COMMENTS

The Medical Savings Account Provision of the HIPAA: Is It Sound Health and Tax Policy?

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INTRODUCTION

On August 21, 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 (hereinafter HIPAA).[1] The stated objective of the HIPAA was:

> To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, *to promote the use of medical savings accounts*, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.[2]

The Medical Savings Accounts (MSAs) authorized in the HIPAA are savings accounts designed to pay for health care expenses.[3] For the past several years, a debate has raged over whether Medical Savings Accounts should be given a preferential tax treatment. The HIPAA contains a provision creating a demonstration program that allows the establishment of a limited number of MSAs with a preferential tax

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* J.D. 1998, Seattle University School of Law; B.A. 1991, University of Washington. The author would like to thank Professor Sheldon Frankel for his suggestions and assistance, the members of the Law Review Editorial Board and the article editorial committee for their careful and thoughtful suggestions and encouragement, and, finally, her family and friends for their neverending support during the writing process.

1. Pub. L. No. 104-191, 110 Stat. 1936 (1996).
2. *Id.* at 1936, Synopsis (emphasis added).
3. Throughout this Comment, MSA refers only to the actual trust or custodial account. The MSAs discussed in this Comment have also, in the past, been referred to as Medical Spending Accounts, Medisave, and Medical IRAs.

treatment.[4] As adopted, this provision represents a compromise between those who advocate unlimited allowance of MSAs and those who are concerned about their potential effects.

Because of concerns that MSAs will cause adverse selection in the traditional health insurance market, the HIPAA contains safeguards designed to prevent, or at least limit, this potential harm. The safeguards placed on this demonstration program include limiting the maximum number of participating accounts to 750,000.[5] In addition, preferential tax treatment is available only for MSAs held either by employees of small businesses or by self-employed people and created in conjunction with a qualified high-deductible health insurance plan.[6] Finally, a four-year study is to be completed by the General Accounting Office (GAO) to determine whether MSAs cause adverse selection or have other negative effects.[7] However, while an attempt has been made to limit the possible negative effects that might occur, these safeguards do not fully address the concerns presented by MSAs.[8]

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4. Pub. L. No. 104-191, 110 Stat. 1936, 2037 (1996), Title III—Tax Related Health Provisions, Subtitle A § 301 (creating I.R.C. § 220, changing current section 220 to section 221, creating I.R.C. § 4890E, and adding and amending other sections).

5. I.R.C. § 220(j)(2)(A) (West Supp. 1997). However, there are lower interim caps for the initial years. Enrollment will be cut off if enrollment limits are reached as follows:

375,000 by April 30, 1997, I.R.C. § 220(j)(1)(A);
525,000 by June 30, 1997, I.R.C. § 220(j)(2)(B);
600,000 by April 15, 1998, I.R.C. § 220(j)(2)(A);
750,000 by April 15, 1999, I.R.C. § 220(j)(2)(A).

However, previously uninsured people who obtain Medical Savings Accounts do not count toward the interim caps. I.R.C. § 220(j)(3).

Note: the Internal Revenue Code (I.R.C.) is title 26 of the United States Code.

6. I.R.C. § 220(c)(1)(A). Additionally, the individual cannot be covered by other insurance. *See* I.R.C. § 220(c)(1)(A)(ii). Exceptions to this rule are coverage for benefits provided by insurance, I.R.C. § 220(c)(1)(B)(i); and by accident, disability, dental, vision or long-term care coverage, I.R.C. § 220(c)(1)(B)(ii).

7. Pub. L. No. 104-191, 110 Stat. 1936, 2052 § 301(l) (1996). However, the study's method is flawed because the limitation that MSAs can be opened only by people who are self-employed or employed by small businesses will not provide an adequate opportunity to determine whether adverse selection will result. Adverse selection will not be properly tested because small businesses generally do not offer more than one choice of health insurance. *See, e.g.*, *IRS Issues MSA Guidelines*, HEALTH LEGIS. & REG. WEEKLY 10, Dec. 11, 1996 (summarizing Gail Shearer of Consumers Union). *See also Finally a Health Bill*, N.Y. TIMES, late ed., July 27, 1996, p. 22. Additionally, the study's four year duration will not show the long-term effects. The flaws in this demonstration program and study will be more fully developed later in this Comment. *See infra* notes 108-20 and accompanying text.

8. The first year of the insurer survey portion of the study has been completed. WESTAT, MEDICAL SAVINGS ACCOUNT DEMONSTRATION SUMMARY FINDINGS FROM FIRST INSURERS SURVEY (submitted to U.S. General Accounting Office Dec. 15, 1997). Because of the cost and low initial enrollment, the General Accounting Office has decided that it will not conduct the demographic study until enrollment in MSAs reaches 375,000. *Medical Savings Accounts: GAO Shelves Demographics Survey, Lobbyists Want Medicare Caps Lifted*, BNA's Medicare Report, Oct.

This Comment will discuss the MSA provision of the HIPAA. Part I discusses the basic operation of MSAs and the study of the effects that MSAs have on the traditional health insurance market and health care costs. The use of tax provisions and tax policy to further the goals of health policy, especially in the context of this provision, will be evaluated in Part II. Part III considers whether this provision meets general tax policy goals, specifically, the goals of equity, simplicity, and efficiency. Finally, Part IV suggests ways that this provision could be changed to make it more consistent with sound policy.

