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REPLY

MSAS CAN BE A WINDFALL FOR THE REST OF US, TOO

Greg Scandlen∗

Regina Jefferson wrote that Medical Savings Accounts (MSAs) are "windfalls for the healthy, wealthy and wise" in a recent issue of the Catholic University Law Review.1 She only got it one-third right. The "wise" (those who are interested in learning more about their health care alternatives) will certainly benefit from having a MSA, but so will the unhealthy and the "unwealthy." Indeed, MSAs have remarkable benefits for people of modest means and average, or less-than-average, health status, as this Article will explore.

The federal government, along with most state governments, currently provides an unlimited exclusion for employer-sponsored health care insurance. That is, the law excludes the value of an employer-sponsored health plan when counting an employee's taxable income. The value of a health benefit is exempt from state and federal income taxes, payroll taxes such as FICA (social security), and Medicare taxes. There is no limitation on this exclusion. Whether the value of the benefit is $2000, $4000, or $10,000, the law excludes it from taxes.

The Lewin Group estimated the federal revenue loss from the exclusion would exceed $120 billion in the year 2000,2 with additional losses for state government and other payroll-based assessments such as state and federal unemployment taxes. This makes employer-sponsored health care the third biggest entitlement program in the country, exceeded only by Social Security and Medicare.

Remarkably, this subsidy is available only to employer-sponsored plans. People who purchase their own health coverage receive no such

∗ Senior Fellow in Health Policy, National Center for Policy Analysis.
benefit. Current law allows the self-employed to take a portion of their health insurance premiums as a deduction from their taxable income, but they do not get the FICA exclusion. Further, workers whose employers do not provide coverage obtain no deduction unless their medical expenses exceed 7.5% of their adjusted gross income.

The effects on our health care system of this peculiar tax policy are profound:

It is regressive. The current health care system provides a much greater federal subsidy for people with high incomes than for people with lower incomes. The Lewin study calculates that families with incomes below $15,000 receive an average subsidy of $79, while families with incomes of $100,000 or more receive an average subsidy of $2638.

It is inefficient. The government subsidizes approximately 40% of the cost of this coverage; therefore, people buy more expensive health insurance packages than they otherwise would, resulting in the overutilization of health care services.

It is inequitable. It provides no assistance to those who need it most, the uninsured and people who buy their own health insurance: those who currently purchase individual health insurance are older and poorer than are those who get employment-based coverage. Those without coverage tend to be younger, poorer, and less educated than average.

It injects the employer into the health care decision-making process. While some large firms have professional benefit managers and a choice of health plans, 83% of all employers do not offer a choice of plans, thereby forcing workers to accept whatever plan their employers choose to offer. This allows employers, such as owners of car repair shops and video rental stores, to choose a health insurance plan that their employees must live with.

There are currently a number of efforts underway in Congress (and elsewhere) to correct these inequities. These efforts seek to either replace the exclusion with a refundable tax credit or supplement the cur-

3. See id. at 4. Sheils estimates that "total spending for employer-sponsored coverage will be $355.9 billion in 2000," against which the total state and federal tax expenditure is $140.9 billion, or 39.6% of the total. See id. at 5-6.


rent system with a tax credit for those who do not have access to employer-based coverage. Either approach would allow people who purchase their own coverage to have tax benefits similar to those whose employers provide the coverage, thus giving consumers more control over their healthcare.

These efforts are the next step in a process of health care reform that began with the enactment of the MSA pilot program in 1996. This is all part of a movement to empower patients to take more control over their own health care needs and to get health care plans and providers to respond to the demands of health care consumers.

I. MSA ESSENTIALS

A. Concept

The concept of the MSA is really very simple: you can reduce your premiums by raising your deductible, then put the money saved into an account to cover expenses below the deductible. This is not exotic. Try it on your auto policy: if you currently have a $250 deductible, find out how much you would save by raising it to $500. Usually the premium savings will exceed the difference in deductible. That is, by raising your deductible by $250, you will probably save more than $250 in annual premium. There are several reasons this is true. The most obvious reason is that the insurer no longer has to pay $250 in potential claims. However, because relatively few people have a claim in any given year, this is only a portion of the savings. More importantly, insurers know from experience that people with higher deductibles are more careful in their behavior. They take fewer risks because they have more at stake.

