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Medical Savings Accounts

An Analysis of the Family Medical Savings and Investment Act of 1995

American Academy of Actuaries

AMERICAN ACADEMY *of* ACTUARIES

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This paper was prepared by the Academy's nine-member Medical Savings Accounts Work Group, which is composed of actuaries and others knowledgeable about the potential effect of Medical Savings Accounts. This is a supplemental report to the group's first report. The report is an analysis of Medical Savings Accounts legislation, the "Family Medical Savings and Investment Act of 1995" (H.R. 1818). This bill is included in the House Budget Reconciliation bill.

Neither the Academy nor the Medical Savings Accounts Work Group support or oppose the enactment of any Medical Savings Account legislative proposals. The sole purpose of this report is to present a clear, objective analysis of Medical Savings Accounts, intended to assist the public policy process.

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Executive Summary

The introduction of H.R. 1818, the "Family Medical Savings and Investment Act of 1995," has brought to the fore a specific proposal for medical savings accounts (MSAs). The MSA Work Group of the American Academy of Actuaries has reviewed this bill and offers an analysis of how H.R. 1818, if enacted, might influence the design of health care coverages and the financing of medical care. This document is a supplement to an earlier monograph, Medical Savings Accounts: Cost Implications and Design Issues, released in May 1995. The potential impact of MSAs on Medicare, Medicaid, and tax revenues are beyond the scope of this paper.

H.R. 1818 would permit individuals to set up tax-favored MSAs under specified conditions. The individual would have to be covered by a catastrophic health plan with a deductible of at least $1,800. The individual, or his employer, could contribute an amount up to the deductible, but no more than $2,500 a year. Contributions to the MSA would not be taxed, but investment income earned by the MSA would be. MSA disbursements would not be taxed if they were used to pay unreimbursed medical expenses or long-term care insurance premiums. Any unused funds in the MSA would remain the property of the individual. A more detailed summary of the major provisions of H.R. 1818 appears in the Appendix.

Four principal questions are addressed in this paper:

- In what ways would MSAs, as set forth in H.R. 1818, affect the marketplace?
- How quickly will MSAs exert a significant impact on the marketplace?
- How would the legislation affect the uninsured population?
- How do the provisions of H.R. 1818 constrain plan design?

Each of these questions will be addressed briefly here, with more detailed discussion in later sections of this report.

- In what ways would MSAs, as set forth in H.R. 1818, affect the marketplace?

We expect that market penetration by MSAs will start slowly, conveying two benefits. First, the participants in the market will have time to adjust to an altered environment without major disruption. Second, the accumulation of experience with MSAs, by both employers and insurers, should provide them with the expected expertise they need to develop coverages that are more responsive to their own needs and more attractive to employees.

While the overall market will respond slowly, some segments of the market—such as individual and small-group insurance in certain regions—in which MSAs will likely capture a large share of the market in just a few years.

The employer's response to the advent of MSAs will be to change his approach to health care benefits only if the proposed change shows promise for reducing his overall health care expenses while at the same time providing attractive options for his employees. Employers who currently offer several health care options (generally the larger employers) would likely consider the possibility of adding an MSA as another option. Typically, smaller employers cannot afford to offer options, so they would either replace their current coverage with a high-deductible/MSA plan or keep their current plan.

If the new option is not properly designed and priced, the effect of adverse selection could increase the employer's total expenses, not reduce them. Adverse selection is a phenomenon whereby individuals, given a choice among health plans, analyze the financial ramifications, for themselves, of each plan, and then choose the one that they think—at that moment—will be the most financially beneficial. That same choice will, as a general rule, be financially harmful to the health plan. Because the MSA is a novel and untested concept, many employers will be slow to consider and adopt it.

MSAs, as currently proposed, could not be integrated with health maintenance organizations (HMOs) because of federal and state laws that prohibit the copayment structures that would meet the $1,800 deductible requirement specified in H.R. 1818. Even if this barrier were removed, it is likely that HMOs, and similar managed-care arrangements, would not, in general, redesign their plans to accommodate HMOs, unless and until MSAs captured a significant share of the insurance market.

The relative attraction of the high-deductible/MSA arrangement would vary by insured group, as well as by individual within a group.

1. **Self-employed.** Many self-employed persons would find the high-deductible policy combined with an MSA both cost effective and tax effective, as compared with current arrangements. It would be especially attractive to those who already carry a high-deductible plan.

2. **Small employers.** Many small employers who currently provide a plan with a relatively high deductible might find it cost effective to increase deductibles up to the amount required for an MSA. Some employers not currently providing any coverage, and who may not have considered high-deductible coverage in the past, would see this as an opportunity to make a high-deductible/MSA plan available to their employees. This could be done at minimal cost to the employer, by having the employee pay most of the premium.