This Comment argues that the MSA provision of the HIPAA fails to meet the goals of either tax policy or health policy. As a result of this failure, the demonstration program should be redesigned to provide valid and reliable information about whether the availability of tax-preferred MSAs will decrease the affordability of health care and its availability to the less healthy.

I. MEDICAL SAVINGS ACCOUNTS GENERALLY AND THE DEMONSTRATION PROGRAM

The MSA provision in the HIPAA[9] creates a demonstration program that allows, on a limited basis, self-employed people and employees of small businesses[10] to open tax-preferred MSAs in conjunction with the purchase of high deductible health insurance.[11] The GAO is required to complete a study to determine the effects that the availability of tax-preferred MSAs has on health insurance and health care costs.[12]

24, 1997, *available in* LEXIS, BNA Lib., BNAmed file [hereinafter *GAO Shelves Demographics Survey*].

9. Pub. L. No. 104-191, 110 Stat. 1936 (1996), Title III—Tax Related Health Provisions, Subtitle A, § 301.

10. For purposes of this Act, a small business is defined as a business employing less than 50 people. I.R.C. § 220(c)(4)(A) (West Supp. 1997).

11. I.R.C. § 220(c)(1)(A)(i).

12. Pub. L. No. 104-191, 110 Stat. 1936, 2037, Title III—Tax Related Health Provisions, Subtitle A, § 301(l). As will be discussed later, Westat, which received the contract to complete this study has made its report of its findings from the survey of insurers for 1997. *See infra* notes 120-30 and accompanying text. The rest of the study has not yet been completed. *See GAO Shelves Demographic Survey*, *supra* note 8.

A. *What Is a Medical Savings Account?*

An MSA is a trust or custodial account that is opened for the purpose of paying the account holder's qualified medical expenses.[13] MSAs are similar in their operation and structure to Individual Retirement Accounts (IRAs).[14] They are also similar to flexible spending accounts (FSAs),[15] except that the employee with an MSA gets to keep any money left at the end of the year, while any money left in an FSA reverts to the employer at the end of the year.[16]

To open an MSA, an individual must obtain a high-deductible health insurance plan.[17] The individual may then place money, tax-free, into a custodial or trust account (the MSA).[18] The MSA funds may be used to pay the high deductible, if and when medical expenses are incurred. Because high-deductible insurance is less expensive, the difference in premiums can be put into the MSA. Further, proponents believe that allowing people to keep all of the money in the MSA that they do not use for medical expenses will create an incentive to utilize medical care more wisely.[19] Wise use of medical care, in this context, is economically efficient use. Use is economically efficient when a patient is fully informed and does not purchase unnecessary or wasteful health care services.

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13. I.R.C. § 220(d)(1) (West Supp. 1997). Qualified medical expenses are those expenses that qualify for medical deduction under I.R.C. § 213(d). I.R.C. § 220(d)(2).

14. Individual retirement accounts are also custodial or trust accounts that allow individuals within certain income limits to receive a deduction for limited amounts of contributions made to a retirement account on behalf of an individual not covered by another retirement program. *See* I.R.C. § 408. The account holder's income affects the amount of contribution eligible for deduction. *Id.* For more information on IRAs, *see* I.R.C. § 408.

15. Flexible spending accounts allow an employee to choose the type and amount of insurance they want. These are offered with cafeteria plans, which are authorized by I.R.C. § 125. Contributions are made to the flex account based on the employee's election. The contributions are taken out of the employee's before tax earnings, because it is considered an employer-provided health benefit. However, the funds in the FSA, if unused, revert to the employer at the end of the year, which creates an incentive to use all of the funds in the FSA. *See* JOHN C. GOODMAN & GERALD L. MUSGRAVE, NATIONAL CENTER FOR POLICY ANALYSIS, CONTROLLING HEALTH CARE COSTS WITH MEDICAL SAVINGS ACCOUNTS 20 (1992) [hereinafter GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS].

16. *Id.*

17. I.R.C. § 220(c)(1)(A)(i).

18. *Id.*

19. *See* JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 249 (1992) [hereinafter GOODMAN & MUSGRAVE, PATIENT POWER]. *See also* GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22.

In theory, wiser, more informed use will result in reduced health care utilization and, therefore, will reduce overall health care costs.[20] According to one estimate, seventy-three percent of all people spend less than $500 per year on health care.[21] Because most people do not use as much health care as they are insured for, proponents believe that a higher deductible will encourage consumers to choose more carefully the health care they receive.[22] Additionally, insurance claims will not have to be filed or processed until the deductible is reached.[23] Overall, such utilization may result in substantial administrative savings.[24]

B. *The Demonstration Program*

The MSA demonstration program is to run for four years, beginning on January 1, 1997, and ending on December 31, 2000.[25] Enrollment will be cut off if it reaches one of the interim caps or 750,000.[26] During this period, the GAO is to contract for a study[27] evaluating the effects of MSAs in the small group market on selection and adverse selection,[28] health costs,[29] use of preventive care,[30] consumer choice,[31] scope of coverage of plans purchased in conjunc-

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20. *See* GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249. *See also* GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22.

21. NATIONAL CENTER FOR POLICY ANALYSIS, BRIEF ANALYSIS NO. 203, MISPLACED CRITICISM OF MSAS (1996) [hereinafter NCPA, BRIEF ANALYSIS NO. 203] (visited Mar. 6, 1997) <http://www.public-policy.org/~ncpa/ba/ba203> (citing 1989 survey findings reported by Gail A. Jensen and Robert J. Morlock in J. AMER. HEALTH, May-June 1994).

