Medical Savings Accounts

American College of Physicians*

This position paper examines medical savings accounts (MSAs) as a supplemental mechanism for financing health care services. Although federal legislation to encourage MSAs did not pass in 1995 and is not likely to pass in 1996, MSAs will continue to be seriously considered by public policymakers.

Individual retirement accounts accumulate funds for retirement; MSAs could be used to accumulate funds for health care expenditures. Changes in the federal tax code would be required to permit tax-deductible contributions and tax-free earnings to individual MSAs. To be withdrawn without penalty, funds from an MSA could only be used to pay for approved medical or health insurance expenses. Each person would own and control his or her account, regardless of changes in employment. Coupled with high-deductible health insurance, MSAs could empower cost-conscious patients in health care decision making, increasing competitive pressure to reduce health care costs. Administrative costs and paperwork associated with health insurance might also be reduced, and some people who currently do not have health insurance might be able to obtain some financial protection.

Medical savings accounts may not help unemployed persons or low- and middle-income persons who cannot afford to contribute to such accounts. These accounts may result in reduced health insurance protection and greater out-of-pocket expenses for those most in need of health care. Problems of adverse risk selection could arise if healthy persons choose insurance options involving MSAs; this choice would cause premiums to increase for persons who desire traditional health insurance.

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The American College of Physicians remains committed to achieving universal health insurance coverage. Medical savings accounts (MSAs) have been proposed as a supplemental mechanism for financing health care services. Medical savings accounts could be used to accumulate funds for health care expenditures just as individual retirement accounts (IRAs) accumulate funds for retirement. Changes in the Internal Revenue Service (IRS) Tax Code would be required to permit tax-deductible contributions by employees and employers to MSAs and to allow interest and earnings to accumulate without taxation. Funds could be withdrawn without penalty only for medical expenses, for the purchase of health or long-term care insurance, or for other expenditures that could be stipulated in the tax code. Each person would own and control his or her account, regardless of changes in employment, and would therefore have a financial incentive to make cost-effective use of health care resources. Coupled with high-deductible health insurance, MSAs could empower cost-conscious patients in health care decision making, increasing competitive pressures to reduce health care costs. Administrative costs and paperwork associated with health insurance might also be reduced, and some persons who currently do not have health insurance might be able to obtain some financial protection.

However, MSAs alone will not achieve the goal of universal access. The College is concerned that MSAs may not help unemployed persons or low- and middle-income persons who cannot afford to contribute to such accounts. These accounts may result in reduced health insurance protection and greater out-of-pocket expenses for those most in need of health care services. Problems of adverse risk selection could arise if healthy persons choose to establish MSAs and obtain high-deductible health insurance; this choice would cause premiums to become less affordable for persons who desire traditional health insurance.

Consequently, the College favors legislation that would permit experimentation and examination of MSAs through research and demonstration projects that would carefully monitor the effects of MSAs and minimize their potential negative consequences.

What Medical Savings Accounts Are

Medical savings accounts are tax-free or tax-deferred bank or personal savings accounts that can be used by individual persons and families to pay for their health care expenses. Also known as health savings accounts, medical IRAs, or Medisave accounts, MSAs are viewed as a way to restore individual control over health care expenditures by linking such expenditures directly to a personal medical bank account. Proponents of MSAs argue that such accounts would encourage consumers to use routine

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health care services more economically because unused funds would accumulate in the account and could be used for future health care needs without restriction. Individual persons and families would therefore have a financial incentive to use routine health care services prudently. Young, healthy persons and other members of low-risk groups who might not otherwise purchase health insurance or save for future health care expenses would have an incentive to make tax-free contributions to their own tax-sheltered MSA. Restoring consumers' cost-consciousness and their control over routine health care spending is seen by proponents of MSAs as the most effective way to reduce health insurance costs and overall health care spending, thereby improving access to health care services (1–3).

