a clear monthly statement detailing contributions, withdrawals, and interest income; electronic transfers from checking or savings accounts; year-end tax forms; access to account information 24 hours a day; e-mail service to answer questions by the next business day; and a savvy Web site at www.americanhealthvalue.com that compiles some of the most complete MSA marketing information available to consumers.

The Women's Clinic in Boise, Idaho, has had an MSA with American Health Value since 1997, according to spokesperson Cathy Treadway.[102] Thirty-eight of the 55 employees have chosen employer-sponsored insurance. Other clinic employees do not participate because they work part-time or are covered under their spouse's plan. The clinic switched to the MSA plan because it was experiencing annual health insurance premium increases of from 18 to 22 percent. MSAs provided flexibility and choice to employees. At the same time, the MSA plan reduced or stabilized the clinic's health insurance costs, and it soon became the health insurance option of choice. However, the Women's Clinic still offers a choice of employee health insurance benefits. Under the MSA option, employees may select individual coverage with a $1,550 individual deductible, and the clinic deposits $975 in one's MSA account. For family MSA coverage, the deductible is $3,030, and the employer-paid MSA deposit remains $975. The Women's Clinic also offers a lower-deductible insurance option, with no MSA but with prescription drug coverage. Currently, about 50 percent of the employees are enrolled in the MSA plan, and the other 50 percent have chosen the lower-deductible insurance plan. Employees express high satisfaction with the MSA option. In many instances, says Treadway, employees appear to have chosen to save their MSA funds and invest them rather than withdraw the money to pay for routine medical care.

Individual consumers are also satisfied with American Health Value's MSAs. Mary Beth Wilson works at the Westchester Anesthesiology Clinic in Westchester, New York.[103] The clinic has 23 employees (19 anesthesiologists and 4 staff members) enrolled in the MSA employer plan. The clinic used to have a low-deductible health insurance plan, but rising premium rates made it unaffordable. The clinic offers two kinds of federally qualified MSA plans—a $2,000 individual deductible plan with 65 percent of the deductible amount ($1,300) deposited in an MSA and a $4,000 family deductible plan with 75 percent of the deductible amount ($3,000) deposited in an MSA. Many clinic employees use their MSAs quite a bit, because they have young children. However, about one-quarter of the employees, including Wilson, have chosen not to withdraw deposited money from their MSAs and prefer to pay routine medical expenses out of their own pockets. Those employees invest their MSA funds in mutual funds in order to save for future high-cost medical expenses or long-term-care needs. Wilson, for example, has accumulated as much as $8,000 in her MSA since the program's inception. She indicated that the only downside to the program, other than the fear that it would not be extended permanently by the federal government, is the education factor. She observed that, in switching from a traditional lower-deductible plan to a high-

The MSA plan reduced or stabilized the clinic's health insurance costs, and it soon became the health insurance option of choice.

deductible/MSA plan, many employees had a hard time grasping the concept of paying for a service up-front with their own money and then getting reimbursed out of their MSA after the fact.

Fortis Health Insurance Company. Fortis Health, in Milwaukee, Wisconsin, is another leading MSA company. Although it has not implemented a specific program to capture all the data associated with its MSA policyholders, Fortis reported the following results:

- Fortis Health serves 35,000 MSA holders, 15 percent of whom were previously uninsured.
- The most likely customers tend to be lawyers, veterinarians, certified public accountants, and other individuals working from home offices. Other major MSA customer occupations include construction, arts or crafts, farming, mechanics, sales, and computers and high tech.
- About 80 percent of Fortis Health customers are self-employed; the rest are small businesses.
- Slightly more than half of Fortis Health's small-group MSAs are for family coverage. For self-employed MSA customers, there are about twice as many family policies as single policies.
- The average Fortis Health MSA policy covers slightly more than two people.
- Fortis Health's individual coverage MSA plans typically cost 30 percent to 60 percent less than comparable policies with a $400 deductible.
- About 65 percent of Fortis Health's customers surveyed did not want a check generated automatically when they spent money for medical expenses. Fortis Health administrators believe those customers are using MSAs to save for the long term, or at least for major medical expenses.[104]

Fortis Health's individual coverage MSA plans typically cost 30 percent to 60 percent less than comparable policies with a $400 deductible.

Here's a revealing profile of a Fortis Health customer. Thor Johnson switched to an MSA plan after he experienced difficulties with traditional insurance coverage. Johnson was an officer with Pan American Airways until it went out of business. He switched to another, smaller airline with a self-funded health insurance plan. The airline soon experienced financial difficulties, and it failed to pay its health insurance claims, unbeknownst to its employees. Johnson had knee surgery while still an employee. By the time all of his claims were processed, the company did not pay any of the bills. Johnson, by then unemployed and uninsured, was stuck with the unpaid balance. Soon he formed his own graphic arts company, Arrow Art International, in Great Falls, Virginia. After having been left with thousands of dollars in unpaid medical bills, he shopped around for a health insurance plan that would offer him better protection. He vowed he would never be placed in the same situation again. The Fortis Health MSA he selected in 1997 offered him the reassurance that he could save for future medical expenses and at the same time pay much lower premiums than charged for traditional, low-deductible health insurance. Johnson and his wife are the only ones in their company with an MSA, because Arrow Art International has a lot of part-time or seasonal employees. However, as the company expands, the Johnsons intend to offer an MSA plan to their employees. In light of their personal experience with unpaid medical bills, the Johnsons have elected not to use their MSA funds to pay for routine medical care but to save the funds for protection against possible future major expenses. They already have accumulated several thousand dollars in their MSA.

Golden Rule Insurance Company. Golden Rule first began offering MSA plans in 1993. It administers more than 40,000 MSAs for self-employed individuals and groups nationwide.[105] Balances in those MSA accounts are automatically rolled over from year to year. In 2000 the MSA balances nationwide for Golden Rule customers totaled $48,118,323 (Table 1).[106] The age and family status of Golden Rule's customers (as of May 2000) are provided in Tables 2 and 3.[107]

Table 1
Golden Rule Insurance Company Customers' Cumulative MSA Balances Nationwide

Year	Total (dollars)
2000	48,118,323
1999	35,252,811
1998	23,340,044
1997	10,381,137
1996[a]	2,059,536
1995[a]	355,921

Source: Jo Ann Robinson, Golden Rule Insurance Company.
[a]Includes only federally nonqualified MSAs. Other years include HIPAA MSA balances and nonqualified MSA balances.

Table 2
Ages of Golden Rule Customers

Age Group (years)	Total (percentage)
0–18	0.09
19–25	2.43
26–35	18.43
36–45	38.56
46–55	29.15
56–64	11.30
Unknown	0.04

Table 3
Family Status of Golden Rule Customers

Family Status	Total (percentage)
Single male	17.18
Single female	12.48
Husband and wife	17.45
Single male with children	5.76
Single female with children	4.70
Husband and wife with children	42.38
Unknown	0.05

Golden Rule offers two MSA plans—the MSA 100 Plan® and the MSA 80® Plan. The high deductibles offered under either plan are $1,600 or $2,400 for individual coverage and $3,200 and $4,800 for family coverage. The MSA 100 Plan® pays 100 percent after the deductible is met, and the MSA 80® Plan pays 80 percent above the deductible until a somewhat higher total out-of-pocket maximum is reached.[108] Both plans offer a preferred provider organization (PPO) or a non-PPO depending on what variations are available in particular states.

This is the story of one Golden Rule customer: Martin Schliessmann is a self-employed graphic artist at Martin Design in Mushawake, Indiana.[109] He has owned his MSA since they were first authorized under HIPAA on January 1, 1997. Schliessmann previously was covered under his wife's employer's health plan until she lost her job. At the time, Mr. Schliessmann had been working for Golden Rule on some MSA marketing materials, and he knew that the MSA was an ideal health benefit plan for his situation. He now has catastrophic insurance coverage with a $3,200 family deductible, and he makes monthly $100 deposits into his MSA. He seldom has withdrawn money from his MSA over the past few years, because his family's health care expenses have been very limited. He has accumulated more than $5,000 in his MSA to cover new health expenses or save for long-term-care needs.