22. *See* GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249. *See also* GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 23.

23. However, to determine when the deductible has been reached, as well as to allow completion of the required IRS reporting, records will still have to be maintained. For more information on reporting requirements, *see infra* notes 62, 185-95 and accompanying text. Therefore, although the administrative burden may be lessened, it will not be entirely eliminated.

24. GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249. One estimate is that use of MSAs could result in a savings of up to $33 billion per year in reduced administrative costs. *Id.* *See also* AMERICAN ACADEMY OF ACTUARIES, MEDICAL SAVINGS ACCOUNTS: COST IMPLICATIONS AND DESIGN ISSUES 15-16 (1995) [hereinafter AMERICAN ACADEMY OF ACTUARIES, COST IMPLICATIONS]; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22.

25. I.R.C. § 220(i)(2) (West Supp. 1997). Continuation after 2000 would be up to Congress, as would increasing the availability of tax-preferred MSAs. However, the tax-preferred status of MSAs opened under this program will not be terminated when the program ends.

26. *See supra* note 5.

27. Pub. L. No. 104-191, 110 Stat. 1936, 2052-53 § 301(l) (1996).

28. *Id.* § 301(l)(1) (1996).

29. *Id.* § 301(l)(2) (1996).

30. *Id.* § 301(1)(3) (1996).

31. *Id.* § 301(l)(4) (1996).

tion with MSAs,[32] and "other relevant items."[33] The GAO contract is to be with an organization that has expertise in health economics, health insurance markets, and actuarial science.[34]

As of June 30, 1997, only 22,051 MSAs had been created under the program, 17,145 of which count toward the caps.[35] Although the first portion of the insurer survey has been completed,[36] the GAO has decided to wait to complete the demographic study until 375,000 MSAs are opened.[37] The GAO claims that it is not cost effective to complete the study until there are more participants.[38]

One focus of the study is adverse selection. Adverse selection occurs when healthy people leave the traditional health insurance pool, leaving the least healthy people in the traditional health insurance pool. This increases the cost of traditional health insurance. Adverse selection is to be studied in this program because of the concerns that MSAs, coupled with high-deductible insurance, are for "the healthy and the wealthy," that they will destroy the traditional insurance pools, and that they will result in only the poor and the sick remaining in the traditional pool. The people left in the traditional insurance pool would face higher premium costs, because of their higher health care expenses. This could price some people out of the private health insurance market. If MSAs cause adverse selection to the extent that opponents fear, the allowance of MSAs will increase the risk to insurers of insuring people under traditional policies.[39]

Thus, the study is supposed to determine whether the availability of MSAs will have a negative impact on the traditional health insurance market.[40] Additional factors to be looked at in the study address some of the other concerns that have been raised about MSAs, such as the effect MSAs will have on the use of preventive care.[41] If MSAs are to be given preferential tax treatment and encouraged, their effects need to be determined. However, as will be discussed later in

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32. Pub. L. No. 104-191, 110 Stat. 1936, 2052-53 § 301(l)(5) (1996).

33. *Id.* § 301(1)(6) (1996).

34. *Id.* § 301(l) (1996).

35. I.R.S. Ann. 97-96, 1997-39 I.R.B. 15. To determine the number of MSAs that count toward the cap the total number of MSAs was reduced by the number of accounts opened by the previously uninsured (3,670) and increased by the number of taxpayers that were reported as excludable because their spouse had also established an MSA (1,236).

36. *See* WESTAT, *supra* note 8.

37. *GAO Shelves Demographics Survey*, *supra* note 8.

38. *Id.*

39. Michael T. Bond, et al., *Medical Savings Accounts: The Newest Medical Cost Reduction Tool for Employers*, BUS. HORIZONS, July 1996, *available in* LEXIS, News Library, Bhoriz File.

40. Pub. L. No. 104-191, 110 Stat. 1936, 2052-53 § 301(1) (1996).

41. *See supra* notes 28-31 and accompanying text.

this Comment, accomplishment of this goal will require that the study be redesigned.[42]

C. The High Deductible Insurance and Medical Savings Accounts

To qualify for a tax-preferred MSA, the accompanying individual high-deductible policy must have a deductible of at least $1,500 per year, but not more than $2,250;[43] the policy's out-of-pocket limit must not be more than $3,000 per year.[44] The deductible for families must be at least $3,000, but not more than $5,000,[45] with an annual out-of-pocket limit of not more than $5,500.[46] Additionally, the individual or family account holder cannot be covered by any other insurance, except that which is specifically allowed under this section.[47]

The out-of-pocket cap limits the amount, other than premiums, that an individual or family may be required to pay "out-of-pocket" for copayments and other *covered* expenses in any one year. The

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42. *See infra* notes 108-20 and accompanying text.