Existing tax laws do not permit the type of tax-free savings accounts envisioned by advocates of MSAs. The concept of MSAs as discussed in the literature is only a proposed way for individual persons and families to pay for health care. Medical savings accounts are tax-free personal savings accounts from which withdrawals can be made, without penalty, only for medical expenses as defined by the IRS. Federal and state legislative action to amend the tax laws would be required if contributions and interest earnings are to be sheltered from taxation. Current federal income tax laws treat contributions to MSAs by employers as taxable income to the employee; any interest earned in an MSA is also considered to be taxable income.

What Medical Savings Accounts Are Not

A few employers are experimenting with arrangements that are similar to MSAs. Currently, employers can establish flexible spending accounts that allow employees to have pre-tax dollars withheld from their paychecks to pay for anticipated medical expenses. Funds can be used for medical expenses (as defined by the IRS) but must be used during the same calendar year in which they are withheld. Unused funds cannot be accumulated from year to year and are forfeited to the employer or plan administrator to offset administrative costs. Consumers must spend all of the money in these accounts by the end of the year or forfeit it; such accounts cannot be used to save for future health care expenses.

Some employers (for example, Forbes, Dominion Resources, and Quaker Oats) have adopted programs that reward employees with year-end cash bonuses for not submitting health insurance claims or for having claims that are less than an annual target amount (4, 5). In 1993, the United Mine Workers negotiated a contract in which they agreed to exchange a health insurance plan with no deductible for one with a $1000 annual deductible. In return, each employee received a taxable $1000 bonus at the beginning of the year, and the employee kept any unspent money at the end of the year (2). These arrangements are often cited as successful examples of how MSAs can reduce health care costs, but they are not true MSAs. In these examples, account balances do not accumulate for health expenses beyond 1 year, unused funds can be used without restriction, and the accounts do not receive favorable tax treatment that would put them on an equal footing with contributions for health insurance.

How Do Medical Savings Accounts Work?

If coupled with high-deductible health insurance policies, MSAs could provide a cost-saving alternative to first-dollar or low-deductible health insurance while providing protection for catastrophic expenses. Typical health insurance policies with first-dollar coverage or low deductibles tend to shield consumers from the full effect of health care prices. They provide little incentive for the consumer to shop for services on the basis of cost. Advocates of MSAs argue that increased cost-consciousness on the part of the consumer and substantial financial savings could be achieved by purchasing low-cost health insurance policies with high deductibles and establishing MSAs to fund the deductible and copayment amounts.

Substantial savings in health insurance premiums may be achieved by switching from low- to high-deductible policies. For an individual person or family buying a nongroup policy, the savings might be as much as the difference in the premium amount (6). Proponents argue that most employers could cut their health insurance premiums by one third with a $2500 deductible, even without changes in health care consumption (6). The savings in insurance premiums obtained from switching to a high-deductible plan could be used by employers to fund employee MSAs and might offset much, if not all, of the employee's increased financial risk for the higher deductible amount. Employees could then take those tax-free funds from their personal accounts to pay for routine medical expenses. As soon as the deductible from the catastrophic policy is met, the insurance would cover expenses for any additional services (4). Employers benefit from reduced health insurance premiums and can expect to curtail future costs. Employees benefit by accumulating unused funds for future health care expenses and by having greater discretion over health care spending done on their behalf.

Example 1: An employer pays $4500 per year for

each employee for standard health insurance coverage. Under an MSA plan, the employer would take $1500, purchase a policy with a $3000 deductible for the employee, and deposit $3000 into the employee's personal MSA (7). In this example, the cost to employer and employee remain the same. The employee has the same amount of insurance protection but now has an incentive to curtail health care spending. The employer's costs have stabilized, and, if employees respond by reducing health care spending, less upward pressure will be exerted on future employer health care costs.