"Moral hazard" expresses the concept that people who are insured engage in riskier behavior than those who are uninsured. People with low-deductible auto policies will drive more carelessly than will people with high deductibles. People who own run-down warehouses on the waterfront are more likely to see the warehouse burn down if they have fire insurance, than if they do not. In health care, moral hazard blends in with another concept known as "induced demand." People who have low-deductible health insurance coverage are far more likely to consume a wide range of services, many of questionable value. Having a higher deductible encourages people to think twice before consuming services.

B. Administrative Costs

There is yet another reason that higher deductibles save money, and that is the severe inefficiency of processing small claims through an insurance mechanism. Jefferson is critical of MSAs because she believes they will add to administrative costs. Specifically, she says, “hospital outpatient departments . . . will find it necessary to restructure their billing procedures to bill patients individually.” Jefferson clearly does not understand how the health care industry processes bills today. Providers are already able to bill individuals because individuals already pay for many services. Thus, there is no “restructuring” involved. Further, it is far less expensive for a provider to present a bill and be paid at the time of service, than it is to file a claim and wait, often for weeks, to be reimbursed by an insurer. One of the most common complaints providers make about insurance companies is the extreme complexity of their billing requirements, with each of many carriers demanding unique systems.

Health care reform advocates suggest that eliminating the billing paperwork through a single payer system would free-up tens of billions of dollars, possibly over $100 billion a year, to pay for direct services. There is an organization of physicians based in Washington state that has promised to charge cash-paying customers half or less of what they charge insured customers—due solely to the reduced overhead of not having to bill the insurers.

The cost and complexity of insurance billing has barely begun when the claim leaves the provider. Whether filed in paper format or electronically, it is expensive for a carrier to adjudicate a claim.

Insurance billing involves several discrete acts. First, the carrier must confirm that the patient is a covered insured and that the provider is a network provider. Next, the carrier must determine whether the insured’s contract covers the billed service and whether the service is appropriate for the diagnosis. Then, the carrier must ascertain whether the insured has fulfilled their deductible and co-insurance responsibilities. Thereafter, the carrier forwards the claim for “re pricing” depending on the provider’s network status and agreed-upon discount. Finally, the carrier cuts the check and forwards it to the provider; then, it sends an Explanation of Benefits (EOB) to the insured, enters the data, and sends a

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summary report to the employer. Additionally, the insurance carrier will
perform periodic audits to confirm that the patient actually received the
services billed, as well as utilization review efforts to ensure appropriate
care. There are also customer and provider service departments to an-
swer questions about claims status and sometimes to explain the denial
of a claim. The process for a small claim is just as lengthy as a large
claim, and the cost of processing a small claim can often exceed the cost
of the claim itself.

With MSA programs, the patient typically pays small claims with a
MSA debit card or personal check at the time of service, saves the re-
ceipt, and then does not even bother the insurance company until the to-
tal claims exceed the $2000-$4000 deductible. Fewer than ten percent of
all patients should even have to talk to their insurers in the course of a
year, which is a major contributor to the lower cost of a high-deductible
insurance plan. Although there may indeed be some administrative costs
associated with the savings account itself, these costs are no greater than
the costs associated with any other savings or checking account and can
usually be paid out of the income generated from the account balance.

II. HEALTHY AND WEALTHY

Jefferson's main complaint about the MSA program is that it will
benefit the healthy and wealthy at the expense of the rest of us. It is a
complaint often made, probably because it is a catchy slogan well-suited
for Washington's spinmeisters, but no truer because of constant repeti-
tion.

Whether one chooses a MSA depends in part on the alternatives. It is
impossible to examine the likelihood of a selection by looking at only
one of the choices. One needs to compare the choices side-by-side.

A. Traditional Indemnity vs. MSAs

A "traditional indemnity" plan, also known as a "fee-for-service"
(FFS) or "major medical" plan, is characterized by a small deductible
(usually $250 to $500) and "co-insurance" that is paid on top of the de-
ductible (typically 20% of claims) by the insured up to some "stop-loss"
level ($1500 or so). As the name implies, a fee-for-service plan pays pro-
viders a fee for providing a service. The plan may base payment on a
fixed fee schedule or may employ a "usual and customary" fee. FFS
plans exercise little control over which providers a patient may use and
exert a minimum of "managed care" efforts, although utilization review
programs are increasingly common in FFS plans.