43. I.R.C. § 220(c)(2)(A)(i) (West Supp. 1997).

44. I.R.C. § 220(c)(2)(A)(iii)(I).

45. I.R.C. § 220(c)(2)(A)(ii). This requirement has been interpreted by Revenue Ruling 97-20, which holds that individual deductibles cannot be aggregated under a family plan and still qualify as a high-deductible account. Rev. Rul. 97-20, 1997-19 I.R.B. 4. However, plans that are established before November 1, 1997, will qualify for this program, even if they aggregate individual deductibles, but only until their renewal and this safe harbor will not extend past December 31, 1998. *Id.*

The survey of insurers, completed in December 1977, found that some of the plans being offered by insurers as "MSA-Qualified" have features that are not allowed under or are inconsistent with the requirements of § 220. *See* WESTAT, *supra* note 8. The features noted were:

> Copayments for physician office visits; first dollar coverage for preventive care where such care is not a state mandated benefit; cost sharing for out-of-network services above the out-of-pocket maximum; embedded deductibles. (Approximately one-third of qualified plans were not structured in accordance with the Treasury ruling on embedded deductibles, which allowed a grace period through November 1997).

Id.

46. I.R.C. § 220(c)(2)(A)(iii)(II).

47. I.R.C. § 220(c)(3).

Permitted insurance. — The term "permitted insurance" means—

(A) Medicare supplemental insurance,

(B) insurance if substantially all of the coverage provided under such insurance relates to—

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations.

Id.

expenses that apply toward the out-of-pocket limit are not mandated by this provision and will vary from policy to policy.[48]

Contributions by an employer to an MSA are excluded from the employee's income, as are an MSA's earnings.[49] Contributions to an MSA made by the account holder are deductible from the account holder's gross income.[50] Annual contributions to an individual's MSA receiving preferential tax treatment are limited to sixty-five percent of the annual deductible for an individual account,[51] and seventy-five percent of the annual deductible for a family account.[52] Either the employer or the account holder can make contributions to the MSA, but both cannot make contributions in the same year.[53]

The amount that an individual or family must spend in the initial year or years could exceed the maximum allowable contribution to the MSA.[54] Because of the limits placed on contributions, if the deductible is reached each year, part of the deductible (at least twenty-five to thirty-five percent, depending on whether the MSA is a family or individual account, or more, depending on the level of individual or employer contribution) must be paid out of after-tax income. Further, any expense beyond the deductible not covered by the insurance would have to be paid out of after-tax income, up to the out-of-pocket limit.

Proponents argue that although an individual MSA holder may spend more than a traditional policy's deductible in any one year, over time the savings and expenditures will balance out.[55] If the plan is

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48. As will be fully discussed later in this Comment, this may lead to expenses well in excess of this "limit" and unexpectedly high costs to the individual or family MSA holder. *See infra* notes 88-91 and accompanying text.

49. I.R.C. § 220(e). Currently, most plans simply bear interest, but with increasing popularity they could come to be invested in much the same way that IRAs are now. Mellon Bank has even introduced a MSA that allows the holder to invest the funds in any legal investment vehicle. *See Banks, Insurers Stampede to Sign MSA Participants*, TREASURY MANAGERS REP., Feb. 14, 1997, *available at* 1997 WL 8644698.

50. I.R.C. § 220(a). *See also* I.R.S. Notice 96-53, 1996-2 C.B. 219.

51. I.R.C. § 220(b)(2)(A). This means that an individual MSA could receive contributions between $975 and $1,465. This maximum contribution is calculated on a monthly availability basis. I.R.C. § 220(b)(1).

52. I.R.C. § 220(b)(2)(B). A family MSA can receive a maximum annual contribution of between $2,250 and $3,375. This maximum contribution is calculated on a monthly basis. I.R.C. § 220(b)(1).

53. I.R.C. § 220(b)(5).

54. This is because annual contributions are limited to less than the amount of the deductible. I.R.C. § 220(b)(2)(A) and (B). *See also* Nancy Ann Jeffrey, *Medical Savings Accounts Offer Benefits, Risks*, WALL ST. J., May 1, 1996, at C1.

55. Because over 73% of the insured population spends less than $500 per year and the individual contribution that could be made to the individual MSA with the lowest deductible is $975 per year, over time it is unlikely that the individual's medical expenses would exceed the maximum allowable contributions to a MSA. *See* Jeffrey, *supra* note 54, at C1. Therefore, if the

started by younger people, it may even result in substantial accumulated savings.[56] Additionally, proponents note that the purpose of an MSA is to create a fund to pay the high deductible, if necessary.[57]

Distributions from an MSA for qualified medical expenses are excluded from income for tax purposes;[58] a qualified medical expense under this provision is any expense that is deductible under Internal Revenue Code § 213(d).[59] The MSA funds may be used, tax free, for any qualified medical expense of the account holder, the spouse of the account holder, or any dependent of the account holder, "to the extent that such amounts are not compensated for by insurance or otherwise."[60]

Although the MSA funds can be withdrawn and used for any other purpose, the amount of the withdrawal will be subject to income tax and a fifteen percent penalty.[61] However, no reporting requirement currently exists.[62] Therefore, unqualified expenditures will not be discovered unless the account holder reports them or is audited.

Self-employed people receive an additional benefit under this provision, as all of the money contributed to a MSA, up to the maximum contribution, is excluded from income, while only forty

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maximum contribution is made, on average there would be at least several hundred dollars of savings placed in the MSA each year. *Id.* To illustrate, one estimate has been made that if $1,800 were put in an MSA each year and $1,000 in medical expenses were taken each year beginning when the account holder was twenty, by the time the account holder turns 65 the account would have accumulated $331,941. *Id.* Additionally, in 1989, 85% of insured people filed claims for less than $2,000 for medical care. *Id.*

56. *Id. See also The Economy Perspective Real Health-Care Reform*, INVESTOR'S BUS. DAILY, Oct. 16, 1996, at B1.