Example 2: A family purchases a catastrophic policy with a $2500 deductible and makes annual tax-free deposits of $2500 into an MSA. The family uses its MSA money to pay for the first $2500 in medical expenses. If the family meets the deductible for the catastrophic policy, any further medical expenses are covered by the health insurance. Any unexpended funds will accumulate and earn interest in the tax-free savings account. If the family has no medical expenses for 5 years, the MSA balance, at 6% interest, accumulates to $14 516 (8). The family then has savings that it would not have had if it had purchased a low-deductible health insurance policy. These savings can be used to pay future health care expenses. In addition, the family has protected itself from the risks of both routine and catastrophic health care expenses.

Medical savings accounts have been used in Singapore since 1984 as part of a system of forced savings in which employers and employees are required to contribute to a government-controlled fund. Under this system, persons must generally rely on self insurance to cover health care, retirement, and disability expenses. Employers and employees contribute 6% of the employee's salary into each worker's MSA until the balance reaches a certain amount (approximately US $8522 in 1992). Once the balance (which is sufficient to cover most hospital costs) is achieved and maintained, additional contributions are placed in the employee's ordinary savings account. This account is intended for retirement, disability, medical expenses, death, or the purchase of a home. Funds in the Singapore MSAs can be used only for hospital care at government hospitals. One effect of the Singapore system is over-reliance on hospital care compared with physician outpatient care. (6)

Discussion

Medical savings accounts have not been tried on a national level in the United States. Changes in federal and state tax laws would be required to permit tax-sheltered MSAs that could be used only for medical expenses. Consequently, the full effect of widespread use of MSAs in the United States is unknown; most current analysis is based on theory and conjecture. The effects of MSAs depend on how they are structured and on the tax treatment that is given to contributions, earnings, accumulations, and disbursements.

Nevertheless, some success in reducing health care costs has been reported by companies that have instituted bonus or incentive plans that reward employees financially for decreasing their health insurance claims (1, 2, 4, 5). Experiments involving incentives for employees to reduce their health care claims indicate that health insurance costs of the employer can potentially be reduced through the combined use of MSAs, high-deductible catastrophic coverage, and increased employee cost sharing.

Medical savings accounts offer a way to encourage people to save for their own health care expenses and increase consumer involvement in health care decision making (*see* Appendix) Coupled with high-deductible health insurance, MSAs may allow people to save for their future health care needs and still receive protection from catastrophic health care expenses. Access to health care services might be improved if MSAs and more affordable (high-deductible) health insurance become widely available. Some people who have no insurance could obtain protection from catastrophic health care expenses while accumulating MSA funds that could be used to purchase routine health care services. Young, healthy persons and those who are self-employed would have financial incentives, which are now generally lacking, to provide for their potential health care needs.

One of the major advantages of MSAs is their ability to provide, for individual persons and families, a source of funds that could be spent as desired for health care without approval from an insurance carrier or other third party. Consumers could use their MSA savings for health expenses that are now largely uncovered by traditional insurance (such as preventive, well-child, mental, and long-term health care). On the other hand, the financial incentives of MSAs that encourage cost-consciousness might discourage some consumers from spending their MSA funds on preventive health services.

Unused funds could be accumulated for future health care needs, such as supplementation of Medicare coverage or provision of long-term care. The tax code could be modified to permit unused funds to be used as death or disability benefits, to be part of the person's estate, or to be restricted to provide only for the health care needs of surviving family members. The tax treatment of MSAs could also be structured to provide incentives for using MSA funds for socially desirable purposes, such as

preventive health care and long-term care. Accordingly, families itemizing deductions and claiming children as dependents could be allowed to make higher tax-deductible contributions to their MSAs to pay for childhood immunizations and other preventive services. Tax-sheltered MSA funds could be permitted to accumulate beyond a certain limit, provided that the excess funds were designated for use after retirement.

Increased cost-consciousness on the part of the consumer could exert downward market pressure on health care prices and decrease use of health care services. Resultant reductions in health insurance premiums and tax code changes that would allow all employers (including the self-employed) to make tax-deductible contributions could encourage more employers to provide health benefits for employees and their dependents.