3. **Larger employers.** Larger employers could choose to replace an existing fee-for-service (FFS) option with the high-deductible/MSA plan or add it to the choices already available to employees. Larger employers would introduce the option only if they thought the new plan could provide benefits attractive to a significant number of employees and, at the same time, reduce or help control their costs.

There are several categories of individuals who would be more—or less—likely to be interested in an MSA.

1. **Young, single individuals**. People who have health insurance now and are in good health would be among the first to accept a high-deductible/MSA arrangement. People presently

without coverage might find it advantageous to purchase a high-deductible individual plan and set up an MSA.

2. **High-income individuals.** Some high-income individuals will find the MSA arrangement an attractive tax shelter. Those most likely to select this option would be the healthy people who have already exhausted the other available tax shelters, such as 401(k) plans.

3. **Low-income individuals.** Most individuals with little discretionary income (especially if they have families) would tend to shy away from MSAs, as long as other choices for health coverage.

4. **The risk-averse.** Many people with coverage typical of the current market would tend to avoid the risk that they might have to pay a high deductible. The offer of a high- deductible plan with an MSA contribution significantly lower than the deductible increase would limit the attraction to risk averse individuals.

5. **People currently in HMOs.** Many of the people now enrolled in HMOs are very satisfied with that form of coverage. For example, for individuals with families, an HMO can provide all the care they need, including maternity care, pediatrics, and preventive care for children. So they would be less likely to find MSAs appealing.

6. **High-risk individuals.** Individuals and families with recurring medical care expenses would generally prefer the current forms of insurance, as opposed to a conversion to a high-deductible plan. If high-risk individuals tend to remain in traditional plans and lower-risk individuals tend to opt out, this could increase adverse selection.

■ How quickly will MSAs exert a significant impact on the marketplace?

A sudden shift to the MSA approach, in response to H.R. 1818, is unlikely. Still, despite the fact that the market is usually slow to change, the introduction of a new tax angle might render it more dynamic, with unexpected results.

Probably, the first changes would appear in the individual market, where many insurers already offer a high-deductible plan. Other insurers would enter this market if it seemed attractive. This could, however, depend on whether the high-deductible plans were encumbered by any state requirements on offering coverage for specific kinds of treatments with either no deductible or a low deductible. In addition, proliferation of state laws requiring insurers to accept all applicants (guaranteed issue) could raise some rates substantially. Individuals in certain classes might shift fairly rapidly to the new arrangement if the premium rates were attractive.

The group market would be next to accept high-deductible/MSA arrangements, with small groups preceding large groups. If the employers who adopt MSAs early reap significant savings in the first few years, they would be followed by others seeking similar savings. However, if the first MSA plans didn't produce savings or proved unpopular, perhaps the MSA concept would be used only in special situations—where a particular employer saw some unique advantage.

In any case, it will likely be several years before MSAs gain a significant share of the total insurance market. Market penetration in the early years, at least, will vary significantly by market sector. For example, MSAs might spread rapidly in the individual or small-group market in certain geographic areas, but penetration in the large-group market will likely be slow. (We have not attempted to quantify the ultimate market share of MSAs.)

■ How would the legislation affect the uninsured population?

If H.R. 1818 were enacted, some uninsured individuals and uninsured small groups would find MSAs attractive, but probably not in sufficient numbers to make a significant reduction in the uninsured population, estimated by the Employee Benefit Research Institute to number approximately 41 million in 1993. If H.R. 1818 were modified so that people could pay their health insurance premiums from their MSAs, as long as they were unemployed, the future uninsured population would decrease, because all the people between jobs, or retired before age 65, could use the funds to purchase transition insurance.

■ How do the provisions of H.R. 1818 constrain plan design?

In a typical rate structure, the maximum allowable amount permitted to be contributed to an employee's MSA would exceed the amount of premium cost saved by switching from a low-deductible plan to a high-deductible plan. Since H.R. 1818 does not permit contributions to the MSA by both the employer and the employee, it is unlikely that maximum advantage could be taken of the MSA concept if the employer were the sole contributor. In consequence, most employers who decided to set up an MSA would look for other ways to shift back to employees the savings obtained by changing to a high-deductible plan. For instance, the employer could use the savings to reduce the employee premium or to increase compensation. This would let people make the most of the tax deferrals permitted by MSAs.