Medical Savings Insurance Company. This Indianapolis-based MSA company began selling plans on January 1, 1997, and its MSA sales have grown significantly in the past year or so, increasing more than 300 percent from May 2000 to May 2001.[110] Medical Savings Insurance Company president Randy Suttles attributes much of the increase to the problems experienced in various states with small-

Guaranteed issue reforms caused small-group market insurers to dramatically increase rates. Many companies have switched from traditional health insurance coverage to MSA plans.

group market reforms implemented over the past couple of years.[111] Suttles believes that guaranteed issue reforms caused small-group market insurers to dramatically increase rates. Many companies that cannot afford the increase in premiums have switched from traditional health insurance coverage to MSA plans, which tend to offer lower premiums because of their higher deductible levels.

Christina Anderson Wright, a recently divorced single mother in Burke, Virginia, had health insurance while she was married. After her divorce, she became uninsured because she could not afford coverage for both herself and her son. However, with an MSA from Medical Savings Insurance Company, she gained the opportunity to buy an affordable high-deductible health plan and deposit additional money in an MSA. Wright used the MSA often, because her son was diagnosed with a speech impediment and needed to see a therapist. Under her previous health plan, that treatment was not covered. With her MSA funds now available, she can provide the necessary services for her son as a nontaxable, qualified medical expense. Wright believes that the MSA option makes the most sense for her as a single parent.[112]

Plan3, Inc. For the past decade, this Rockville, Maryland, benefits company has been a pioneer in MSA-style programs for corporations of all sizes. Plan3 administers both federally qualified and nonqualified MSA plans. Plan3 president Dennis Kelly emphasizes that consumers need to be aware that their insurance claims for routine health care drive up the cost of premiums and divert funds that could be spent on direct employee benefits. "For every dollar spent on typical insurance premiums, approximately 40 percent goes toward yearly routine claims, while 35 percent is reserved for insuring major incidents, and 25 percent for life-altering incidents," says Kelly.[113]

The Cato Institute, in Washington, D.C., is one of Plan3's business clients. Cato provides a comprehensively designed benefit plan made up of a combination of employer-sponsored benefits underwritten by the Guardian Life Insurance Company and administered by Plan3. In addition to prescription drug card discount benefits, optional dental coverage, and a voluntary PPO network, Cato offers its employees a high-deductible MSA plan. Cato began offering its employees MSA benefits in January 1997, shortly after passage of HIPAA. At that time, Cato had fewer than 50 employees and was eligible for federally qualified MSAs as a small employer. Now "grandfathered" in, Cato's 90-plus employees can still enjoy the tax benefits of federally qualified MSAs.

The HIPAA-qualified deductible is $2,250 for individual coverage and $4,500 for family coverage. After satisfaction of the high deductible, the plan reimburses 100 percent of reasonable and customary charges for most services including prescription drugs. Mellon Bank administers the interest-bearing MSA component of the Cato plan. Each year, on a monthly prorated basis, Cato deposits $1,463 in each participating employee's MSA. Employees with family coverage may elect to contribute as much as an additional $1,912 in pretax wages to their MSAs through voluntary salary reduction agreements.

As a self-insured employer, Cato is responsible for 100 percent of covered claims above an employee's $2,250 individual deductible, up to $7,500.[114] Cato pays for 100 percent of covered claims above the $4,500 deductible for employees with family coverage, up to $15,000.[115] In addition, Cato pays 50 percent of covered claims beginning at levels above $7,500 up to a ceiling of $17,500 for employees with single coverage, and its third-party insurer Guardian Life pays the other 50 percent.[116] For employees with family coverage, Cato pays 50 percent of covered claims beginning at levels above $15,000 up to a ceiling of $35,000, and Guardian pays the other 50 percent of those claims.[117] Guardian is responsible for 100 percent of all remaining amounts of annual covered claims above $17,500 for individual coverage and above $35,000 for family coverage.

More than 85 percent of Cato's employees were participating in the MSA plan as of September 2000. Employees with other

Although Cato employees paid higher amounts out of pocket for health care, their total MSA deposits were even higher, resulting in a net savings for employees.

insurance coverage (e.g., a spouse's plan) can exercise a Deferred Deductible Account option for supplemental health benefits (up to $1,800 annually), which they may use as a tax-deductible source of funds to pay any legitimate out-of-pocket medical or dental expenses (i.e., not reimbursed under their other non-Cato insurance coverage), including premiums for other health insurance coverage. The unspent balance in the DDA is paid out as a cash bonus at the end of the plan year and is taxed as ordinary income.

The Cato plan combines several cost-saving tools. By setting relatively high deductibles

In 2000, 79 percent of Golden Rule's 687 employees with MSAs received year-end refunds averaging $989.

Table 4
Cato Institute Health Benefits History

	1998	1999	2000
1 Total employee-months	786	804	865
2 Avg. no. employees/month	65.5	67.0	72.1
3 Total dependent-months	184	297	218
4 Avg. no. dependents/month	15.3	24.8	18.2
5 Individuals who hit the deductible ($2,250)	3	12	19
6 Families who hit the deductible ($4,500)	0	1	0
7 Total expenses billed to employees	$26,908	$56,542	$80,902
8 No. times Cato hit the 100 percent self-insurance cap (individuals)	1	9	5
9 No. times Cato hit the 100 percent self-insurance cap (families)	0	1	0
10 No. times hit Guardian 100% coverage	0	1 (ind.)	0
11 Total expenses covered by Guardian (50/50 share +100%)	$4,842	$33,728	$18,664
12 Total expenses billed to Cato (100% + 50/50 share)	$14,820	$58,183	$65,739
13 Total Cato paid for employee premiums	$53,392	$53,983	$55,652
14 Total Cato contributions to MSAs	$95,829	$98,02	$105,461
15 Total health costs to Cato (sum of lines 12, 13, 14)	$164,041	$210,189	$226,852
16 Total under claim experience (sum of lines 7, 11, 12)	$46,570	$148,453	$165,305
17 Premiums per employee per month	$67	$67	$64
(line 13 divided by line 1)	.93	.14	.34
18 Total Cato health benefits	$2,504	$3,137	$3,147
cost/employee (line 15 divided by line 2)	.44	.15	.08
19 Total monthly Cato employer health benefits	$208	$261	$262
cost/employee (line 18 divided by 12)	.70	.43	.26
20 Total health claims costs/employee	$711	$2,215	$2,293
(line 16 divided by line 2)	.00	.72	.25
21 Total monthly health claims cost/employee	$59	$184	$191
(line 20 divided by line 12)	.25	.64	.10

Source: Guardian Life Insurance Company.

Note: Complete records for 1997 are not readily available.

for every employee's insurance coverage, the plan encourages workers to become better consumers of health care. The opportunity to accumulate savings in their MSAs by spending less out of pocket on health care provides a further incentive to make economical choices. As its covered employees demonstrated that they had become prudent health care shoppers, Cato was able to increase the portion of additional risk above workers' insurance deductibles that it retains as a self-insured employer. As a result, Cato's health care costs per employee remained essentially the same in 1999 and 2000 ($262.26 per month in 1999, $261.43 per month in 2000), as indicated in Table 4. In addition to leaving employees in

Table 5
Survey Results: Cato MSA Accounts

ID No.	Months	Contribution	Tax-Qualified Withdrawals	Non-Tax-Qualified Withdrawals	Savings	Average Savings per Month	Years Hit Deductible
				Individual Coverage			
1	43	5,242.44	-2,375.65	0	2,866.79	66.67	-
2	43	5,242.00	-4,365.00	0	877.00	20.40	97,98,99,00
3	44	5,369.96	0.00	0	5,369.96	122.04	-
4	43	5,242.44	-1,435.90	0	3,806.54	88.52	99,00
5	43	5,242.44	0.00	0[a]	5,242.44[a]	121.93	-
6	30	3,657.60	-289.25	0	3,368.35	112.28	-
7	4	490.48	-160.00	0	330.48	82.62	-
8	5	578.91	0.00	0	578.91	115.78	-
9	7	853.44	-354.09	0	499.35	71.34	-
10	5	579.29	0.00	0	579.29	115.86	-
11	15	1,828.80	-370.62	0	1,458.18	97.21	-
12	9	1,103.58	0.00	0	1,103.58	122.62	-
13	14	1,716.68	-315.00	0	1,401.68	100.12	-
14	43	5,247.46	-3,418.21	0	1,829.25	42.54	-
15	18	2,193.82	0.00	0	2,193.82	121.88	99,00
16	1	121.92	0.00	0	121.92	121.92	-
Average savings per month per employee						$95.23	
Average savings per year per employee						$1,142.80	
				Family Coverage			
17	38	10,687.88	6,129.47	0	4,558.41	119.96	-
18	27	7,594.02	6,817.69	0	776.33	28.75	99
19	43	12,097.33	9,627.00	0	2,470.33	57.45	-
20	31	5,717.00	5,000.00	0	717.00	23.13	00
21	43	12,093.25	11,020.00	0	1,073.25	24.96	-
22	1	243.00	0.00	0	243.00	243.00	-
23	42	11,812.92	2,200.00	0	9,612.92	228.88	-
24	29	7,237.92	5,467.73	0	1,770.19	61.04	99
Average savings per month						$98.40	
Average savings per year						$1,180.75	