The establishment of MSAs holds clear advantages for relatively healthy people who do not currently realize a favorable financial return from their (or their employer's) investments in health insurance premiums, but would many people who are now uninsured obtain coverage in this manner? Young adults 18 to 24 years of age represent more than 21.4% (n = 7.9 million) of nonelderly uninsured persons (9). How many persons in this group would establish tax-sheltered MSAs? Middle- and upper-income persons and families would derive greater tax advantages from establishing MSAs, but they represent only a small portion of the uninsured. More than three quarters of nonelderly uninsured persons live in families with incomes that are less than three times the poverty level (9). Low-income persons and many middle-income persons are not likely to have funds available to set aside for future health care needs. Consequently, MSAs raise questions about the inequities involved in providing relatively greater tax subsidies to upper-income taxpayers, because these persons are better able to allocate funds for their family's health care.

The coupling of MSAs with high-deductible insurance also raises concerns about the availability and cost of more traditional, low-deductible health insurance. Standard health insurance plans could face problems of adverse selection; persons who are healthy and at low risk would be likely to choose MSAs and high-deductible insurance arrangements. If employees could choose either traditional insurance or an MSA in conjunction with a high-deductible policy, they could choose the MSA option and switch back to a low-deductible plan if they became seriously ill or started to incur substantial medical expenses. Restrictions could be imposed that might limit these kinds of enrollment changes. Nevertheless, premiums for community-rated standard plans would increase, reflecting higher claims expected from a covered population at greater risk for illness. Health insurance costs for standard, low-deductible policies would then be less affordable for those who would need them most.

It is often asserted that the insurance premium savings that result from exchanging low- for high-deductible health insurance could be used to offset, and perhaps even to fully fund, the higher deductible amounts. This may be true for persons purchasing insurance at non-group rates, but it is not generally true for large group insurance, in which premium savings would be closer to one third. The Congressional Budget Office (10) found that the premium savings claimed by proponents of MSAs were "implausibly large" and "unobtainable by typical workers nationwide." The Hay Group, a benefits consulting firm, prepared estimates for the Congressional Research Service indicating that high-deductible insurance policies ($2500) would save a maximum of $500 to $600 annually. The Congressional Research Service concluded that premium savings from high-deductible insurance would be inadequate to fund most MSAs. They found that MSAs "may be suitable only for people who are well-off or healthy" (2). The American Medical Association estimates that the premium savings are about 50 to 60 cents per dollar of increased deductible (3).

Consequently, MSAs could be established with insufficient funds to cover higher health insurance deductible amounts. Persons with standard coverage could have increased out-of-pocket expenses as employers choose high-deductible insurance. Employees would then be exposed to greater financial risk. Those with high medical expenses may never accumulate balances sufficient to meet the annual deductible amounts and would lose money under an MSA and high-deductible arrangement. Current differentials in insurance premiums might also change if sales shifted from low- to high-deductible polices.

A contrary concern is that consumers may become less cost-conscious as their account balances grow over time. A substantial MSA balance might enable consumers to obtain uncovered or unnecessary health care services that would otherwise be disallowed by utilization review or other efforts by third-party payers to control health care expenditures.

Medical savings accounts are expected to reduce health care costs because patient cost sharing generally leads to reduced health care use, primarily by reducing the number of contacts rather than the intensity of services. However, decreased use occurs for effective and necessary services as well as for ineffective and unnecessary services (11). Cost sharing can also have a greater deterrent effect on the use of services by poor and low-income families, which particularly affects the use of acute care ser-

vices for poor children (11). Greater reliance on MSAs, involving increased cost sharing and self insurance, could therefore deter patients, particularly those in low-income families, from obtaining needed and effective medical care. On the other hand, if persons who are currently uninsured have incentives to establish MSAs, they would have savings with which to pay for health care services that they might otherwise forgo or obtain as charity care.