57. *See* Paul Ferrara, *Medical Savings Accounts: Not Just for Healthy*, CONSUMERS' RES. MAG., May 1, 1996, at 16.

58. I.R.C. § 220(f)(1) (West Supp. 1997).

59. I.R.C. § 220(d)(2)(A). However, health insurance, except for coverage for continuation required under federal law, qualified long-term care, or while the account holder is receiving state or federal unemployment compensation, may not be purchased out of the MSA. I.R.C. § 220(d)(2)(B). Allowing the use of the MSA funds for any qualified medical expenses means that the MSA may be used for expenses that do not apply to the deductible or out-of-pocket limit of the high-deductible plan, which could result in greater out-of-pocket expenses than were anticipated. AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 3. For example, dental and vision services, while qualified medical expenses under I.R.C. § 213, may not be covered services under a high-deductible health insurance plan. *Id.* If they are not covered, these expenditures would not count toward the out-of-pocket caps, so total expenses could be higher than expected. *Id.* This is a problem that will be further discussed later in this Comment, *see infra* notes 88-91 and accompanying text; however, its solution is beyond this Comment's scope.

60. I.R.C. § 220(d)(2)(A).

61. I.R.C. § 220(f)(4).

62. *See* I.R.S. Notice 96-53, 1996-2 C.B. 219 (the trustee or custodian is not required to determine whether the distributions are used for medical expenses).

percent of the costs of traditional health insurance are deductible from income.[63] Individuals who would otherwise pay medical expenses out-of-pocket and use their MSA funds on their medical care may also receive an added benefit. Generally, only qualified medical expenses in excess of seven and a half percent of the taxpayer's adjusted gross income are deductible,[64] but contributions made by an account holder to an MSA are fully deductible from gross income.[65] Distributions from the MSA for qualified medical expenses are exempt from taxation.[66] Unused MSA balances carry over from year to year and continue to accrue tax-free interest. Additionally, like an IRA, money in the MSA may be withdrawn without penalty, subject only to regular income tax, at retirement.[67] Moreover, MSAs receive more favorable treatment at the death of the account holder than IRAs.[68]

Two significant shortcomings of the MSA provision are its failure to require that MSA funds be used to pay for services or expenses not covered by insurance, and its failure to require that expenses paid for with MSA funds apply toward the deductible and out-of-pocket limits of the high-deductible health plan. These shortcomings may cause higher-than-expected health care expenses for the account holder.

Because medical expenses the account holder pays for do not have to apply toward either the deductible or the out-of-pocket limit, the account holder may experience higher-than-expected costs. Because there is no requirement that the MSA be used to pay for medical expenses, they may be paid for with after-tax dollars. This means that MSA holders may collect tax-free earnings on the account, using this simply as a tax shelter, which is contrary to its purpose.[69]

D. *Arguments for and Against MSAs*

Strong arguments have been raised both for and against giving MSAs a tax-preferred status. One argument against providing a tax-

63. I.R.C. § 162(l)(1)(B). This is also a benefit for self-employed people because prior to the HIPAA only 30% of the costs of a self-employed person's health insurance were deductible. I.R.C. § 162(l). The 40% deduction will be increasing over the next several years to 80%. I.R.C. § 162(l)(1)(B).

64. I.R.C. § 213.

65. I.R.C. § 220(a).

66. I.R.C. § 220(f)(1).

67. I.R.C. § 220(f)(4)(C) (the additional tax does not apply to payments or distributions made after the account holder reaches the age specified in § 1811 of the Social Security Act).

68. *Compare* I.R.C. § 220(f)(8) *with* I.R.C. § 408(d).

69. As previously noted, even if some, but not all, of the annual contribution is used for medical expenses, there may still be substantial accumulated savings. *See supra* notes 55-57 and accompanying text.

preferred treatment for MSAs is that MSAs are solely for the "healthy and the wealthy." Opponents fear that MSAs will cause adverse selection, resulting in a deterioration of the traditional health insurance pool, making health insurance so cost-prohibitive for those who most need medical insurance that they will be unable to obtain it.[70]

Proponents of tax-preferred MSAs believe that MSAs will encourage savings, encourage more active participation in the health insurance market by consumers, and lessen administrative costs.[71] Proponents claim that increased participation should result in an overall reduction in health care costs.[72] Savings will be encouraged by allowing tax-free accumulation of unused contributions and the earnings thereon. Consumers will be encouraged to be more cost-conscious and to take a more active role in the use of health care dollars because they will be spending their own money, rather than that of the insurance company.[73]

Opponents counter that consumers may not have sufficient information to change or control much of their health care spending.[74] Consumers often do not have an opportunity to gather prices or shop competitively for medical services. An injured person on the way to an emergency room is not likely to ask the ambulance driver which hospital is cheaper. The same is true of services once the patient is at the hospital. Additionally, individual consumers may not have enough bargaining power to receive better prices from doctors or hospitals.[75]

MSA-spawned adverse selection would defeat the primary purpose of health insurance, which is to pool the risks and reduce the cost to each insured individual.[76] Adverse selection in this context would

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70. *See* AMERICAN ACADEMY OF ACTUARIES, *supra* note 24, at i; *and* Mark V. Pauly and John C. Goodman, *Incremental Steps Toward Health System Reform*, 14 HEALTH AFF. 125, 136 (1995).