[a]Funds in excess of $3,500 transferred to an MSA brokerage subaccount for higher interest earnings.

charge of managing their routine health care expenses and beginning its self-insured coverage at higher thresholds, Cato saved additional money by raising the levels at which it purchased its own third-party reinsurance coverage (monthly premiums paid by Cato per employee dropped from $67.93 in 1998 to $67.14 in 1999 and to $64.34 in 2000). Although Cato employees paid higher amounts out of pocket for health care, their total MSA deposits were even higher, resulting in a net savings for employees for the 1998–2000 period of approximately $565 per employee per year ($299,314 total MSA deposits, $164,352 total covered health care expenses billed to employees, leaving total net employee savings—apart from interest earnings—equal to $134,962).

A survey of Cato employees conducted in August 2000 revealed that all but one of them retained positive balances in their MSAs, no one had ever withdrawn MSA funds for nonhealth spending purposes, and balances grew higher the longer one participated in the MSA health plan. Average savings retained in MSAs were $95.23 per month ($1,143 annually) for those employees with individual coverage and $98.40 per month ($1,181 annually) for surveyed employees with family coverage (Table 5).

In addition to gaining a new source of enhanced personal savings and greater control over their individual health care choices, Cato employees profited from the MSA plan's health spending economies when Cato used its budget savings to help finance a new 401(k) retirement benefit plan.

Nonqualified MSA Plans for Larger Employers

Like many medium- to large-sized employers, Golden Rule Insurance Company did not qualify for the HIPAA MSA demonstration project because it employed more than 50 workers. Therefore, the company continued to offer its 1,000 employees the nonqualified MSA plan options that Golden Rule had in place before the HIPAA MSA program.

Golden Rule offers its employees three choices in health insurance plans. Employees may choose between two types of MSA plans and a traditional indemnity plan. Under each plan, Golden Rule offers its employees the opportunity to choose coverage within a full doctor/hospital network or hospital networks where available. Use of a network provider will result in significant cost savings. Under this full preferred provider organization coverage, the provider used must participate in the designated network. Benefit payments to other nonparticipating providers are reduced by 20 percent. However, this "penalty" applies to payments for claim amounts above the plan's applicable deductible, and it is capped at $5,000 per person per calendar year. The penalty will be waived in emergency situations, as defined by the insurance policy.[118]

Golden Rule's MSA option offers a high-deductible health insurance plan along with a company-sponsored fund, which employees can use to pay for any health expenses below the deductible level. Any money left in the fund at the end of the year is distributed to employees as taxable income. The Golden Rule MSA requires only one deductible for all family members. Under the MSA 100% Option®, benefits are paid at 100 percent of covered expenses after the deductible is met. Under the MSA 80% Option®, benefits are paid at 80 percent of covered expenses after the deductible is met, with a maximum additional out-of-pocket expense of $1,000. Benefits then are paid at 100 percent of remaining covered expenses.

Golden Rule's other health insurance option, the Traditional Plan®, pays for benefits at 80 percent of covered expenses after the $500 deductible is met. Each family member, up to a maximum of three, has to meet a separate deductible. Each family member (no maximum) is subject to maximum out-of-pocket costs of $1,000 per covered person (20 percent of the $5,000 per person out-of-pocket maximum exposure above the $500 deductible).

Prescription drug coverage is included under all Golden Rule plans with preferred

The Bush administration's proposals for reform and expansion of MSAs, along with the Medical Savings Account Availability Act, target the key steps needed to provide a fairer test of MSAs for all Americans.

Table 6
MSA Refunds to Golden Rule Employees

Year	Total	Average Refund
2000	$533,948	$989
1999	$556,927	$1,016
1998	$581,177	$963
1997	$624,747	$924
1996	$707,693	$976
1995	$823,022	$997
1994	$734,037	$1,002
1993	$468,549	$603
Total	$5,030,100	$603

Source: Jo Ann Robinson, Golden Rule Insurance Company.

pricing provided through a prescription card service. All plans have a $1 million maximum lifetime benefit limit per covered person. The premium payments for those plans may be made with pretax dollars through a section 125 plan. Golden Rule pays 75 percent of those premiums and the employee pays the remaining 25 percent through the section 125 option.

Nearly 98 percent of Golden Rule's employees with company-sponsored insurance coverage have chosen the MSA option. In 2000, 79 percent of the 687 employees with MSAs received year-end refunds averaging $989 each (Table 6). Most employees chose to receive their MSA balance refund as a check, although they have the option of rolling it over to cover the following year's health care expenses. Even if an employee chooses to roll over his MSA refund, it still is not tax advantaged because the Golden Rule plan is not a HIPAA-qualified plan. The rollover would be into an annuity that allows withdrawals for any medical purpose without an additional penalty or fee. Under a traditional health insurance plan, those accumulated funds would already have been paid toward the insurance portion of the policy. Golden Rule's MSA plan saves that money and distributes it to employees and their families. From 1993 to 2000 the company refunded a total of $5,030,100 to its employees.[119]

Reconsidering the Future for MSAs

Although the current HIPAA MSA pilot program for certain Americans under age 65 was set to expire December 31, 2000, Congress voted on December 15 to extend that deadline another two years, until December 31, 2002.[120] (It also gave federally qualified MSAs a new name, "Archer MSAs.") After that date, all eligible individuals who previously made or received MSA contributions (or who are employed by certain employers whose employees previously used those employers' MSA plans) will still be able to make or receive MSA contributions—as long as they remain eligible individuals (e.g., they continue to be self-employed or they do not switch to another employer that does not currently, or did not previously, sponsor an MSA plan).[121] Despite this temporary "stay of execution" for the HIPAA MSA demonstration project, the remaining structural flaws and handicaps within current law remain unchanged.

Political momentum for fixing MSA problems increased during the 2000 presidential campaign. Republican candidate Gov. George W. Bush advocated permanent legal status for an expanded version of MSAs that would be available to all Americans. Bush favored lifting the federal cap of 750,000 on the number of accounts. He would allow all employers to offer MSAs to their workers. He supported lower minimum deductibles for accompanying catastrophic health insurance plans ($1,000 for individuals and $2,000 for families), and he would let both employers and employees contribute to MSAs.[122] During the second presidential campaign debate in Winston-Salem, North Carolina, on October 12, 2000, Governor Bush noted that his plan to make health care affordable and available included expanded access to MSAs. He explained:

> First, there are some who should be buying health care who choose not to. . . . Some of the healthy folks, you know the young kids say I'll never get sick; therefore I'm not going to have—don't need health care right

now. And for those, what I think we need to do is to develop an investment-type vehicle that would be an incentive for, for them to invest. Like medical savings accounts with rollover capacity. In other words, you say to a youngster, it'll be in your financial interest to start saving for future illness.[123]

On the other hand, Democratic candidate Vice President Albert Gore was opposed to efforts to broaden MSAs, arguing that such proposals have the potential to segment healthy populations from the sick in the insurance market and leave sicker populations with higher health care costs.[124]

After he was elected president, Bush followed through on his commitment to MSAs in developing his administration's new health care reform agenda. His budget message to Congress on February 28 included new tax provisions to extend Archer MSAs permanently.[125] The Bush administration's budget plan also proposed removal of the 750,000 cap on the number of accounts in the MSA program, effective after December 31, 2001. The administration would expand eligibility to include all individuals and employees of firms of all sizes covered by a high-deductible health plan (except individuals claiming a proposed refundable tax credit for health insurance premiums for the same taxable year). The Bush plan also would modify the definition of "high deductible" to permit deductibles as low as $1,000 for individual coverage policies and $2,000 in all other cases. It would increase the maximum annual tax-preferred MSA contribution to 100 percent of the deductible; allow those tax-preferred contributions to be made by the employee, the employer, or both up to the applicable annual limit for the individual; and allow contributions to MSAs under cafeteria plans.[126]

The Medical Savings Account Availability Act of 2001, sponsored in the House (H.R. 1524) by Representatives Thomas and Lipinski and in the Senate (S. 1067) by Senators Grassley, Torricelli, and Craig, would enact the Bush proposals described above (except for the refundable tax credit disqualification). The bills also would provide incentives for PPOs to offer MSAs, by allowing MSA-eligible PPOs to offer first-dollar coverage on preventive care that is not mandated by state law.