In 1992, the Congressional Budget Office (10) examined the impact and effectiveness of two legislative proposals for creating MSAs. These proposals would have allowed deposits and interest earnings in MSAs to be excluded from taxable income. Withdrawals to pay for medical care would also be tax free; other withdrawals would be considered taxable income and would be subject to a 10% penalty (the same penalty for early withdrawals from an IRA). The preliminary conclusion was that, despite the cost-saving incentives obtained from the use of MSAs with high-deductible insurance, "these proposals are unlikely to restrain medical spending much" (10).

The Congressional Research Service estimates that more than half of aggregate health care expenditures in any given year are attributable to persons who have large annual health care expenditures (≥$2500). These persons would incur out-of-pocket expenses equal to the high-deductible catastrophic insurance amount and might not be able to accumulate sufficient MSA savings to meet the annual deductible. Although they may encourage mindful spending on health care services, MSAs would have little effect on most health care spending, even if everyone were enrolled in MSA plans (2).

Surprisingly, as of mid-1995, the Congressional Budget Office, the General Accounting Office, and the Congressional Research Service had not prepared estimates of the effect on federal revenues of creating tax-sheltered MSAs. Presumably, the effect would be a substantial loss of tax revenues if persons could reduce their taxable incomes by amounts deposited in MSAs and if employer contributions and interest earnings were also tax free.

As proposed, MSAs would help maintain the fee-for-service payment system. Patients could select providers of their choice and would have funds with which to pay for services covered by insurance, services not covered by insurance, or disallowed charges. This would give patients more freedom but could result in the use of more unnecessary and ineffective services. Most consumers would be unable to accurately assess the scientific and technical qualities of care they receive. Some health care providers might also respond differently if they knew that no third party was involved with payment.

Because high-deductible insurance would deter policyholders from filing small claims, administrative costs and paperwork could be reduced. Insurance companies would not have to make payments until patients met their annual deductible, thus avoiding the processing costs for small claims. Policyholders who do not expect to meet their annual insurance deductible might purchase services without involving third-party payers at all. This would reduce the number of health insurance claims, administrative paperwork, and intervention by third-party payers. However, many policyholders would still file insurance claims to satisfy insurance copayment and deductible provisions. Thus, third-party payers would need to continue making determinations of usual, customary, and reasonable charges to assess amounts that would apply toward the deductible. Policyholders might also file claims to limit their financial exposure under participating provider agreements.

Economist Mark Pauly (12) found that MSAs are unlikely to substantially improve the efficiency of medical care. He notes that if the tax incentives to use MSAs are set at levels that induce widespread participation, then total health care spending is likely to increase, not decrease. He argues that current tax exclusions for health insurance premiums are inefficient and inequitable, fostering insensitivity to health care prices and greater use of health care services, because persons in higher income tax brackets reap greater tax advantages than persons in lower income tax brackets. Extending tax subsidies to all medical spending through MSAs would enhance these inequities and inefficiencies. More consumers would benefit from tax subsidies and thereby become less sensitive to health care costs. Consequently, health care spending would be likely to increase. Pauly concludes that MSAs "are likely to be a small improvement at best, and may even be worse than the current policy" (12).

Other economists (13) disagree. They argue that third-party payments by conventional insurance providers insulate consumers from the costs of their health care decisions. They contend that MSAs are a way to restore consumer involvement in decision making about health care and that the most effective way to control health care costs is to rely on consumers to make informed decisions.

Conclusions

It can be argued that MSAs may reduce or control health care costs, particularly for employers. However, whether MSAs can expand access to health care services is less clear. Some individual persons and families might have improved financial access to health care services if they could establish MSAs. Unless the necessary tax-code changes for

tax-deductible MSAs are carefully structured, a relatively small portion of the uninsured population might benefit. Rather, the most likely beneficiaries would be young, healthy persons or those in upper-income brackets—not most of the persons now uninsured. Proponents of MSAs contend that favorable tax treatment of MSA contributions and low insurance premiums for high-deductible health insurance might prompt some employers, particularly the self-employed and other small employers not currently providing health insurance benefits, to make some contributions on behalf of their employees.