Another coverage option is the Preferred Provider Organizations
(PPOs), which are customarily considered to be part of "managed care," but act more like traditional FFS plans than like Health Maintenance Organizations (HMOs). PPOs rely on deductibles and co-insurance and pay providers on a fee-for-service basis. PPOs differ from FFS plans in that they usually negotiate discounted rates from their "preferred" network of providers. PPOs direct their patients to the preferred providers by charging a higher co-insurance rate for going "out of the network."

The MSA is structured similarly, but with a higher deductible and a savings account for paying expenses below the deductible. A typical MSA program, as established by Congress in 1996,\(^1\) starts with a health insurance policy with a deductible of $2000 for an individual or $4000 for a family. The individual (or the employer) may deposit $1300 into her savings account (the MSA itself), while a family may deposit $3000. These deposits are "excluded" if made by the employer (free of income and payroll taxes) and are "deductible" if made by the account holder (free of income tax alone).

In the first year, there is a corridor of expenses covered neither by the MSA nor by the insurance policy. For an individual, the corridor would be the $700 between the $1300 MSA balance and the $2000 deductible at which point the insurance kicks in. In the second year, that corridor may be removed if there is money left over in the account after the first year.

Account holders may use the money in the MSA to pay for health care expenses at any time without penalty. Alternatively, one may invest the money in the MSA and any income in the account can build up tax-free over time. Account holders may also withdraw money to pay for other needs, but must pay taxes plus a 15% penalty on the amount withdrawn.

The essential idea behind the MSA is that the account holder can deposit the money saved on premiums into the savings account. By going from a $250 deductible FFS plan to a $2000 deductible MSA plan, an individual might save enough to pay the maximum $1300 contribution. Obviously, whether that happens in reality depends on local market conditions, the attitude of the insurance company, and risk factors associated with the insured. Nevertheless, the idea of saving $1300 in premiums by raising the deductible by $1750 is not unrealistic.\(^2\)

Ultimately, as illustrated below, most people will spend less money out-of-pocket with a MSA than they would with a FFS or PPO plan. Im-

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\(^2\) For example, this author was running a small trade association in the early 1990s. The five-person trade association switched from a $250 deductible PPO in one year to a $1000 deductible FFS program thereby saving $973 per person in premiums.
Importantly, not only high income or healthy people will spend less. Both high and low utilizers and high- and low-income people will spend less. Only a small sliver of expenditures involves higher out-of-pocket costs for the MSA program.

Because plan designs may vary, we will look at four different scenarios to see how the finances play out. Plan A is a $250 deductible FFS plan with a 20% co-insurance on the next $7500 of claims. Plan B is a $500 deductible with a 20% co-insurance on the next $5000 in claims. Plan C is a MSA with a $2000 deductible and a $1000 contribution in the account, and Plan D is a MSA with a $2500 deductible and a $1500 contribution to the account.

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In these hypothetical scenarios, there is only a small range of expenses for which the MSA out-of-pocket exposure is greater than the traditional FFS program—claims between $2000 and $3500. In fact, because account holders pay the FFS expenses with after-tax dollars, but receive tax-preferred treatment of MSA expenses, the range is even smaller, depending on the marginal tax rate of the insured.

The notion that the unhealthy and the "unwealthy" do better in a traditional FFS indemnity plan than they would in a MSA is false. People with few expenses do better under the MSA, regardless of their income, as do people with very high expenses regardless of their income.

When we consider that a person with few expenses actually will have money left over at the end of the year for next year's MSA, the "healthy
and wealthy” charge becomes more absurd. For example, a person with $250 in expenses in the first year may have $750 left over at the end of the year. This $750 is far more meaningful to someone earning $10,000/year than to someone earning $100,000/year. It amounts to a bonus of 7.5% of the former person’s income, but less than 1% of the latter’s.

Jefferson also suggests that people with MSAs are less likely to take advantage of preventive care.” Again, this is not true because the money in the savings account provides a source of funds that is not available in a traditional FFS plan to pay for exactly those kinds of services, especially for people of modest means.

B. HMO vs. MSA

If a MSA is better for the unhealthy and “unwealthy” when compared to a traditional FFS or PPO plan, how does it fare when compared to an HMO? An HMO environment presents an entirely different dynamic and set of choices than a FFS plan does. As a rule, HMO premiums cost slightly less than the MSA/high deductible insurance plan combination, and usually involve lower cost sharing. A lower-income person probably would prefer the HMO, all other things being equal. As it turns out, however, not all other things are always equal.