71. *See supra* note 55.

72. GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22; *and* Emmett B. Keeler, et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?* 275 JAMA 1666, 1667 (June 5, 1996) *available in* Westlaw, AMA-JNLS Database.

73. GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22; *and* Keeler et al., *supra* note 72, at 1667.

74. William C. Hsiao, *Medical Savings Accounts: Lessons From Singapore*, 14 HEALTH AFF. 260, 266 (1995).

75. *Id.*

76. *See* Len M. Nichols, *Medical Savings Accounts and Risk Segmentation*, 14 HEALTH AFF. 275, 275-76 (1995).

also defeat one of the primary purposes of the HIPAA, which is to increase the affordability of health insurance.[77]

However, the use of MSAs has not been widespread enough to date to determine whether they will cause adverse selection in the health insurance market. Additionally, the favorable results experienced by Singapore, discussed below, may not be the same here because of both cultural differences and structural differences in plan design.[78]

Opponents also fear that MSAs will cause a reduction in the general level of health of account holders. They believe that MSAs may create improper incentives; that people may have less incentive to obtain preventive health care because they will be spending their own money. Decreased use of preventive care could result in a reduction in the general level of the health of account holders.[79]

However, some MSA users say that they have used preventive care services which they would not otherwise have used because their *employer-provided* MSA had the money to pay for those services.[80] They claim that traditional health plans provide less incentive to use preventive care because the cost of preventive care is less than the deductible and therefore has to be paid for out-of-pocket.[81]

If state law requires coverage for preventive care without a deductible, this provision will not disqualify a high-deductible insurance policy that allows preventive care without a deductible.[82] Proponents believe that many people, particularly low-income, single parents, cannot afford the out-of-pocket costs for preventive care under a traditional plan.[83] Proponents also claim that lower use of preventive care is not necessarily bad, if the reduction in utilization is the result of more thoughtful and informed choices about what kinds of treatment and health care are really necessary for the individual insured.[84]

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77. *See supra* note 1 and accompanying text.

78. Hsiao, *supra* note 74, at 266. *See also infra* notes 132-52 and accompanying text. *See also* THOMAS A. MASSARO, M.D., PH.D. & YU-NING WONG, NATIONAL CENTER FOR POLICY ANALYSIS, POLICY REPORT NO. 203, MEDICAL SAVINGS ACCOUNTS: THE SINGAPORE EXPERIENCE (1996) (visited Mar. 6, 1997) <http://www.public-policy.org>.

79. MARK V. PAULY, AN ANALYSIS OF MEDICAL SAVINGS ACCOUNTS: DO TWO WRONGS MAKE A RIGHT? 3 (1994). *See also* Bond et al., *supra* note 39.

80. *Review & Outlook: Consumer-First Health Care*, WALL ST. J., July 21, 1994, at A-14 (editorial).

81. *Id.*

82. I.R.C. § 220(c)(2)(B)(ii) (West Supp. 1997).

83. *Review & Outlook*, *supra* note 80.

84. GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22.

John Goodman, a leading proponent of MSAs, has argued that, because of the flexibility available for provider and treatment selection with a MSA, even sick people could be better off with a MSA.[85] Unlike HMOs and preferred provider plans, most high-deductible plans do not require that the insured go to specific providers to get treatment.[86] This allows the individual enormous freedom in selecting treatments and providers.[87]

However, opponents believe that consumers may be confused because they may not realize the limitations of their high-deductible policy.[88] Although money can be withdrawn from the Medical Savings Account for any medical expense that is qualified under section 213(d) of the Internal Revenue Code,[89] many qualified medical expenses may not apply toward either the policy's deductible or out-of-pocket cap.[90] The result could be much higher cash expenses than the account holder expected to incur.[91]

Additionally, the policy may have waiting periods for coverage of some services or procedures; if one of these services or treatments is received before the end of the waiting period the expense will not apply to the deductible. Also, some procedures or services may be excluded. The cost of excluded services and procedures will not apply to the deductible, even though the expenses may legitimately be paid for out of the MSA.

The account holder is also required to determine whether expenses paid for with MSA funds are qualified medical expenses.[92] The trustee or institution that holds the funds does not monitor whether distributions are for qualified medical expenses.[93] In one sense, this

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85. John C. Goodman, *A Healthy Choice for Sick Patients*, WALL ST. J., Oct. 17, 1995, at A20.

86. *Id.*

87. *Id.*

88. Jeffrey, *supra* note 54. These expenses would still be deductible under I.R.C. § 213 to the extent that total qualified medical expenses exceed 7.5% of the account holder's adjusted gross income.

89. I.R.C. § 220(f)(1) (West Supp. 1997) (I.R.C. § 213(d) allows deduction for medical expenses).

90. Jeffrey, *supra* note 54. *See also* Steven Findlay, *Experimental Health Plan Makes Its Debut*, USA TODAY, Jan. 10, 1997, *available at* 1997 WL 6991102. Section 213(d) allows deduction for such items as vision and dental care, both of which are generally excluded from high-deductible health plans. I.R.C. § 213(d).