Although MSA proponents have apparently overstated the premium savings that result from switching to MSAs and high-deductible insurance, the RAND study (11) and the examples of cost reductions achieved by existing employee cost-sharing incentive plans indicate that MSAs could potentially contain costs. Some additional employees could plausibly be offered health insurance coverage through their employers if MSAs and high-deductible insurance were to reduce health insurance premiums.

Medical savings accounts might also improve access to health care services by giving patients greater discretion over health care spending. Funds accumulated in an MSA would be retained by a person regardless of changes in employment. Medical savings accounts may also reduce administrative hassles for patients and physicians. With this system, patients pay for health care services with their own MSA funds and do not file insurance claims unless they expect to exceed deductible amounts.

It is unclear how MSAs would affect the use of preventive health services. There is concern that increased cost-consciousness may deter some patients from spending their MSA funds on preventive services, such as periodic physical examinations, immunizations, or Papanicolaou tests. However, the RAND study (11) showed that higher consumer copayments decreased personal health care spending without resulting in any apparent harmful effects on health. Proponents assert that MSAs would enable consumers to choose preventive health services and other health care services that often are not covered by normal insurance.

Concerns have also been raised about the potential effect of MSAs on the availability and cost of traditional health insurance. Premiums for low-deductible, community-rated plans could increase as a result of adverse selection, as young, healthy people switch to MSA and high-deductible arrangements. The persons who most need or desire health insurance may no longer be able to afford traditional coverage. However, safeguards could be adopted in the Federal Income Tax Code to restrict switching of coverage between MSAs and traditional insurance and to minimize problems of adverse selection.

Another major concern is that MSAs could have a substantial negative effect on federal and state tax revenues. Tax revenues would decrease as funds are sheltered in MSAs. An annual limit on contributions to an MSA and a maximum amount that could be accumulated might address some concerns about social equity and reduce the potential tax shelter for affluent persons.

Nevertheless, in a pluralistic society, many approaches may be required to give all persons access to health care. Voluntary MSAs are one option that may appeal to some individual persons and families who would not otherwise have health insurance or savings for health care expenses. Some employers who do not currently provide health benefits might be induced to contribute to employee MSAs or to offer catastrophic health insurance coverage. Limited use of MSAs is not likely to have a dramatic effect on either cost or access. Medical savings accounts alone will not achieve universal health insurance coverage. Comprehensive reform will still be needed, although MSAs should be considered as one alternative within an array of reforms intended to increase access to health care services, improve quality, and reduce costs. The American College of Physicians, therefore, would support legislation to authorize experimentation with tax-deductible MSAs, if provisions are enacted to minimize potential negative consequences and provide for careful monitoring.

Appendix: Arguments for and against Medical Savings Accounts

Pros

According to their proponents, MSAs would decrease overall health care costs by eliminating much of the third-party role of insurers in payment for certain medical services. Many economists believe that a contributing factor to increasing and excessive health care costs is that patients and their providers are shielded from the true costs of services. Although both groups subsidize those costs indirectly, the bill is most often paid by a third party (usually a private insurer or the government). Many consumers and providers are therefore not cost-conscious when using health care services; as a result, costs are driven upward. Advocates also believe that the use of MSAs will increase access to health care services, improve quality of care, enhance the physician–patient relationship, and reduce administrative hassles.

Effects of MSAs on health care costs include the following:

1. Health care spending may decline as consumers use services more economically as a result of paying for them directly.

2. Health insurance premiums may be reduced because

of cost-conscious spending by consumers, resulting in lower costs to employers and employees.

3. Healthy individual persons and families would accumulate positive account balances instead of paying to cover premiums for unused insurance.

Effects of MSAs on access to health care include the following:

1. Some persons without insurance, particularly those who are young and healthy, might start accumulating savings for future health care expenses, particularly long-term care.