It is the employers with traditional FFS plans for individuals who will find it the easiest to introduce high-deductible/MSA plans, because the H.R. 1818 requirements fit so neatly with their current plan design. While FFS plans may be the primary target for MSAs, Congress may want to consider other kinds of designs that would serve to broaden participation in MSAs. For example, HMOs would be more likely to participate if the bill permitted alternative copayment designs consistent with their traditional (and usually required) structure. Such an alternative could be designed to induce utilization reductions similar to expected reductions generated by MSAs. Also, insured individuals with families would be more likely to participate if the current practice of letting people use individual deductibles within the family maximum were also permitted under the high-deductible policy.

In our earlier report, we said that administrative expenses associated with an MSA could be as low as 2 percent of the MSA contribution. While H.R. 1818 does not involve complicated rules for qualifying plans, there are some minimum specifications to be met, and the deductibility of contributions must be demonstrated to the IRS. We therefore expect that administrative expenses will be greater than 2 percent—but still well below the expenses associated with many insurance products on the market today.

Fitting MSAs into the Marketplace

Plan Design and Selection by Participants

Employers who currently offer several health plan options (generally, larger employers) would likely consider adding an MSA as an additional option, but only if this new approach to health care shows promise for reducing employer health care expenses, while, at the same time, providing attractive options for employees. Several factors are relevant:

- Plan design
- Adverse selection
- Employee demographics
- Geographic location.

Plan design is critical. A properly designed MSA would be attractive to employees while reducing costs for employers. The employees would take an active part in controlling utilization and cost and, thereby, help reduce total health care expenditures. Most employees would see a reduction in total outlays for health care costs.

In contrast, poorly designed high-deductible/MSA plans could result in either higher costs for employers (and higher total costs) or greatly increase what the employees have to pay out of pocket for health care. The difference between proper and poor design is largely a function of the ability to predict which employees will select each offered option and the extent of utilization of health care by those employees and their families.

When employees are offered coverage under an insurance plan, each can decide whether to select it or not. When they are offered a choice among coverages, each can select one of the choices or reject them all. Even though, on average, a group of employees can be expected to move in a certain direction, most will try to make their own choice based on their own economic self-interest, as viewed at the time the choice is made. For many, the choice is essentially immaterial because they are not heavy users of medical care services. However, there is always some segment, generally 10% to 20% of the group, who have substantial medical care expenses and are capable of making a wise choice that serves to minimize their own financial outlay and maximize the amount paid by the plan they selected.

This leads to the principle of *adverse selection*, a key factor to consider in plan design. When employees are offered a choice between having health care coverage or not having it, or between two or more health care plans, the specific provisions included in the health care plans and the prices charged for them must be carefully designed in order to compensate for the undesirable consequences of adverse selection.

Take a simple example: if the amount employees would have to contribute to an insured employer-sponsored health care plan (if they enroll) is too high, many will choose not to have coverage at all, and participation will be low. A high proportion of those who do enroll will likely be among those at high risk for substantial health care costs. If the insurer has set per capita rates at a level that assumed a high rate of employee participation, the resulting adverse selection can give rise to a claim level that can not be supported by those rates. If the employee contribution rate is lowered, the desired level of participation may be achieved, but only if the employer pays a larger share of the premium. In this example, note the need to find a balance between what employees are willing to pay, what the employer is willing (or able, given economic competition) to pay, and what the insurer needs to receive in premiums in order to avoid insolvency.

While some degree of adverse selection will result whenever employees have a clear choice among health plans, that is not necessarily a reason to refrain from introducing a new option. Adverse selection can be exacerbated, however, when the new option is very different from all the other options, as is likely with MSAs. Insurers are particularly concerned about adverse selection because they are competing for customers. Employers, however, have a captive market and can minimize the impact of adverse selection through careful design of benefits and employee contributions. Usually, the employer who expands options will install a benefits/contribution design that will keep costs constant. If that is the criterion, and the selection of options by employees is correctly predicted, there will be no change in the total employer cost. If the selection process does not correspond with prior expectations and, in consequence costs increase to an unacceptable level, the employer can tinker with the mix of benefits and contributions in the next year and thus achieve target amount for total contribution level.

Also, the premium charged to the employee need not be linked with the cost of those who choose each individual option. As is common today, the employer may set a premium differential that reflects the relative value of each plan if all employees were covered by that plan, rather than what the cost would be if adverse selection were considered. The employer's secondary goal in offering options, after consideration of overall costs, is that each option be attractive to some portion of his work force. If the premium charged to the employee (or any other reason, such as level of service) renders an option unpopular, the employer will probably drop that option.

Switching to arrangements that combine a high-deductible plan with a tax-advantaged MSA requires special care in developing the design, so the potential for unwanted (and expensive) side effects is minimized. If the amount of money "saved" by the MSA is more than offset by increases in employer costs for the other packages, the exercise will have been in vain.