Low-income workers might still prefer to pay the added cost of the MSA program because, if they are careful in their health care spending, they will have money left over at the end of the year. As with the example above, the opportunity to save $750 or more in a personal account means a lot more to a lower-income worker than it does to the “wealthy.” The value of extra cash to the working poor may be much higher than the value they place on extra doctors’ visits. Taking advantage of this opportunity is admittedly a matter of personal choice. Not everyone places more value on cash than they do on doctors’ visits and many other factors influence the perceived value of one or the other. For instance, proximity of services is a major factor. It is much easier for a low-income family with children to make use of an HMO’s services if it has facilities or participating providers close-by. The value of the benefit diminishes greatly and the prospect of money in the bank may look more attractive if the closest facility is across town or in the distant suburbs.

Hence, for lower-income workers, the appeal of a MSA may be a toss-up when compared to an HMO. Some will prefer one, while some will

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13. See Jefferson, supra note 1, at 708 n.134. “Opponents, however, argue that this price-shopping will result in a neglect of preventive care, such as annual checkups.” Id.
prefer the other. But what about the unhealthy? Would they prefer a HMO or MSA? Again, it is hard to say. Certainly, the answer is not as simple as Jefferson suggests.

As we have seen lately with the "managed care backlash," many people fiercely resist the idea of having a limited choice of doctors, or of having the health plan second-guess recommended services. The "unhealthy" (people with chronic or acute medical conditions) are far more sensitive to the problems of managed care than are people of average risk who encounter the health care system only rarely. Very often, these "high-utilizers" have their own personal network of doctors they know and trust. If one of those doctors does not participate with an HMO or the HMO drops the doctor from its network, that patient will be a good candidate for a MSA. High-utilizers are also far more likely to experience the other problems associated with managed care. This includes difficulty getting through on the phone, long waits to get an appointment, long waits in the doctor's office, being assigned to an inappropriate specialist, and having prescribed treatments questioned.14

Perhaps more important in evaluating the attraction of MSAs relative to HMOs is correcting the notion that Jefferson and others seem to have that there are two kinds of people—the healthy and the unhealthy, and never the twain shall meet. Jefferson states, "[a]pproximately 70% of Americans account for only 15% of national medical expenditures. Nearly seventy-five cents of every dollar spent on health care in the United States is attributed to only 10% of the population."15 These numbers may be approximately right—in a single given year. However, this year's 10% of high-utilizers are not the same people as last year's 10% or next year's 10%. In fact, most acute health care expenses involve either end-of-life care or episodic illness that may appear for a year or two, but then are gone. One study published by the National Bureau of Economic Research (NBER) found "that high expenditures levels typically do not last for many years."16 This study modeled a MSA-type program17 based on the experience of a large Midwestern manufacturing firm. Even without considering any behavioral response to increased cost sharing, the study found that "about 80% of employees are left with

15. Jefferson, supra note 1, at 715.
17. See id. (characterizing it as an "Individual Health Account").
at least 50% of total (MSA) contributions (at retirement), but about 5%
have less than 20%.” If one accounted for behavioral responses, the re-
results would be “perhaps substantially more equal than [the study’s] re-
sults suggest.”

C. Behavioral Change

Of course, failing to consider behavioral changes is a substantial limita-
tion in the NBER study. Jefferson addresses this issue in a section enti-
tled “Questionable Underlying Theory.” She asserts that “[t]he basic
theory underlying the MSA program is that American health care con-
sumers will consume as much health care as available, unless financial
disincentives are created. This theory may be true for most goods and
services; however, health care is fundamentally different from other con-
sumption items.” The balance of her argument is unpersuasive and un-
substantiated. She argues there is no “personal benefit” from consuming
excess health care services, unlike the excessive consumption of food,
which is a “personal choice.” Beside the philosophical reply that too
much of any good thing is not good for you, there is empirical evidence
aplenty to contradict her. A good starting point is the Rand Health In-
surance Experiment, and additional evidence arises out of current ef-
forts to manage patient care because “unmanaged” care results in excess-
ive costs.