How to Improve and Expand MSAs for Everyone

The federal MSA program has been unnecessarily handicapped, if not permanently crippled, by HIPAA's unreasonable restrictions on the MSA demonstration project. The Bush administration's proposals for reform and expansion of MSAs, along with the Medical Savings Account Availability Act, target the key steps needed to provide a fairer test of MSAs for all Americans. Last year's simple extension of the flawed HIPAA experiment for two additional years did not otherwise change the original terms of the program. If Congress wishes to improve health care choices for consumers, it should not only permanently authorize federally qualified MSAs. It should also

- lift the 750,000 enrollment cap and allow an unlimited number of people to have MSAs;
- expand MSA eligibility to include employees in businesses of all sizes, as well as employees without employer-sponsored insurance;
- allow MSA plans to offer a much wider range of deductibles, with lower minimum and much higher maximum level requirements;
- allow MSA holders to fund fully their MSAs each year (at least up to 100 percent of the insurance policy deductible);
- allow employers and employees to combine their contributions to MSAs at any time within a given year; and
- either preempt first-dollar state-mandated benefits or provide the flexibility for MSA plans to adjust to comply

Without permanent authorization of tax-qualified MSA insurance options, major insurers will remain reluctant to enter a limited, short-term market and commit significant resources to expanding it.

with those conflicting insurance mandates.

Permanent Authorization. The two-year extension of the Archer MSA program still provides no certainty that this insurance market will be able to continue and grow beyond 2002. Without permanent authorization of tax-qualified MSA insurance options, major insurers will remain reluctant to enter a limited, short-term market and commit significant resources to expanding it. Most innovative tax products require longer than four to six years to fully take hold. For example, IRAs, which were not handicapped with as many eligibility restrictions and product design requirements as MSAs, were first introduced in 1974, and by 1978 fewer than 100,000 of them had been sold.[127] It takes time to develop and market new employee benefits to the general public.

Lifting Enrollment Caps. The current numerical limit of 750,000 was temporarily removed under the two-year extension of the Archer MSA program, but it remains unclear whether it would be restored in the future, particularly if enrollment surged closer to the old limits. The old numerical cap clearly kept the largest insurance players out of the MSA market during its early years, by discouraging them from aggressively marketing an MSA product nationwide for such a small number of customers.[128]

Eligibility for All Businesses and All Workers. HIPAA limited MSA eligibility to employers in the small-group market and the self-employed in the individual market. Unfortunately, small employers lack the time, resources, staff, and expertise to experiment with innovative health care benefits, evaluate alternatives, improve existing benefits, or educate their employees about new options. The small-group market operates under more volatile economic conditions as well as the burden of the most onerous state regulations and mandated benefits. Removing the size limits on businesses eligible for MSAs would allow insurers to market plans to large employers and provide a much fairer test of MSAs in all market segments.[129]

Allowing a Wider, More Flexible Range of Deductibles. The narrow range between minimum and maximum deductible levels allowed for Archer MSAs fails to meet consumers' needs. It prevents insurers from offering a greater variety of qualified policies and adjusting to demands from different market segments and population groups. Current minimum deductible level requirements may be too high for lower-income families. Possible alternatives include switching the minimum deductible level to a required minimum amount of total cost-sharing exposure or setting lower minimum deductibles and gradually raising them as MSA funds accumulate. Maximum deductible level ceilings for Archer MSAs also prevent market forces from determining how much out-of-pocket cost sharing different consumers face. Limits on cost sharing also may hamper efforts by managed-care plans to encourage use of network providers. They may restrict coverage of particular benefits customarily subject to high coinsurance requirements (e.g., mental health, prescription drugs) and eliminate incentives to control costs after policyholders meet their deductibles. HIPAA rules also prevent health plans from varying deductibles according to types of medical services (e.g., discretionary versus preventive or emergency) or geographic differences in health care costs.[130]

Full and Flexible Funding of MSAs. Allowing MSAs to be funded annually in an amount at least up to 100 percent of the insurance deductible level, and at any time of the year, would make MSAs more appealing and available to consumers. Instead of being limited to prorated monthly MSA contributions, consumers could set aside money early in the year for enhanced protection against unexpected medical bills. An earlier full funding option also would reduce current disincentives for MSA plan sales in the latter half of any given year. Permitting combined contributions by an employer and an employer to a single MSA would further enhance prospects for sufficient funding.[131]

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Dealing with State Insurance Mandates. Most state-imposed regulatory barriers to MSA plan availability could be knocked down either by preempting benefits mandates for MSA plans or by allowing accompanying high-deductible insurance policies to cover state-mandated "preventive" services benefits.

Additional Options. MSAs could be made even more attractive by allowing workers to roll over unspent money in their flexible spending accounts at year-end into their MSAs on a tax-free basis. Tax penalties could be eliminated for withdrawals from MSAs for nonqualified expenses, as long as the distributions do not reduce the remaining MSA balance below the level of the annual insurance deductible. Congress also could authorize the Federal Employees Health Benefits program to offer MSA options, and it could allow MSAs to be offered under cafeteria plans for tax-advantaged employee benefits.

Conclusion

The fight over MSAs in Congress remains fundamentally about control. MSAs give control to patients and physicians. Advocates of nationalized health care understand that expanded use of MSAs and their institutionalization in private health care markets will block any hope for a government-run health care system. Managed-care insurance companies understand that MSAs represent a new competitive alternative that could undercut the value of the insurance products in which they have invested over the last few decades.[132]

After several years of restrained increases, health insurance premiums are rising again at rates several times the rate of inflation. These premium hikes are expected to continue over the next three years and will result in more people, particularly middle-class families and those working in small businesses, becoming uninsured. Many small employers are experiencing even higher annual rate increases of 15 to 20 percent. When premiums rise, employers are often forced to pass on those costs to their workers, or eliminate health benefits entirely. Many workers simply become uninsured, because they either cannot afford the additional cost of their employers' insurance or cannot pay for their own individual insurance policies.

More than seventy percent of Americans covered by insurance file less than $500 in medical claims a year. Expanding the availability of federally qualified MSAs with high-deductible coverage could allow many of those people to economize on insurance costs, save for future medical and long-term-care expenses, and still be protected against the expense of a catastrophic illness. Potential MSA customers certainly will be interested in purchasing more flexible and better-structured MSA plans. A nationwide random survey from the Kaiser Family Foundation and Harvard University found that, of 1,001 adults surveyed, 43 percent said they would be very likely to somewhat likely to choose an MSA if the deductible were $2,000. If the deductible were $5,000, 37 percent said they would be very likely to somewhat likely to choose an MSA.[133] Other market studies by the Council for Affordable Health Insurance and the National Blue Cross Blue Shield Association found that almost half of all employees would definitely or probably switch to an MSA if it were offered to them.

We have enough evidence to indicate the right and wrong ways to provide MSA insurance options. Congress should see the merits of MSAs and allow everyone the opportunity to establish one. Simply peeling off the special legislative and regulatory restrictions on federally qualified MSAs would go a long way toward correcting the problems that hamper the current MSA program.[134] In the meantime, nonqualified MSAs remain available as an alternative.

As Cato's director of health and welfare studies, Michael Tanner, observed shortly after the original MSA experiment was authorized in 1996: "While MSAs are not a 'silver bullet' that would instantly solve the problem of Americans without health insurance, they

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would be a major step on the road to universal access. . . . It would be a shame if naked self-interest or ideological zeal prevented genuine, consumer-oriented health care reform."[135]

Notes

1. State MSAs provided *state* income tax deductions for contributions made to MSAs. The first MSA prototypes typically were employer-sponsored health benefit MSA programs that provided less comprehensive health insurance (i.e., greater employee cost sharing) and put aside additional money in separate health accounts for employees, but they did not necessarily provide special tax treatment for those accounts. For a more detailed discussion of early MSA-type programs, see Peter Ferrara, "More Than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis no. 220, March 14, 1995; and Stan Liebowitz, "Why Health Care Costs Too Much," Cato Institute Policy Analysis no. 21, June 23, 1994, pp. 20–21.