The *employee demographics* will determine whether a high-deductible/MSA approach is feasible. If most of the jobs are

low-paying—say, between $10,000 and $20,000—there would likely be very little interest in any plan with a deductible as high as $1,800, because low-paid employees may not have enough money to self-insure the high deductible. Even less interest would ensue if employees were required to contribute to the MSA, instead of employers, because low-paid employees usually have very little discretionary funds.

On the other hand, if there were substantial numbers of employees with salary of, say, $50,000 or more, the chance to put money into a tax-advantaged fund could be very attractive. Such employees are better able to self-insure the high deductible and have more in the way of discretionary funds to contribute to the MSA. High-income employees would probably prefer that the employer not contribute to the MSA, so they could shelter the maximum income.

Health care costs vary significantly by geographic location; there could be less (or more) potential for substantial savings on the kinds of expenses paid for from the MSA for employee groups and individuals, depending on where they are located.

INTEGRATION WITH EXISTING PLANS

One important question is how MSAs, as defined in H.R. 1818, would co-exist with current plans such as HMOs, preferred provider organizations (PPOs) and point-of-service (POS) plans, as well as the low-deductible FFS plans. Since HMOs appear to be the least compatible with H.R. 1818, they will be considered first, and in some detail.

Health Maintenance Organizations. Under H.R. 1818, the deductible for an individual under the catastrophic health plan must be at least $1,800 ($3,600 for a family). The restrictions on HMO copayments in federal and state laws mean that an HMO could not offer a plan that meets the H.R. 1818 requirements.

Whether HMOs would actually go ahead and offer an MSA option if the legal barriers were removed is difficult to predict. Perhaps the most important factor involved is that the basic rationale for MSAs (to give individuals more choices in selecting providers and plans of treatment) is contrary to that of an HMO. In other words, the objective with an MSA is to give the individual sufficient incentive to become himself a wiser consumer of health care services, while the HMO concept assumes that it is the health care experts who do the best job of managing health care in a way that promotes optimal outcomes at a reasonable cost. HMOs encourage early access and preventive care, whereas high deductibles may encourage the individual to postpone seeing a physician until the MSA balance approaches the level of the deductible.

There are, in general terms, three options to consider as possible changes in the permissible copayment structure for HMOs, so that MSAs can be integrated with them. The first, and perhaps the most difficult to achieve, would be to revise federal and state laws to permit HMOs an exception to provide a plan that meets the H.R. 1818 requirements. The second would be to permit health plans that are constrained by other federal or state laws to use a lower deductible, on an exception basis.

The third approach would be to permit plan designs equivalent to the $1,800 deductible, but more consistent with the design of an HMO. For example, HMOs could be permitted to introduce a package of copayments requiring individuals with high medical expenses to pay at least $1,800 out of pocket.

Even if HMOs could establish a high-deductible plan, major structural changes would be needed before they could fold in such a deductible. While not impossible, it is unlikely that many HMOs would adopt high-deductible plans in the near future. If high-deductible/MSA arrangements were to make major inroads into the current HMO participant base, we assume that major HMOs would make the changes necessary to adapt to the new market. HMOs have proven to be very quick to adapt to any changes in the market environment that threaten to undermine their participant base.

Like any health plan, HMOs will be very concerned if there is substantial loss of market share to high-deductible plans that qualify for MSAs. This concern will be intensified if, as is likely, the enrollment that is lost has a significantly lower average cost than the average population remaining in HMOs. In addition, with a smaller share of services, the HMO would have less leverage to negotiate provider discounts.

It likely that high-deductible plans would provide little competition for the traditional HMO market during the first few years after a new law permitted them. If high-deductible plans, coupled with MSAs prove successful in the traditional HMO market, it is likely that HMOs would modify their structure to, at minimum, offer high-deductible plans as one option.

Point-of-Service Plans. POS plans offer the insured the choice of an HMO-type plan or a traditional FFS plan at the time that the service is needed. While the traditional FFS element of the plan could be modified to require an $1,800 deductible, it is contrary to common HMO practice for the HMO-type choice to incorporate an $1,800 deductible. Since the insured could select the HMO offering any time, a POS plan with an $1,800 deductible applied to the out-of-network services only would not qualify as a plan that permits insureds to set up an MSA.

POS plans would have considerations similar to those of HMOs. Most POS plans would not change unless the high-deductible plans started to attract a significant portion of their market share. If that did happen—and that share had a substantially lower cost than the average population—POS plans would cease to be an attractive buy for insureds, and POS plans would have to adapt or terminate.