The Rand study randomly assigned several thousand families into dif-
ferent plans with different cost-sharing provisions over an eight-year pe-
riod. One plan had free care, another had 25% co-insurance, another had
50% co-insurance, and another 95% co-insurance. In each of the cost-
sharing plans, the total out-of-pocket expense was capped at $1000 (this
was conducted in the late 1970s, so the $1000 deductible adjusted for to-
day’s prices would be closer to $2500). The results were profound, if un-
surprising. Project Director and Harvard Professor Joseph Newhouse
writes, “[u]se of medical services responds unequivocally to changes in
the amount paid out of pocket . . . . Per capita expenses on the free plan []
are 45 percent higher than those on the plan with a 95 percent co-

18. Id. at 6.
19. Id. at 4.
21. Id. (citations omitted).
22. Id.
23. See generally JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL?: LESSONS FROM
insurance rate . . .” 24 He adds, “[t]he more families had to pay out of pocket, the fewer medical services they used.” 25 Importantly, the lower use of services did not have a negative effect on health outcomes.

Managed care, too, is a response to the willingness of people to consume excessive health care services when they are available. Unlike the Rand Experiment and MSAs, managed care controls the use of services from the supply side. That is, patients cannot get care because it is not available, not because they have chosen to avoid it. Managed care sets up obstacles to acquiring the care the patient demands by the use of “gatekeepers,” utilization controls, benefit limitations, provider limitations, and provider incentives to under-treat. It is a small wonder that patients are unhappy. The whole purpose of a managed care organization is to keep patients from the care they desire.

MSAs work on precisely the opposite side of the equation. Rather than withholding the supply of desired health care services, MSAs try to affect the demand for services. MSAs encourage people to think twice about the care they want because of the high price for wasteful consumption. The patient, in consultation with her family and physician, makes the value judgments about whether a particular service is worth the cost. These value judgments and decisions are not imposed from the outside, but are developed from within, in keeping with the values and priorities of the individual.

Jefferson does raise an important issue concerning the influence of occasional very high utilizers. The issue is that large portions of annual health care expenses exceed the deductible of a MSA/high-deductible plan, and thus are not subject to whatever cost-constraining effects the MSA might provide. She says, “a more effective way of decreasing medical care costs is to encourage the 10% of the population that spends the most to cut back on unnecessary or wasteful services.” 26 Controlling those high-cost situations is certainly important, but it does not violate the MSA concept at all. The MSA program exists to control low-cost routine expenses, something managed care does not do very well. Once a patient has exceeded the deductible, she is then in the insurance portion of the package and whatever cost-controlling mechanisms apply to other insurance plans can be applied to the MSA-compatible insurance coverage.

Today, most MSA programs include a PPO for the high-deductible

24. Id. at 40.
25. Id. at 338.
portion of the coverage. Lawmakers never intended MSAs to be the sole answer to all of our health care problems. Instead, Congress intended MSAs to help patients take more control over the routine health care encounters that are the bulk of our transactions, if not the bulk of the costs.

III. RETIREMENT POLICY

Perhaps the oddest section of Jefferson's article is an extended detour into the world of retirement programs. This is presumably spawned by the fact that someone once referred to a MSA as a "medical IRA." She says that the "term suggests MSAs have a single, or at least a primary, medical savings purpose. This conclusion is incorrect." Why is it incorrect? Because, as Al Crenshaw once wrote in the Washington Post, people who avoid making withdrawals from their MSAs could wind up with a "healthy nest egg." This whole discussion is unnecessary for several reasons:

1. Congress certainly modeled the savings account concept after Individual Retirement Accounts (IRAs). MSAs have a penalty on non-medical withdrawals, similar to IRAs' penalties for early withdrawals. Nevertheless, the mere fact that lawmakers modeled the tax structure after an IRA does not make a MSA a retirement program (any more than the current discussion of "Education Savings Accounts" turns them into health care plans).

2. It is true that once a person reaches Medicare eligibility, he or she may withdraw MSA balances without paying additional penalties on top of the taxes. Congress, however, did not tie this provision to retirement, but to Medicare eligibility.

3. The same penalty-free withdrawal applies to death or disability at any age, but Jefferson does not suggest that a MSA is really a life insurance policy in disguise.

4. The legislation makes it clear that Congress was hoping MSA balances would be used for several specific health care purposes that are addressed in the law and not subject to either tax or penalty:

   - Retaining coverage during times of unemployment such as through the COBRA continuation laws, or while receiving

27. Id. at 696.
28. Id.
31. See id. § 220(f)(4)(B).
unemployment compensation.\textsuperscript{33}  

- Paying for long-term care insurance premiums\textsuperscript{34} or directly for long-term care services.  
- Paying for health care expenses not covered by an insurance plan, but eligible as § 213(d) health care expenses.\textsuperscript{35}

5. Jefferson is very concerned that "MSA's distribution rules substantially deviate from traditional pension policy . . . [and] could affect [a retiree's] income security."\textsuperscript{36} Maybe so, but using those funds for that person's health care needs prior to age sixty-five is exactly the purpose of those funds. If an account holder ends up with some left over funds upon retirement, that is more than they could have had under a traditional insurance plan.