2. Employer-sponsored flexible spending accounts (FSAs), first authorized under the Revenue Act of 1978, already allowed workers to make pretax contributions to accounts earmarked for health care expenses. However, because unspent portions of annual FSA employee contributions that are dedicated to health care expenses are forfeited to the employer at the end of the plan year, FSA incentives to "save" for health care are very short term.

3. Victoria Craig Bunce, "Snapshot: What Are Medical Savings Accounts?" Council for Afford-able Health Insurance Policy Brief 2, no. 7, July 1, 1998, updated as Policy Brief 4, no. 1, September 2000. The states include Arizona, California, Colo-r-ado, Idaho, Illinois, Indiana, Louisiana, Michigan, Mississippi, Missouri, Nevada, Montana, New Mexico, Ohio, Oklahoma, Pennsylvania, Utah, Washington, and West Virginia.

4. Internal Revenue Service, Announcement 99-95, *Internal Revenue Bulletin,* no. 1999-42, October 18, 1999.

5. "Bush and Gore: Issue by Issue: An Update," *National Journal,* September 30, 2000.

6. The Community Renewal Tax Relief Act of 2000, H.R. 5542, was incorporated in the Labor–Health and Human Services appropriations bill, H.R. 4577, and approved by the House and Senate on December 15, 2000.

7. Office of Management and Budget, *A Blueprint for New Beginnings* (Washington: Government Printing Office, February 28, 2001).

8. The main difference between federally qualified and nonqualified MSAs is that qualified MSAs are available only for the self-employed and employees working for an eligible employer that has 50 or fewer employees. Employers with more than 50 employees that set up MSA-type programs do not receive the federal tax benefits provided under HIPAA. However, many nonqualified MSAs do receive state income tax relief, and HIPAA's special rules for qualified MSAs do not apply to them.

9. For example, the premium for a $3,100 deductible policy can be almost half that for a $500 deductible policy. See Bunce, "Snapshot," pp. 1–4.

10. Self-employed workers enjoy greater tax advantages with high-deductible MSA health plans than with a traditional insurance plan. Under current law self-employed workers may deduct only 60 percent of conventional health insurance premiums. The health insurance tax deduction for the self-employed is set to increase to 70 percent in 2002 and to 100 percent thereafter. On the other hand, a self-employed individual who purchases a federally qualified MSA plan may already deduct 100 percent of his contributions to the MSA component.

11. In 1993 the Alexandria, Virginia–based Council for Affordable Health Insurance, my employer, purchased health insurance for its employees with a $1,000 annual deductible for each covered worker. CAHI also provided $700 (pretax funding) in periodic payments to each employee's MSA, prorated on a monthly basis. (Employees were allowed to borrow the entire $700 from CAHI to prefund the high-deductible amount, if necessary, provided that they first signed a form and received approval.) Workers shopped around for routine medical services and substituted generic prescription drugs for brand name drugs in an effort to save "their" money. At the end of the year, CAHI employees could cash out any remaining money or roll it over for future medical expenses. I needed to see a specialist during the first year of CAHI's MSA plan. I negotiated with my doctor the price of several in-office tests. I reduced the total bill from $800 to $500 simply because I was paying out of my own pocket and my doctor was not submitting the claim directly to the insurance company. I still received all the tests necessary to make a diagnosis, at a lower price.

12. Health Care Financing Administration, "Table 9: Personal Health Care Expenditures by Type of Expenditure and Source of Funds: Selected Calendar Years, 1991–1998," HCFA Office of the Actuary, undated, http://www.hcfa.gov/stats/ nhe-oact/tables/t9.htm.

13. Ferrara; and Liebowitz.

14. Liebowitz concluded in 1994 (almost a decade ago) that overall health care spending in the United States was approximately double what it would have been in the absence of any third-party

payments for health care. He also estimated that excessive administrative costs due to our third-party payment system might have been as high as $33 billion per year.

15. For more information on indemnity, preferred provider organizations, and other managed-care insurance plans, see James Perry and Victoria Craig Bunce, "HMOs and PPOs: Differences for Lawmakers and Policy Holders," Council for Affordable Health Insurance Policy Brief 3, no. 7, August 5, 1999, pp. 1–10. To the extent that managed-care insurance offers comprehensive, first-dollar coverage of routine medical services, it increases health care utilization. In order to overcome that effect and still reduce or contain overall costs, health maintenance organizations (HMOs) aggressively control the health care treatment of their policyholders through precertification of hospital care and more restricted access to other types of long-term, high-cost (and, arguably, less-effective) treatments. HMOs typically use a gatekeeper to steer a patient through their network of health care providers in a cost-conscious manner.

16. A $1,000 deductible in 1982 (when the RAND HIE concluded) is equivalent to about a $2,800 deductible in today's dollars. The four different coinsurance rates (the percentage of covered expenses to be paid out of pocket) were 0, 25, 50, and 95 percent. Each plan also had a maximum dollar limit on annual out-of-pocket expenses of 5, 10, or 15 percent of family income, up to a maximum of $1,000. Beyond that amount, the insurance plans reimbursed all covered expenses in full. Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review* 77, no. 3 (June 1987): 253.

17. Ibid., p. 259.

18. Ibid., p. 251.

19. Robert Brook et al., "The Effect of Co-Insurance on the Health of Adults," RAND Corporation, Santa Monica, Calif., 1984; and Manning et al.

20. The average deductible under most private health insurance coverage remains relatively low. For example, only 9 percent of employees participating in non-HMO health plans sponsored by medium- and large-sized private employers in 1995 faced annual deductibles greater than $300. Only 15 percent of employees participating in non-HMO health plans sponsored by small private employers in 1995 faced annual deductibles greater than $300. (HMOs traditionally do not impose deductibles on policyholders.) Paul Fronstin et al., *EBRI Databook on Employee Benefits,* 4th ed. (Washington: Employee Benefit Research Institute, 1997), p. 257.

21. In a 1997 study of MSAs for the Buckeye Institute, Cleveland State University professor Michael Bond noted that the American Academy of Actuaries estimated that MSA administrative expenses should run around 2 percent of total MSA contributions in a given year. With more conventional low-deductible insurance plans, there are many more relatively low-cost items for which administrative expenses represent a high percentage of the claim payments. When an employee uses the savings component of his MSA to pay smaller, routine expenses, he bypasses costly insurance bureaucracies and their forms. Bond found that estimates of the administrative savings from MSAs for a standard family policy were in the range of $400 or more annually. Michael T. Bond, "Medical Savings Accounts: A How to Guide for Ohio Businesses and Employees," Buckeye Institute for Public Policy Solutions, February 1997, p. 10; and "Medical Savings Accounts: Cost Implications and Design Issues," American Academy of Actuaries Public Policy Monograph no. 1, May 1995, pp. 7, 11.

22. Vern S. Cherewatenko, www.simplecare.com, March 30, 2000, visited August 23, 2000.

23. Ibid.

24. SimpleCare was organized in Seattle, Washington, by a group of physicians led by Vern Cherewatenko, M.D.; David MacDonald, D.C.; and Nass Ordoubadi, M.D. The group focuses on serving the 20 percent of patients who either are uninsured or are covered by insurance policies with high deductibles. Its parent organization, the nonprofit American Association of Patients and Providers, has developed SimpleCare into a nationwide program. Its mission is to educate health care providers and encourage them to charge fair and reasonable fees to patients who are willing to pay in full at the time they are seen, so there is no billing or coding involved. Members include more than 600 primary and specialty physicians, laboratories, pharmacies, and hospitals. To date, there are several thousand patient subscribers, and that number is growing rapidly. Keri Andrews, SimpleCare Membership Department, personal communication, August 23, 2000. For more information, visit www.simplecare.com.

25. For example, Dr. Cherewatenko offers three types of office visits: short ($35), medium ($65), and long ($95). There are no codes, and chart notes are of the old-fashioned type: terse and limited to information that he needs to treat the patient. Because he charges an additional $50 for billing the patient, almost all patients write a check before

they leave the office. Cherewatenko says that, on each $79 office visit under managed care, he lost $7 overall to additional overhead expenses. Now, for the same "short" visit (approximately 10 minutes), he nets $5 from a charge of only $35. *AAPS News* 54, no. 9 (September 1998). See also www.sitewave.net/aaps/newsletters/setp98.htm; www.aapp.net; and www.simplecare. com.