2. Consumers would be assured freedom of choice among providers in an environment of increasing managed care.

3. Patients might have greater access to preventive, mental health, and long-term care and to other services not usually covered by traditional low-deductible insurance policies. However, some patients may be more reluctant to use preventive health care services if they have to spend their MSA funds.

4. Unlike traditional health insurance, MSAs would be personal accounts that could be retained regardless of changes in employment.

Effects of MSAs on quality of health care include the following:

1. Greater consumer involvement in the purchase of health care services would improve the quality and efficiency of care because of increased competitive pressure resulting from an informed consumer population.

2. Physician–patient relationships would be strengthened as the role of the third-party payer becomes more limited.

Effects of MSAs on the administrative costs of health care include the following:

1. Paperwork and administrative hassles for physicians would decrease because more patients would pay directly for services by using funds from their MSAs.

2. Consumers could pay for certain services with MSA checks or debit cards, avoiding the hassle of completing claim forms.

3. Administrative burdens for employers who offer MSAs would be minor.

Cons

Critics of MSAs doubt that such accounts would successfully reduce health care costs. They question the extent of the premium savings that can be achieved from exchanging low-deductible insurance for high-deductible insurance in combination with an MSA. A limited number of uninsured people would gain coverage. Tax-subsidized MSAs would provide a benefit primarily for young and healthy persons at the expense of those who remain covered by traditional health insurance. Older and less healthy consumers would be faced with premiums greater than those of their previous low-deductible insurance.

Medical savings accounts would not substantially reduce health care costs because of their limited appeal and because more than half of all health care expenditures are attributable to patients whose health care bills exceed the typical catastrophic policy deductible. If MSAs were widely used, adverse selection would cause traditional health insurance rates to increase. Most families have limited savings; those without employer contributions to their MSAs sufficient to offset higher deductible amounts could face unmanageable out-of-pocket expenses. Medical savings accounts are seen as inequitable, because persons in upper-income tax brackets (who can also afford to purchase traditional insurance) obtain a greater benefit from each tax-sheltered dollar as a result of the progressive nature of the tax code. Meanwhile, tax-sheltered MSAs could have a substantial negative effect on federal and state tax revenues.

Effects of MSAs on health care costs include the following:

1. Consumers with MSAs may continue to purchase unnecessary or ineffective services, thereby sustaining a market for inappropriate services and contributing to overall health care expenditures.

2. Premium savings resulting from shifts to high-deductible insurance may be overstated. Data suggest that those savings are insufficient to entirely fund MSAs as proposed. For example, employer contributions equal to payments for standard low-deductible coverage would not be enough to fully fund MSAs for the higher deductible amount and the entire premium cost of a catastrophic policy.

3. Incentives to limit spending may be ineffective if MSA balances grow substantially over time because of tax shelters and spending restrictions. Consumers may feel less cost-conscious in their purchase of health services if they have high account balances.

4. Federal and state governments would incur costs because of lost tax revenues from the tax-sheltered MSAs.

Effects of MSAs on access to health care include the following:

1. Access to health care could be reduced for persons with insufficient MSA balances, which may cause consumers to forego necessary medical services.

2. Many uninsured persons would not have better access to health care. Small companies, which employ most uninsured workers, would not be likely to voluntarily contribute to MSAs.

3. Premiums would increase for community-rated, low-deductible insurance plans because young and healthy persons would probably choose MSAs and catastrophic coverage.

Effects of MSAs on quality of health care include the following:

1. Many consumers are unable to accurately assess the scientific or technical quality of the medical care they receive. Competitive pressure based on better quality at sustained or reduced cost is unlikely to result from MSAs.

2. Increased patient sensitivity to prices may cause consumers to move among various providers in search of the best bargain without regard for quality and continuity of care.

Effects of MSAs on the administrative costs of health care include the following:

1. Administrative costs for the Internal Revenue Service would increase because of new regulations and the need to monitor compliance.

2. Providers would still have to verify to insurers the expenses attributable to deductible amounts.

3. Patients would have to keep accurate records to satisfy health insurance deductible amounts.

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