6. Further, the notion that there is some unified national policy towards retirement income is false. Retirees may receive income from many different sources, including Social Security payments, defined contribution programs like 401(k)s, defined benefit pension programs, IRAs, SEPs, Roth IRAs, annuities, reverse annuity mortgages, traditional savings, equity investments, investments such as bonds, and possibly part-time employment. Each activity has its own set of rules. To the extent MSAs may add to the mix under another set of rules, so be it.

7. Jefferson notes that MSAs may be "appealing especially to individuals with limited financial resources who may be reluctant to save in traditional IRAs or employer sponsored retirement plans for fear of losing access to their funds."\textsuperscript{37} Then she turns around and worries that the MSA will be funded at the expense of traditional programs. But if the MSA is "appealing" to people who would not participate in the "traditional" program, then it is not cutting into the traditional program's funds, but supplementing them with money that would not have existed otherwise.

8. In one very strange twist of logic, Jefferson notes that people who currently exceed the allowable $2000 IRA contribution may also open a MSA (assuming they have a qualifying health insurance plan) and save another sum (possibly another $2000) in the MSA. She analogizes that possibility as a doubling of the IRA limit, but then she treats that analogy as fact. She states that "[t]he only beneficiaries of the increased IRA

\begin{footnotes}
\item[33] See id. § 220(d)(2)(B)(ii)(III).
\item[34] See id. § 220(d)(2)(B)(ii)(II).
\item[35] See id. § 220(d)(2)(A).
\item[36] Jefferson, supra note 1, at 697.
\item[37] Id. at 698.
\end{footnotes}
contribution limit are individuals who already contribute the maximum amount to their IRAs. Consequently, the MSA program increases the disparity between the tax subsidy received by individuals who currently can afford to save and those who cannot. 38 If it were true that only those people who had contributed the maximum to an IRA were allowed to open a MSA, then she would be right to protest. But it is not true. MSAs do not tack on to the back end of an IRA. In fact, they run side-by-side, and many people who cannot afford to contribute to an IRA may find that they can contribute to a MSA. Why? Because they are using a source of funds other than current income for the MSA contribution. The source of funds for the MSA is the premium savings that come with changing from a low-deductible health plan to a higher-deductible plan. The money that goes into the MSA is money that would otherwise have gone into insurance premiums!

9. Finally, Jefferson frets too much about the relationship of MSAs to ERISA. The health plan portion of the MSA (the high-deductible insurance policy) is every bit as subject to ERISA as any other employer-sponsored health plan. The savings account portion is not subject to ERISA because the worker owns it, not the employer. The employer may not control the account or require the worker to use any particular account vendor. Employees are free to change account administrators at any time without the permission, or even the knowledge, of the employer. Jefferson misplaces her concern in any event. Congress created ERISA, and Congress is free to amend it, repeal it, go around it, substitute for it, or carve out exemptions to ERISA. If Congress wanted MSA accounts to be subject to ERISA, it would have said so.

IV. OTHER ERRORS BY JEFFERSON

Jefferson makes a number of other errors in logic and research as well:

1. She has a one paragraph comparison of MSAs and FSAs (Flexible Spending Accounts). Section 125 of the Internal Revenue Code allows for FSAs. They enable workers to set aside tax-free money to spend on health care expenses not otherwise covered by their insurance, or to pay for health insurance premiums. FSAs are similar to MSAs with one exception; that is, money not spent by the end of the calendar year is forfeited with a FSA but may be rolled over into the next year with a MSA. The FSA provides exactly the wrong incentive because it forces workers to spend needlessly at the end of the year to avoid forfeiting their own money. The MSA encourages workers to be thrifty in their health care

38. Id. at 705-06.
spending because they may retain unspent funds. Yet, Jefferson seems
to approve of the FSA and disapprove of the MSA, without explaining
why.

2. Jefferson argues that “the cost of high-deductible plans vary and,
in many instances, are more expensive than proponents suggest.” This
means, she says, that employers will not have enough savings to put into
the MSA, and employees would have increased out-of-pocket expenses.
That could very well happen because there is no guarantee that insur-
ance companies will lower their premiums for the high-deductible plan.
The solution, however, is simple: if the savings are not sufficient, do not
buy the MSA. Stick with the plan you currently have.