Preferred Provider Organizations. Employers with PPO plans negotiate discounted fees with a network of health care providers. These plans encourage employees to use the network providers by paying a larger share of their fees than for providers who are not in the network. The variation in benefits is primarily tied to differences in the copayments.

The patient faces either (1) the same deductible in or out-of-network or (2) a lower deductible in-network. If the deductible were raised to $1,800 for in and out-of-network services, insureds would use in-network providers less frequently, since they would pay the same share of the cost of the services before meeting the $1,800 deductible. With a smaller share of services to bargain with, the employer or insurer would have less leverage in negotiating in-network discounts.

While PPOs could adapt more readily to high-deductible plans than HMOs and POS plans, any reduction in use of the in-network providers would render the PPO plan less attractive. Since, in many respects, PPOs are more like FFS plans than HMOs or POS plans are, they would find the task of designing plans to conform to MSAs less daunting, especially PPOs that already have high deductibles.

Fee-for-Service Plans. Since FFS plans are designed around an existing deductible, the design problems of the other types of plans are not present. Employers would take one of three approaches. One would be to increase the deductibles of the FFS plans to meet the H.R. 1818 requirements. Another would be to keep the deductibles at the current level and not permit MSAs. The third approach would be to offer a choice between the current plan and the high-deductible/MSA plan.

SIZE OF THE INSURED GROUP

The size of the insured group will greatly influence receptivity to the concept of the MSA and their attendant high-deductible plans. Most large employers already offer a range of choice; for them, this new kind of plan would be just one more possible option. Both the small-group (fewer than 25 employees) and individual markets would encounter special problems (as well as special opportunities).

Large Groups. Most large groups offer a range of options, including local HMOs and either a PPO or POS arrangement. Most also offer an FFS with a deductible in the $200 to $500 range, but this option is becoming less and less popular. The Employee Benefit Research Institute reports that, for medium and large private employers, the percentage of full-time employees participating in FFS plans dropped from 98 percent in 1980 to 50 percent in 1993. We expect this trend to continue and that many employers will remove the FFS option from their menu of choices. Introduction of MSAs might slow or reverse this trend.

Some large employers who have considered a high-deductible/MSA approach have expressed caution about adding a high-deductible plan, as an option. They tend to look upon high-deductible plans as counter to the trend to managed-care approaches. Some of these employers have had extensive experience with offering multiple options and believe that the high-deductible plan will not be attractive to a major part of their work force. For example, as we will discuss later, when DuPont offered a high-deductible plan opposite an HMO and a POS plan, it was selected by only 4 percent of the employees.

Other large employers will see the high-deductible option as an attractive choice for some portions of their work force and will open up a new option, or adjust a current option, to permit the choice. For instance, such an employer might limit the coverage to employees in high income categories, based on concerns that the high-deductible plan might not be appropriate for low- income employees.

Small Groups. An employer with only a small number of employees may or may not offer health care coverage at present. Where there is coverage, there is generally only one plan, which applies to all employees. Therefore, if MSAs become available, the employer will have to decide whether to replace the current coverage with a high-deductible plan, thus permitting the employees to set up MSAs.

There are two ways to do this. The employer can arrange to have the high-deductible coverage only, and let each employee decide whether or not to supplement it with an MSA. The employer would not participate in administration of the MSAs or contribute to them. Or, the employer could arrange (perhaps through an insurer or a bank) for the MSAs in addition to securing the high-deductible coverage. Such an employer might contribute to each MSA (thus precluding the employees from doing so) or have each employee make his own contributions.

The incentive to adopt a high-deductible FFS plan is much greater for small groups than for large groups, for three reasons. First, the administrative expenses involved take up a much larger proportion of the current cost for small groups than for large groups and the high-deductible/MSA plans reduce administrative expenses. Second, it is less likely for small-group FFS plans to have an HMO or POS option. Third, many of the deductibles are already $500 or more, so the move to an $1,800 deductible is much less of a jump than it is for the typical large-employer plan.

An employer with other insurance, or with no insurance, might now offer the high deductible plan for two reasons. First, the offer would open up an opportunity for employees to establish an MSA. Second, passage of national legislation serves to legitimize high-deductible insurance as a mainstream insurance product.

It is possible that some insurers would develop very low cost very high deductible plans with quite limited benefit provisions. For example, a plan with a $100,000 deductible, 50% coinsurance, and strict case management limits could be offered at extremely low cost. Employers could then offer that plan primarily to provide employees (especially, perhaps, the owner) with the opportunity to set up their own MSA without providing substantial insurance benefits. In many states, however, insurance commissioners may require that the policies provide a greater level of reimbursement.