26. "Doctor Charges $2 a Minute at Walk-In Clinic," *Wall Street Journal,* April 24, 2000.

27. Victoria Craig Bunce, "Medical Savings Accounts: Questions and Answers," Council for Affordable Health Insurance Issue Brief, May 1996.

28. Katherine Swartz, "Rising Health Care Costs and Numbers of People without Health Insurance," Prepared for the Council on the Economic Impact of Health System Change conference, "Renewed Health Care Spending Growth: Implications and Policy Options," Washington, January 11, 2001. Swartz notes that the majority of standardized policies currently available are "generous and expensive—making them unaffordable to low-income people." On the other hand, catastrophic insurance for very large, less-predictable health care expenses reduces moral hazard incentives. It forces consumers to bear the full marginal costs of health care up to the point where their use of health care exceeds the deductible. Swartz recommends that such health insurance coverage define "catastrophe" relative to an insured customer's income.

29. If the holder of a tax-qualified MSA under HIPAA changes employment and moves to a company that has more than 50 employees, he still owns the current MSA funds but loses the ability to make additional contributions to the account. Any accumulated funds remain available for medical care payments, without penalty.

30. MSA funds may be withdrawn, without any tax consequences or additional penalties, to pay insurance premiums for COBRA-type health care continuation coverage or other health coverage while an individual receives unemployment compensation. Internal Revenue Service, "Providing Answers to Commonly Asked Questions about Medical Savings Accounts," Notice 96-53, *Internal Revenue Bulletin,* no. 1996-51, December 16, 1996, pp. 5–8.

31. U.S. General Accounting Office, "Comprehensive Study of the Medical Savings Account Demonstration," GAO/HEHS-98-57, December 31, 1997.

32. Betsy Hart, "A Simple Choice for Less-Expensive Medical Care," *Naples Daily News,* August 16, 1999.

33. www.opm.gov/insure/health/index.htm.

34. Victoria Craig Bunce, "State Tracking for CAHI Members, 2001," Council for Affordable Health Insurance, 2001. CAHI tracks state and federal legislation and regulatory rules for its members and provides them information on both the CAHI Web site and a quarterly CD-ROM.

35. Victoria Craig Bunce, "What Is Section 213(d) of the Internal Revenue Code and How Does It Relate to MSAs?" Council for Affordable Health Insurance Policy Brief 2, no. 6, July 1, 1998, pp. 1–6, updated as Policy Brief 4, no. 2, September 2000.

36. Account holders with federally qualified MSAs established under the HIPAA pilot program may withdraw accumulated funds for nonmedical purposes at age 65 with no additional tax penalties.

37. The "use it or lose it" forfeiture rule applies to FSAs that are funded by voluntary, pretax reductions from an employee's wages.

38. Jesse Hixson, principal economist, American Medical Association, Chicago, Illinois, personal communications, August 28, 2000, and January 8, 2001. Hixson began circulating his health bank concept in the mid-1970s.

39. Paul Worthington, who was a fellow at the Social Security Administration when he helped develop the health bank concept with Hixson, outlined it further in "Alternative Prepayment Finance for Hospital Services," *Inquiry* 15, no. 3 (September 1978).

40. For more information on MSAs from the American Medical Association, see www.ama-assn.org. Recently, the AMA made an MSA program available to its members.

41. John Goodman and Richard W. Rahn, "Salvaging Medicare with an IRA," *Wall Street Journal,* March 20, 1984.

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

43. Ferrara; and Rachel Wildavsky, "Health Care Reform That Works," *Reader's Digest,* October 1993. Because of a recent merger, Dominion no longer offers this particular health benefit plan, according to Dominion's manager of employee benefits Dennis Wright. Personal communication, June 21, 2000.

44. Jo Ann Robinson of Golden Rule Insurance Company, Indianapolis, personal communica-

tions, June 2000 through December 12, 2000. Robinson explained that, in the case of coverage for a family of four, there were three separate individual deductibles of $500 each and a 20 percent copayment for all four family members, for a total out-of-pocket maximum of $5,500.

45. Ferrara; and www.msanews.com. Information verified with Jo Ann Robinson, personal communication, August 29, 2000.

46. Golden Rule Insurance Company is a founding member of the Council for Affordable Health Insurance and helped CAHI lobby for the enactment of MSAs in the states.

47. Missouri House Bill 564 established MSAs for employer plans, effective July 1, 1993. Christine F. Popolo and Duane Parde, "Health Care Reform in the States, 1995," Council for Affordable Health Insurance, September 1995.

48. Bunce, "Snapshot."

49. Ibid.

50. Ibid. As of June 2001, CAHI reports that those states are Alaska, Arizona, Colorado, Louisiana, Michigan, Montana, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, and Washington.

51. Victoria Craig Bunce, "Side by Side of Medical Savings Account Legislation," Council for Affordable Health Insurance, August 1992 and December 2000 (updated regularly). Other significant MSA bills included S. 2387, introduced on September 8, 1992, by Sens. John Breaux (D-La.), Tom Daschle (D-S.Dak.), Sam Nunn (D-Ga.), Dan Coats (R-Ind.), David Boren (D-Okla.), Richard Lugar (R-Ind.), and Alan Dixon (D-Ill.).

52. The most significant MSA bill was H.R. 3065, introduced by Reps. Andy Jacobs (D-Ind.) and Bill Archer (R-Tex.).

53. Emmett B. Keeler et al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association* 275, no. 21 (June 5, 1996): 1666–71.

54. Ibid., pp. 1668, 1669.

55. Ibid., pp. 1667, 1669.

56. Ibid., pp.1669, 1671.

57. Ibid., p. 1671.

58. Ibid.

59. Public Law 104-191, 110 Stat. 1936.

60. The Internal Revenue Service counts all family members as a single unit when counting MSA holders since the count is based on individual tax returns. HIPAA's numerical limitation for 1997 would have been exceeded if the number of MSAs established as of April 30, 1997, had exceeded 375,000, or as of June 30, 1997, had exceeded 525,000. For 1998 the MSA numerical limit would have been determined to be exceeded if the estimate of the secretary of the treasury had exceeded 600,000, and, for 1999, if it had exceeded 750,000. Because the statutory limits for those preceding years were never exceeded, the number of taxpayers allowed to hold MSAs throughout 2000 remained limited to the first 750,000 account holders as tabulated under IRS rules (e.g., a family counted as one account holder and previously uninsured individuals establishing MSAs would not be counted toward this threshold level). For additional details, see 26 U.S.C.S. sec. 220 (1996).

61. The Internal Revenue Service provided the cost-of living adjustments for tax year 2000 in Revenue Procedure 99-42, *Internal Revenue Bulletin,* no. 1999-46, November 15, 1999, p. 571, http://www.irs.ustreas.gov/prod/bus_info/bullet.html. For MSAs, the cost-of-living adjustments set the following limits for high-deductible levels and out-of-pocket costs: Self-only coverage—$1,550 minimum annual deductible, $2,350 maximum annual deductible, $3,100 maximum annual out-of-pocket expenses. Family coverage—$3,100 minimum annual deductible, $4,650 maximum annual deductible, $5,700 maximum annual out-of-pocket expenses.

In late December 2000, the IRS announced new cost-of-living adjustments for tax year 2001: Self-only coverage—$1,600 minimum annual deductible, $2,400 maximum annual deductible, $3,200 maximum annual out-of-pocket expenses. Family coverage—$3,200 minimum annual deductible, $4,800 maximum annual deductible, $5,850 maximum annual out-of-pocket expenses.

62. According to www.msacentral.com, eligible medical expenses under sec. 213(d) of the Internal Revenue Code may extend well beyond those that are ordinarily covered under most health insurance plans. Tax-exempt MSA withdrawals may be for acupuncture, alcoholism treatment, birth control pills by prescription, blood tests, chiropractors, dentures, prescription drugs, funeral expenses, glasses, guide dogs for the visually impaired, health club dues, hearing aids and batteries, hospital bills, household help, certain insurance premiums, lead paint removal, maternity clothes, meals related to hospital care, opera-

tions, optometrists, oxygen, personal use items, psychiatric care, psychoanalysis, smoking cessation programs, telephone and television for the hearing impaired, therapy, wheelchairs, x-rays, and so on. For a complete list, see www.msacentral.com; "Medical and Dental Expenses," IRS Income Tax Publication 502; and "Medical Savings Accounts," IRS Income Tax Publication 969, www.irs.gov.