3. Jefferson assumes there is one big insurance pool, and if healthy
people leave it, costs will go up for everyone else. She says “[t]he
healthiest individuals will remove themselves from the larger insurance
pool for traditional insurance arrangements, leaving only older and
sicker individuals to be covered by these insurance arrangements.” This
statement raises several issues:

We have already answered the basic premise—that MSAs will attract
only the healthy and the wealthy. All of Jefferson’s other thoughts seem
to rest on that mistaken assumption.

What does Jefferson mean by “traditional insurance arrangements”? That expression usually refers to “traditional indemnity” programs
(those other than managed care). Is she suggesting, then, that Congress
outlaw managed care along with MSAs? Or does she think managed
care has become “traditional”?

The notion that there is a single insurance pool could not be further
from the truth. There are tens of thousands of insurance pools in the
country, and none of them subsidizes the others. Every self-funded em-
ployer group is its own pool, independent from all others. Every insur-
ance company and every HMO is independent from every other insur-
ance company, and they do not subsidize each other. Even within a
single insurance company, there exist separate and independent insur-
ance pools for different states and different blocks of businesses. For ex-

39. Id. at 707.
40. See Daniel Zabinski et al., Medical Savings Accounts: Microsimulation Results
From a Model with Adverse Selection, 18 J. HEALTH ECON. 195, 196 (1999). A more re-
cent study conducted by researchers at the Agency for Health Care Policy and Research
noted that earlier MSA studies treated “the employment-related health insurance market
as a single entity (pool) . . . . In practice, however, the insurance market may not function
as a single pool, and the insurance choices in one pool need not affect the premiums in an-
other pool.” Id.
41. Jefferson, supra note 1, at 708.
ample, the Insurance Commissioner in Iowa will not allow a company to raise its rates in Iowa to cover losses in California. Similarly, a company’s small group block of business is subject to entirely different rules and rating procedures than its block of individual, non-group business is.

Jefferson’s article includes a section entitled: “MSAs Disproportionately Benefit the Most Informed.” Indeed they do, but it is hard to see why being well informed is something that should be discouraged. As in every other area of our lives, the people with enough foresight and intelligence to become well informed will do better than those without. MSAs encourage people to take more control over their health care needs and to gather the information they need to do so. Knowledge is not static. It is available to anyone motivated to find it. This has never been truer than today with the widespread use of the Internet. But knowledge without power is meaningless. MSAs provide consumers with the power to affect their own health care and the opportunity to get the information to do so well.

Finally, Jefferson notes that the current MSA design is complex and “could have a negative impact on its success.” Sadly, she is right. The design enacted by Congress is absurdly complicated and nearly impossible to explain to a potential buyer. Some commentators have argued that Congress, particularly Senator Kennedy (D-Mass.) and his allies who oppose the whole idea of patient empowerment, designed the program to fail. Also, the federal law confines MSAs to the self-employed and groups with fifty or fewer employees, which is not exactly the most innovative sector of the health care market. Moreover, the enrollment limits have kept out many of the larger players in health care financing—750,000 potential enrollees are not enough to get their attention.

Still, some 60,000 MSA accounts have been opened through 1999, nearly a third by people who were previously uninsured. Enrollment is steadily growing at a rate of 55% per year. So, like other new product offerings, a small group of innovators has picked up MSAs, and the larger population is slowly warming to the idea. This evolution should not be surprising. It took some twenty years for HMOs and 401(k) plans to get off the ground, and MSAs will probably take as long.

42. Id.
43. Id. at 719.
V. CONCLUSION

No one has argued that MSAs are the best approach for all people at all times. Two separate studies, a marketing research study by the Blue Cross Blue Shield Association and a public opinion survey by the Kaiser-Harvard Foundation on the Public and Health, each found that 43% of workers would choose a MSA if one were offered. That means 57% would not. The important thing is that people have a choice.

HMOs are a good choice for many, MSAs are a good choice for many others, and other forms of health care financing (PPOs, traditional indemnity, the newer “Provider Service Organizations,” and whatever else may come along) will all have their customers. Some of the companies offering these products will do a good job and will prosper. Others will do a poor job and will fail. That is how the American economy grows and evolves in every sector except health care. It is time to subject health care to the same discipline.