91. Jeffrey, *supra* note 54. These expenses would still be deductible under § 213 to the extent that total qualified medical expenses exceed 7.5% of the account holders' adjusted gross income. I.R.C. § 213(a).

92. I.R.S. Notice 96-53, 1996-2 C.B. 219.

93. *Id.* However, the Secretary of the Treasury has the discretion to require the trustee to make reports on the "contributions, distributions and any other matters the Secretary determines

is good because it will lessen administrative costs. However, this also means that there is no effective way to track MSA distributions.

Opponents also argue that MSAs will result in an inequitable distribution of expenses. People with greater disposable income and an MSA may choose to continue to accumulate tax-free earnings, opting instead to pay for medical expenses out of after-tax income, using the account as a tax shelter.[94] On the other hand, people with lower disposable income likely will not have the option of obtaining this tax benefit. Moreover, this inequity will be even more severe if adverse selection results, because the cost of insurance will be increased to those people remaining in the traditional insurance market.

E. *Actual Experience of Firms Offering MSAs to Employees*

Between 1,000 and 1,300 companies already offer plans combining an MSA and a high-deductible insurance plan to their employees.[95] Many of these companies, including Forbes, Inc., and Golden Rule Insurance Company, have reported that the use of high-deductible health plans coupled with MSAs have resulted in greater savings for employees, have reduced the employer's insurance costs, and have increased the employees' satisfaction with the health insurance options available.[96]

Golden Rule Insurance, the insurance company leading the drive for favorable treatment of MSAs, estimates that currently 25,000 people have the plans, without the tax-preferred status.[97] Many of the companies offering MSAs and high-deductible insurance have experienced reductions in their insurance costs; these savings can be returned to the employees.[98]

However, Mark Pauly, a health economist, believes that the results from Forbes and similar plans are not comparable to a program that provides a preferential tax treatment for MSAs.[99] These results are

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appropriate." I.R.C. § 220(h). These reports are to be made at the time and in the manner required by the Secretary. *Id.*

94. 142 CONG. REC. H6684-05 (daily ed. June 20, 1996) (floor Comments of Rep. Jim McDermott).

95. *See* Ron Panko, *Insurers Must Move Fast on MSA Opportunity*, 97 BEST'S REV. - LIFE-HEALTH INS. ED. *5, Oct. 1, 1996, *available at* 1996 WL 13935394. *See also Medical Savings Accounts: Why Do They Work?*, BENEFITS Q., 2d Qtr. 1996, at 78-83, *available in* LEXIS.

96. *See* Keeler et al., *supra* note 72, at 1667-68.

97. *See* Elizabeth Neus, *Will Savings Cure Health-Care Ills? A Savings Account Teamed with an Income Tax Break Has Been Touted as Medical-Care Protection for Small Business; Many of the Potential Beneficiaries Are Skeptical*, THE MORNING NEWS TRIB., Dec. 29, 1996, at F3.

98. *Review & Outlook*, *supra* note 80.

99. PAULY, *supra* note 79, at 3.

not comparable because preferential tax treatment of MSAs will change the account holder's spending incentives.[100]

F. *Simulations Involving MSAs as an Insurance Option*

Although there has not been widespread testing of MSAs in the insurance market, several simulations have attempted to gauge the effects that MSAs may have. The two primary simulations were conducted by RAND[101] and the American Academy of Actuaries (AAA).[102] Both of these simulations based their findings primarily on the data from the RAND Health Insurance Experiment.[103]

After updating the data from the Health Insurance Experiment, the RAND simulation found that health-care costs would be reduced by between zero and thirteen percent if everyone switched to an MSA.[104] However, if not everyone selected an MSA, health-care costs would be reduced by two percent or less.[105] According to these results, the current demonstration program may not significantly reduce health care costs because tax-preferred MSAs are not even available to most of the insured population.

Based on the RAND Health Insurance Experiment data, its own experience, and other data sets, the AAA simulation found that the effect of MSAs on individual spending will largely depend on whether people view their MSAs as savings or as insurance.[106] This simulation found that if MSAs were optional, insurance premiums for traditional low-deductible health insurance could be increased by as much as sixty-one percent.[107] Under the current demonstration program, MSAs are not only optional, but they are also unavailable to most people. Therefore, it is possible, according to the AAA

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100. *Id.*

101. *See generally* Keeler et al., *supra* note 72.

102. *See generally* AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24.

103. *See generally* JOSEPH P. NEWHOUSE AND THE INSURANCE EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1986) (providing a complete and comprehensive discussion of the RAND Health Insurance Experiment and its findings; the experiment collected over 20,000 person-years of data). However, the American Academy of Actuaries simulation did look at, and to some extent incorporate, some other data sets. AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 24-27.

104. *See* Keeler et al., *supra* note 72, at 1668.

105. *Id.*

106. *See* AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 10.

107. *Id.* at 9. This conclusion was drawn from an assumption that if everyone was free to choose a traditional or a high deductible plan 75% would choose the high deductible plan. *Id.*

simulation, that traditional health insurance costs could increase substantially.

These simulation results indicate that unrestrained selection of MSAs may cause little change in overall health care costs, particularly if individuals view their MSAs as insurance. However, they also indicate that if adverse selection occurs the effects on traditional, low-deductible insurance cost could be substantial. These simulations indicate that the demonstration program as designed is unlikely to result in any significant savings because of the enrollment restrictions and the optional nature of the MSAs.