A problem for small employers in some states, such as Florida and Kentucky, is that state law limitations prohibit insurers from offering them plans that would otherwise qualify for an MSA under H.R. 1818.

Individuals. Persons currently covered under individual health insurance policies would have a chance to switch to the high-deductible policy and then be able to set up an MSA. One factor that might make this approach attractive to many is the continuing rise in the costs of individual policies, resulting in part from ongoing efforts by states to mandate the inclusion of certain benefits in individual policies. Each time a new benefit is mandated, costs increase. The current trend toward wider use of guaranteed-issue laws would, if such laws were enacted, also exert substantial upward pressure on premiums. This may make it cost effective for many people to switch to a high-deductible/ MSA plan.

Like the small employer with no current insurance, the individual with no insurance might purchase a very low cost policy, and thereby become able to set up an MSA. In that case, the individual would essentially continue to self-insure his health care expenses, but would now be able to do so in a tax- advantaged way. This might have some appeal for people in high tax brackets who can afford to set aside, from current income, the amounts necessary to fund an MSA.

ADMINISTRATIVE EXPENSES

The work group's May 1995 report suggested that administrative expenses for MSAs could be as low as 2 percent of the MSA contribution. However, we also noted that an expense level this low could only be achieved in an entirely unregulated context. The record-keeping necessitated for MSAs as contemplated by H.R. 1818 would increase the administrative expense to some level higher than 2 percent, but still less than the 15 percent average for insurance plans today.

Employers who contribute to MSAs will have to adjust their accounting systems to make sure that contributions are made in a timely manner and, in addition, to produce periodic statements on employees' MSA balance.

Administrators of MSA accounts will find that each account is much like a bank checking account, with regular deposits and irregular withdrawals. It will be important to have a system that lets the account-holder determine the current balance at any time. In addition, tax forms will have to be produced and periodic financial statements prepared for each account-holder. Thus, the expense characteristics of MSAs could be similar to those of bank checking accounts.

How Soon Would MSAs Have Market Impact?

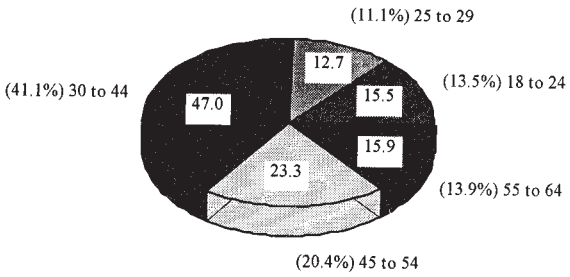
A critical question: how popular will MSAs really be—and how soon? At this point, it seems unlikely that there will be anything like an "Oklahoma land rush" to MSAs, if only because of the trepidation people feel in confronting something new and different. Furthermore, the current version of H.R. 1818 does not seem to offer a major financial advantage for any identifiable large segment of the public. There may, of course, be instances where the employees' current choices for health care coverage are poorly designed or simply unpopular. In such instances, there might be a rapid transition to MSAs, but that situation would probably be rare.

Charts 1 and 2 show the distribution of the current market, by age and source of insurance. We expect that the high-deductible/MSA concept will be most popular among the 34 million employees in small firms or with individual coverage. By age group, we would expect that the greatest appeal would be among the 28 million adults under age 30.

Although an option to switch to a deductible of $1,800 could have a substantial impact on certain segments of the insurance market in some areas (e.g., individuals and small groups in areas with few HMOs), the pace of the shift of employees into MSAs, with most plans, is likely to be slow, thus giving HMOs, insurers and employers sufficient time to adjust to the new environment.

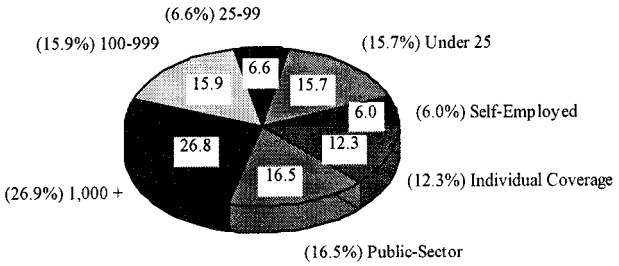
Both employers and employees can be extremely cautious in their response to change; even the best ideas can be slow to catch on. In fact, some never do. However, if an approach is clearly advantageous to employers and individuals, it is expected to gradually come to assume greater market share. The history of HMOs can serve as a good example. The concept was first introduced over sixty years ago and, at first, was confined to limited areas and industries. Gradually, however,

Chart 1
Persons Aged 18–64 with Private Health Insurance, by Age, in Millions, 1993



Source: Employee Benefit Research Institute Issue Brief no. 158, February 1995.