63. COBRA requires employers who provide group health plans and have 20 or more employees to offer continuation coverage to any of those employees and their dependents who experience specific qualifying events, including changes in job or family status. In general, when a covered employee experiences termination, or reductions in hours, of employment, the period of continued coverage available to the employee and any qualified beneficiaries may be as long as 18 months. For other qualifying events (e.g., death, divorce, legal separation, or if a child turns the age of majority under the plan), the maximum duration of coverage is three years. See Public Law 99-272, 100 Stat. 83.

64. The MSA withdrawal penalty is 5 percent greater than the early withdrawal penalty (10 percent) for individual retirement accounts (IRAs). In addition, the MSA holder may roll over a distribution (withdrawal) of assets from one MSA to another MSA without penalty if he follows the one rollover per year rule. Generally, the rollover must take place within 60 days after the distribution to qualify as tax-free.

65. Internal Revenue Service, "Providing Answers to Commonly Asked Questions about Medical Savings Accounts," Notice 96-95, *Internal Revenue Bulletin,* no. 1996-51, December 16, 1996, pp. 5–8. The notice states in Q-25/A-25: "After the pilot project ends, all eligible individuals (as described in A-2) who previously made or received MSA contributions (or who are employed by certain employers whose employees previously used MSAs) can make or receive MSA contributions, if they remain eligible individuals. In addition, eligible individuals can continue to receive distributions from MSAs (as described in A-20 through A-22).

66. U.S. General Accounting Office, "Medical Savings Accounts: Results from Surveys of Insurers," GAO/HEHS-99-34, Report to congressional committees, December 1998. GAO also noted that insurers view high-deductible insurance plan enrollees as lower claim risks than enrollees in traditional low-deductible plans. The ratios of the actuarial value of insurance benefits to the enrollees' premiums for the benefit were significantly greater than the ratios for low-deductible plans. However, the difference in premium between qualifying high-deductible plans and low-deductible plans in 1998 was not as large as the difference in plan deductibles.

67. Kelly Loussedes, "MSA Vendor List," Council for Affordable Health Insurance, January 2001, www.cahi.org (updated regularly). This count is based on industry comments to CAHI, and it should not be considered a comprehensive or necessarily up-to-date list because companies' products and business decisions change frequently. CAHI contacts the companies approximately quarterly to see if they are still in the market and updates the information accordingly. CAHI also tracks the states and markets in which the companies are doing MSA business.

68. HIPAA required MSA trustees and custodians to report to the IRS by August 1 of each year (1997, 1998, and 1999) the number of MSAs established before July 1 of that year. Information reporting required by statute for MSAs was similar to information reporting for IRAs—contributions, distributions, and deductions. The IRS then announced the information no later than October 1 of the relevant year. After October 1, 1999, there was no longer any need for the IRS to announce the information, because of the then-imminent sunset date of December 31, 2000.

69. Internal Revenue Service, Announcement 99-95, p. 520.

70. "Washington Report: New Type of Health Plan Remains Available," *Lawyers Weekly USA,* October 18, 1999.

71. Council for Affordable Health Insurance, "Medical Savings Accounts: Common Questions from Member Survey," December 1996; and Council for Affordable Health Insurance, "Member Survey on MSAs," December 1997. Insurers have cited a number of problems in marketing HIPAA MSAs. Brokers need more training to sell qualifying plans effectively because of the added complexity of the tax effects of MSAs. Because insurance agent commissions generally are calculated as a percentage of policy premiums, they are generally lower for high-deductible products than for more comprehensive, lower-deductible products (in general, brokers receive little or no compensation for selling the savings vehicle component of the MSA product). Agents and brokers also seem to spend more time on average selling the qualifying plans and MSAs than selling other health insurance products.

72. Greg Scandlen, "Medical Savings Accounts: Obstacles to Their Growth and Ways to Improve Them," National Center for Policy Analysis Policy Report no. 216, July 1998, pp. 3–4.

73. For current year limits, see Internal Revenue

Service, Revenue Procedure 99-42, p. 571.

74. It is standard industry practice to allow for geographic differences in the cost of living. For example, a health insurance policy in New York City will not cost the same as in Centerville, Ohio. The MSA deductibles should have allowed for geographic differences to reflect the cost of living in higher-cost areas as well as that of lower-cost areas.

75. Council for Affordable Health Insurance, "Medical Savings Accounts"; and Council for Affordable Health Insurance, "Member Survey on MSAs." Although some CAHI members reported that their premiums for qualifying plans dropped compared with premiums for other high-deductible health plans, that generally reflected a desire to make qualifying plans more competitive and the expectation that their claims experience with HIPAA MSAs would be more favorable than with their other high-deductible health plan blocks of business. Despite expectations that some HIPAA MSA holders would reduce administrative costs and lower premiums by refraining from filing any claims or withdrawing any money until the end of the calendar year, several insurance companies observed that the difference in premiums between qualifying high-deductible health plans and other low-deductible health plans was not as large as the difference in plan deductible levels. The primary factors involved were additional costs due to administrative problems associated with gaining state regulatory approval of high-deductible MSA plans, as well as greater expenses for marketing and agent training. See also U.S. General Accounting Office, "Medical Savings Accounts," p. 14.

76. Because an individual may fund only as much as 65 percent of his annual deductible ($2,250), the maximum allowable contribution amount on a yearly basis would be $1,462.50. That would be equivalent to a monthly MSA contribution of $121.87. For six months of prorated payments, total allowable MSA contributions would equal $731.25. See Council for Affordable Health Insurance, "Medical Savings Accounts."

77. Internal Revenue Service, Revenue Ruling 97-20, *Internal Revenue Bulletin,* no. 1997-19, May 12, 1997, p. 4. The HIPAA legislation became effective January 1, 1997. Health insurance companies wishing to sell MSAs as soon as possible had to have their qualifying high-deductible health plans approved by individual state departments of insurance before that initial date. Many insurance companies were concerned that the IRS remained silent on a number of important issues. If insurers later had to amend MSA contracts to comply with IRS interpretations of HIPAA provisions, they would risk damage to their reputations with customers, open themselves up to lawsuits, and incur the increased costs of revising marketing materials and agent training videos and materials.

78. Guaranteed issue requires that insurers sell policies to any customer who applies and agrees to pay the premium (even customers who wait until they are already sick before they decide to purchase insurance). Open enrollment provides particular limited periods of time when individuals may switch health plans or enroll in a plan for the first time, without being subject to medical underwriting, restrictions on coverage for preexisting conditions, or other insurance limits based on their health status. Community rating requires insurers to charge the same price to everyone in a community, regardless of the differences in risk that individual policyholders may represent.

79. See Joe Holahan, "Guaranteed Issue and Community Rating: States Struggle to Repair the Damage," Council for Affordable Health Insurance Policy Brief 2, no. 1, January 14, 1998, pp. 1–11; and Melinda L. Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," Heritage Foundation Backgrounder no. 1211, August 20, 1998. The Schriver and Arnett study points out that, between 1990 and 1994, 16 states passed very aggressive laws designed to increase access to health insurance for their citizens by imposing mandates and regulations on health insurance for small employers and individual citizens. By 1996 all 16 states experienced an average annual growth in their uninsured population eight times greater than that of the other 34 states. Although many employers bypass most of the burden of state insurance overregulation by self-insuring (such employer benefit plans are protected against state insurance regulation by the Employee Retirement Income Security Act), this option is not widely available for smaller businesses.

80. Victoria Craig Bunce, "State Environment of Health Insurance Laws," Council for Affordable Health Insurance database, www.cahi.org (updated regularly). Bunce has tracked more than 1,200 state-mandated benefits and providers. In the mid-1960s there were approximately seven state-mandated benefits, but by the late 1990s the number had grown to more than 1,200 mandated benefits and providers. An analysis by Milliman & Robertson, Inc., for the National Center for Policy Analysis estimated that the costs of 12 common state mandates collectively can increase the price of health insurance as much as 30 percent. See National Center for Policy Analysis Brief Analysis no. 237, August 13, 1997.

81. Victoria Craig Bunce, "Medical Savings Account State and Federal MSA Environment," Council for Affordable Health Insurance, June 2001, www.cahi.org (updated regularly). See also Bunce, "What Is Section 213(d)?" CAHI identified, in addition to the District of Columbia, the following states: Connecticut, Delaware, Kansas, Maine, Maryland, Minnesota, New York, North Dakota, and Pennsylvania.

82. Bunce, "Medical Savings Account State and Federal MSA Environment." CAHI reports that, as of December 2000, those jurisdictions included Connecticut, which requires a $50 home health deductible in the individual and small-group markets; Washington, D.C., which mandates that 75 percent of the first 40 mental health outpatient visits be covered in the small-group market; Delaware, which does not permit high-deductible health plans in the individual market; Minnesota, which requires small-group market plans to provide 80 percent coverage of the first 10 hours of mental health outpatient therapy and 75 percent of the next 30 hours; North Dakota, where small-group market insurers must provide a first-dollar mental health benefit; and New York, where only basic and standard plans with very low deductibles are allowed in the individual market. In both the group and individual markets, New York state requires skilled nursing coverage, except for plans marketed as a "limited health benefit plan."

83. U.S. General Accounting Office, "Medical Savings Accounts."

84. The Balanced Budget Act of 1997, Public Law 105-33. No Medicare MSAs have been offered thus far because of the narrow rules of the Medicare+Choice program.

85. "MSA, Other Tax Items Would Spur Summers to Urge Managed Care Bill Veto," *BNA's Health Care Policy Report,* July 31, 200, p. 1295.

86. Robert Torricelli, "MSAs Deserve a Healthy Boost," *Wall Street Journal,* July 28, 2000.

87. Peter Deutsch, "Solving the Uninsured Crisis," *Washington Times,* July 28, 2000, p. A15.

88. John C. Goodman, "MSAs: What's at Stake for Patients," National Center for Policy Analysis Brief Analysis no. 207, June 14, 1996.

89. Greg Corie, American Health Value, personal communication, December 11, 2000.

90. Mark Pauly et al., "What Would Happen If Large Firms Offered MSAs?" *Health Affairs,* May–June 2000, pp. 165–72.

91. The firm's decision is based on the preferences of the individual workers. Dana P. Goldman, Joan L. Buchanan, and Emmett B. Keeler, "Simulating the Impact of Medical Savings Accounts on Small Business," *Health Services Research* 35, no. 1 (April 2000): 53–73.

92. Ibid., p. 53.

93. Matthew J. Eichner, Mark B. McClellan, and David A. Wise, "Insurance or Self-Insurance? Variation, Persistence, and Individual Health Accounts," National Bureau of Economic Research Working Paper no. 5640, June 1996.

94. Ibid. See also "Perspective: Real Health Care Reform," *Investor's Business Daily,* October 16, 1998; and National Center for Policy Analysis, "Study Finds Workers Benefit from MSAs," 1997, www.ncpa.org.

95. Although an employer's total cost for *single coverage* under those MSA plans averaged 26 percent more than traditional indemnity plan coverage, Bond, Hrivank, and Heshizer noted that if employers had set the amount of out-of-pocket costs for employees under MSA plans to equal the out-of-pocket costs for the traditional plans, total employer costs for MSA plans then would be only 3 percent higher than for traditional plan costs. A similar adjustment for MSA family plans (equalizing maximum out-of-pocket costs with those under traditional family plan coverage) would reduce employers' MSA plan costs to 55 percent below traditional plan costs. Michael T. Bond, Mary W. Hrivnak, and Brian P. Heshizer, "Reducing Employee Health Expenses with Medical Savings Accounts," *Compensation and Benefits Review* 28, no. 5 (September–October 1996): 51–56.

96. Ibid; and Michael T. Bond, Brian P. Heshizer, and Mary W. Hrivnak, "Medical Savings Accounts: Why Do They Work?" *Benefits Quarterly* 12, no. 2 (1996): 83. Bond and his coauthors noted that another 1995 survey of 17 firms using MSAs found average remaining balances of around $600 for single coverage MSAs and approximately $900 for family coverage MSAs. Up to 80 percent of the employees had funds remaining in their MSAs at year's end. See also Stephen Barchet, J. Anderson, and L. S. Chapman, "Medical Savings Accounts: An Option to Reduce Health Care Costs and Increase Health Care Satisfaction," *ACA Journal* (Autumn 1995): 34–47.

97. www.americanhealthvalue.com.

98. Corie, personal communications, December 11, 2000, June 11, 2001.

99. Idem, personal communications, June 8, 2001, June 11, 2001.

100. Idem, personal communications, December 11, 2000, June 8, 2001.

101. Delaware Investments, established in 1929, is headquartered in Philadelphia. Delaware Investments manages more than 60 mutual funds with more than $17 billion in assets. Information available at www.americanhealthvalue.com.

102. Cathy Treadway, Women's Clinic, Boise, Idaho, personal communication, July 5, 2000.

103. Mary Beth Wilson, Westchester Anesthesiology Clinic, personal communication, June 28, 2000.

104.. Scott Krienke and Kerry Smith, Fortis Health Insurance Company, Milwaukee, "MSA Factoids," Prepared for a Council for Affordable Health Insurance presentation, Alexandria, Va., Fall 1998; and Smith, personal communications, June 2000 through June 2001.

105. Robinson, personal communications, June 2000 through June 11, 2001.

106. Golden Rule's MSA plan for its own employees is not a federally qualified MSA plan because the company employs more than 50 workers.

107. Robinson, personal communication, June 22, 2000.

108. The stop-loss limits under the MSA 80® Plan range from $3,100 to $3,150 for single coverage and from $5,700 to $5,800 for family coverage.

109. Martin Schliessmann, personal communications, July 26, 2000, June 6, 2001.

110. Sixty-three percent of the company's MSAs are purchased as family coverage. Thirty-one percent of all MSA purchasers are more than 50 years old, and fewer than 6 percent of all MSA purchasers are under age 30. Randy Suttles, Medical Savings Insurance Company, personal communications, June 6, 2001, June 28, 2001.

111. Suttles, personal communications, July 5, 2000, June 11, 2001.

112. Christina Anderson Wright, personal communication, June 29, 2000.

113. Dennis Kelly, Plan3, Inc., Rockville, Maryland, personal communications, March 2000 through August 29, 2000.

114. The ceiling was $5,000 in 1997–99.

115. The ceiling was $10,000 in 1997–99.

116. The 50 percent payment corridor for single coverage ranged from more than $5,000 up to $10,000 in 1997 and 1998 and from more than $5,000 up to $15,000 in 1999.

117. The 50 percent payment corridor for family coverage ranged from more than $10,000 up to a ceiling of $20,000 in 1997 and 1998 and from more than $10,000 up to a ceiling of $30,000 in 1999.

118. Robinson, personal communications, June 2000 through June 11, 2001.

119. Ibid.

120. The Community Renewal Tax Relief Act of 2000, H.R. 5542, was incorporated into the Labor-HHS appropriations bill, H.R. 4577, and approved by the House and Senate on December 15, 2000.

121. Internal Revenue Service, Notice 96-53, *Internal Revenue Bulletin,* no. 1996-51, December 16, 1996, pp. 5–8.

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123. "The 2000 Campaign: 2nd Presidential Debate between Gov. Bush and Vice President Gore," *New York Times,* October 12, 2001, p. A22.

124. "Candidates on the Issues: Medical Savings Accounts," Associated Press, State and Local Wire, October 27, 2000.

125. Office of Management and Budget, *A Blueprint for New Beginnings*.

126. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2002 (*Washington: Government Printing Office, 2001), p. 42; and U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2002 Tax Relief Proposals* (Washington: Government Printing Office, April 2001), pp. 29, 30.

127. Krienke and Smith.

128. John Goodman, "MSAs for Everyone, Part I," National Center for Policy Analysis Brief Analysis no. 318, March 31, 2000.

129. Scandlen.

130. Ibid.

131. Ibid.

132. Michael Tanner, "Why the Campaign against

MSAs?" Cato Institute This Just In, December 20, 1996, pp. 1, 2.

133. "Survey of Americans on Health Policy: Questionnaire and National Toplines," Kaiser-Harvard Program on the Public and Health/Social Policy, Harvard School of Public Health, July 30, 1996.

134. Merrill Matthews Jr. and Jack Strayer, "Making Medical Savings Accounts Better," National Center for Policy Analysis Brief Analysis no. 295, July 11, 1999, pp. 1, 2; and Michael Casey, "Will Medical Savings Accounts Stay or Go?" *Managed Care Newsperspectives,* May 11, 2000.

135. Tanner.

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