Chart 2
Persons Aged 18–64 with Private Health Insurance Offered by Employers or Individually Purchased, in Millions, 1993



Source: Employee Benefit Research Institute Issue Brief no. 158, February 1995.

HMOs increased in popularity and geographic reach until, today, according to the Group Health Association of America, there are some 56 million people covered by plans that are administered by HMOs. And even that gradual process required significant adaptation of the HMO concept as circumstances changed through time.

High-deductible/MSA plans, if eventually successful, will probably have a similar history. The first changes will come in the individual market, where insurers will rapidly introduce high-deductible plans for individuals, and the individuals for whom the plan makes sense will gradually come to decide to trade in their current plans for high-deductible/MSA plans.

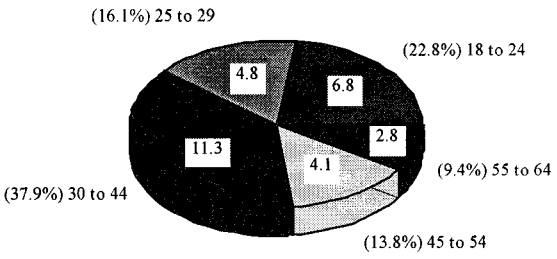
Employers will likely begin to introduce the high-deductible/MSA plans in 1997, and a relatively small number of employees can be expected to join during their first few years. But if these employers show savings, the option could become common within five to ten years. The number of employees electing the plan will gradually increase as well, to the point where most people for whom the plan is advantageous will have joined. At that point, the maximum impact of adverse selection will have been reached. We also expect that growth in the small-group market will precede growth in the large-group market.

We conclude that the overall impact of high-deductible/MSA plans in the first few years after enactment would be relatively minor. The various markets will experiment with different approaches, and if they find that it is possible to develop plans that are attractive to individuals and, in addition, reduce costs for employers, the plans will gradually increase in popularity. As a result, there will be little disruption in the overall insurance market. The market will by then will have had sufficient time to adapt if high-deductible/MSA plans eventually attract a major portion of the market.

Effect on the Uninsured

A primary question in regard to any health reform measure is the extent to which its passage might reduce, or increase, the number of people without insurance. According to the Employee Benefit Research Institute, in 1993, there were some 41 million individuals without health insurance. A distribution of those over age 18, and therefore with access to some form of insurance, is shown in Chart 3.

Chart 3
Uninsured Persons Aged 18–64, by Age, in Millions, 1993



Source: Employee Benefit Research Institute Issue Brief no. 158, February 1995.

The discussion of the impact on the uninsured requires, first, a definition of insurance. If insurance is defined as a health insurance plan that covers a substantial portion of expected health expenses, then H.R. 1818 might have very little impact on the number of uninsured. If, however, the definition of insurance includes anyone with an MSA balance and/or a very low cost plan, there could be a significant shift from "uninsured" to "insured."

There has already been some discussion of how uninsured small groups and individuals might be attracted to the MSA arrangement. The availability of MSAs might reduce the number of uninsured people in several other ways.

Many of the uninsured are in a transition between jobs. An individual with a balance in his MSA, who leaves his job, would continue to have funds available for health care expenses for some period. If H.R. 1818 were modified to allow MSA funds to be used to pay for some kind of transitional coverage (such as COBRA premiums), a significant reduction in the number of transitional uninsured might result. The modification would have to be carefully constructed if the intention were to avoid extending tax-favored status to premiums paid by self-employed individuals. Also, an individual who loses coverage on termination of employment, but who receives a severance payment, might use some of it to buy a high-deductible individual policy and set up an MSA.

Another group of the transitional uninsured consists of people who retire before they become eligible for Medicare and whose employer does not provide post-retirement coverage. Those who had built up a substantial balance in their MSA would be helped over this gap. The MSA option would be particularly effective in covering this gap if H.R. 1818 were amended to permit payment of premiums for post-retirement insurance plans.

Design of High-Deductible Plans

After cost, the primary consideration of employers and insurers is the relative attraction of the high-deductible plans for individuals. If the high-deductible plans necessary for establishment of an MSA are not attractive to the employees or insureds, then there will be few MSAs. If high-deductible plans with MSAs are attractive alternatives to other options, then, at least in the long run, these plans could emerge as a significant market force.

An important consideration in plan design is the provision in H.R. 1818 that either the employer or the employee may contribute to an MSA, but not both. Most employers will find that the savings from introduction of a high-deductible plan are significantly lower than the amount of the maximum contribution to the MSA permitted by the bill. For example, as shown in our May 1995 report, an increase in the deductible from $200 to $2,000 would generate about $828 in savings for the average employee group, if the entire group were to choose the high-deductible plan. These savings would be lower if employees were free to elect other options. We assume that employers would want to reduce costs, or, at least, hold them constant. Therefore, an employer contribution to an MSA would be substantially below the maximum permitted. In the example, an employer would contribute no more than $828, but an employee would be free to contribute up to $2,000 to the MSA if there were no employer contribution.

The DuPont situation previously cited offers an example of the choices that would be available for employees of a large employer. The traditional choices were an HMO with an annual employee contribution of $318 or a POS plan with an annual contribution of $101. The out-of-network benefits of the POS provided 70 percent coinsurance after a $330 deductible to a maximum of $3,000. The additional choice offered was a $1,000 high-deductible plan, with 60 percent coinsurance to a maximum of $4,000, which generated a $498 credit for those who elected it. Even though the credit could either be taken as salary or put in a flexible spending account, only 4 percent chose this option.

These comments, and calculations, are for the average insured work force. There will be many situations where the savings will be greater and, in a few, the savings might even exceed the increase in the deductible. On the other hand, the savings might also be very small—or even negative. Each employer and insured group will have to examine its own situation to estimate how attractive the high-deductible/MSA plan will be.

As a result, it is likely that the most feasible approach for employers would be to return part or all of the savings to the employee through other means. Most plans require employee contributions. For these plans, the most direct approach would be to reduce the required employee contribution to the high-deductible plan by the difference in cost between the low- and high- deductible plan for those electing the latter. Or, employers could improve benefits in permitted areas (such as accidents, dental, and vision care) or simply increase the employee's compensation.

The health care arrangements in existence today vary widely in efficiency at controlling medical care costs. Those currently less efficient could see considerable savings from switching to an MSA arrangement. Those that have already achieved substantial efficiencies, though, would be less likely to achieve further savings.

There is one significant design problem: the current FFS plans incorporate an individual deductible in the family policy. As a result, the increase to a $3,600 deductible for an individual in a family could prove to be a significant barrier to the use of MSAs by families. For example, a typical plan today might have an individual deductible of $200 and a family maximum deductible of $400. An individual in a family would have to increase his risk by $3,400 ($3,600 less $200) to participate in an MSA. However, an individual in non-family coverage would have only an increase in risk of $1,600 ($1,800 less $200).

Plan design can be strongly influenced by the specific language used in H.R. 1818. To avoid uncertainty, it would be helpful if terms such as "health plan," "employer contribution," "married individuals," and "dependents" were carefully defined. Furthermore, as the bill is now written, it is difficult to tell which health plan premiums are non-qualified distributions and, also, difficult to determine the precise nature of the interaction between MSAs and flexible spending accounts.

Finally, it is vital to coordinate H.R. 1818 with other legislation, such as Senator Kassebaum's bill, S. 1028, which would compel major changes in the health insurance market.

Appendix

Summary of H.R. 1818, the "Family Medical Savings and Investment Act of 1995"

A Medical Savings Account (MSA) may be set up by or for an individual only if the individual is covered by a catastrophic health plan and only if the individual is not covered by a plan other than a catastrophic health plan. Funds in the MSA remain the property of the individual.

The catastrophic health plan may be either an individual policy or a group policy.

The catastrophic health plan must have a deductible of at least $1,800 for an individual and $3,600 for a family. Both numbers are indexed for inflation. The policy could not provide any first dollar coverage for, e.g., preventive services. Exceptions are permitted for benefits for dental, vision, and accidents.

Contributions to an MSA may be made by an individual, in the case of an individual policy. In the case of a group policy, contributions may be made either by the employee or by the employer, but not by both.

The contributor to the MSA gets a straight tax deduction for the contributions. Employer contributions are excludable from employee gross income and are not subject to payroll taxes, including FICA taxes.

An individual who contributes to an MSA gets a maximum deduction of $2,500 ($5,000 for family), but not more than the deductible under the catastrophic health plan. Special provisions apply to portions of a year and where there is a transfer from a flexible spending account.

Qualified distributions from the MSA may be made for any medical expenses (not covered by insurance) that qualify for itemized deductions and for premiums for long-term care insurance. Premiums for regular health insurance, including the catastrophic health plan, are not qualified distributions.

Qualified distributions are excludable from gross income and may not be used as itemized deductions. This exclusion is available whether or not the individual itemizes.

Non-qualified distributions are included in gross income and are subject to a 10% penalty.

Investment income credited to the MSA is taxable.

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