G. *The Demonstration Program and Its Study*

Because the MSA demonstration program does not allow employees of larger businesses to participate in tax-preferred MSAs, the study to be conducted is unlikely to be representative of the overall population. Because such a large portion of the population will be excluded from participation in this program, the results of the study could be skewed. According to the Rand and AAA simulations,[108] the actual effect on the health insurance market will depend upon the proportion of people who select MSAs instead of traditional health insurance. One reason the study's findings about selection of MSAs may be inaccurate is that small employers often offer only one plan,[109] while larger employers may offer greater choices regarding insurance plans.[110] The results will not be accurate if members of the excluded groups have a different incidence of selection than members of the included groups. There could also be very different levels of employer funding of MSAs between large and small employers.[111] Therefore, unless it is an open demonstration program, the actual effects on the health insurance and health care markets may not be truly reflected, and the study's selection and adverse selection results could be inaccurate.

Another potential problem with the study is that it will only be carried on for four years. This may not be a sufficient duration to

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108. *See* Keeler et al., *supra* note 72; AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 23.

109. Michael A. Morrisey, Gail A. Jensen, and Robert J. Morlock, *Small Employers and the Health Insurance Market*, 13 HEALTH AFF. 149, 152 (1994). *See also* AMERICAN ACADEMY OF ACTUARIES, MEDICAL SAVINGS ACCOUNTS: AN ANALYSIS OF THE FAMILY MEDICAL SAVINGS AND INVESTMENT ACT OF 1995 3 (1995) [hereinafter AMERICAN ACADEMY OF ACTUARIES: ANALYSIS].

110. AMERICAN ACADEMY OF ACTUARIES: ANALYSIS, *supra* note 109, at 3.

111. Len Nichols, *Who Will Jump into the MSA Pond?* Oct. 1, 1996 BUS. & HEALTH 47, *available at* 1996 WL 8998404.

allow observation of the long-term effects on health insurance and health care costs.

Another flaw in this study may be its failure to require or provide for a control group so that the effect of MSAs on traditional health insurance and health care costs can be compared.[112] A restriction on the geographic areas of availability would be one way that a control group could be created.[113] Similar areas, with and without access to tax-preferred MSAs, could be compared. This would allow a more accurate determination of whether changes in health care and health insurance costs were attributable to the availability of tax-preferred MSAs or to other market forces. Another possibility would be simply to require comparison with a similar group that chooses not to participate in the MSA demonstration program. This solution would be more difficult administratively. Regardless of the approach used, a control group is necessary so that it will be possible to determine whether any changes that occur in the insurance market are attributable to the availability of tax-preferred MSAs.

Finally, under the demonstration program the number of MSAs that may be formed is limited to 750,000.[114] Additional participants will be allowed to establish MSAs with tax-preferred treatment only if Congress acts to allow an increase in the number of participants, when the interim cap is reached, when the overall cap is reached, or when the program ends.[115] Each account will only be counted once to determine whether the cap has been reached, even if it covers a family.[116] Because family accounts are counted only once as many as 1.5 to 2 million people could be affected by the allowance of 750,000 tax-preferred MSAs.[117] This demonstration program could

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112. *Id.*

113. *See* Iris J. Lav, *MSA Demonstration: Research Suggests Controls Needed to Prevent Adverse Affect on Insurance Market* (visited Dec. 29, 1997) <http://epn.org/cbpp/cbmsa7.html> (allowing participating companies only in a few states). Although creation of a control group by use of geographic restrictions would be the simplest way to create a control group, the political difficulties that could arise because of the potential perception that an advantage was being given to one area and not to another could make such a division difficult.

114. I.R.C. § 220(j) (West Supp. 1997).

115. *See supra* note 5.

116. I.R.C. § 220(j)(4)(D).

117. Nichols, *supra* note 111, at *17. However, people who obtain Medical Savings Accounts during this demonstration program, under current law, are not forced to give them up at the end of the program should Congress decide to discontinue the program because it proves to be infeasible or unwise.

affect as much as ten percent of the small group market,[118] but this is only about one percent of the insured population.[119]

A demonstration program as such should not affect too large a segment of the population, and this MSA demonstration reaches only a very small percentage of the total insured population. However, because the percentage affected is small it may be difficult to accurately gauge whether, and to what extent, adverse selection occurs, particularly because there is no requirement that a control group also be studied. Because of the small percentage of the insured population that will be affected, the impact on health insurance rates and health care costs will most likely be minimal, even if adverse selection results; it is questionable whether the effects will even be discernible.[120]

The study's methodology and participation limits must be changed for this study to satisfy its goals. Requiring a control group, extending the study period to allow for observation of the long-term effects, or allowing larger employers to participate would go a long way toward solving the problems of this demonstration program and its study of the effects MSAs will have on traditional health insurance markets.

H. *The Results So Far*

Four competitive contracts were awarded by the GAO to firms "with experience in health economics, health insurance, and actuarial science."[121] Westat, a research firm, received the contract to complete the insurer survey.[122] Because the enrollment in this program has been so limited, the insurer's survey is the only part of the study that has begun.[123] The remainder of the study will not begin until enrollment reaches 375,000.[124]

Westat's findings were submitted to Congress on December 15, 1997,[125] and the insurer survey will be repeated each year.[126] Westat's findings indicated that there are several reasons that

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118. Nichols, *supra* note 111, at *9.

119. *Id.*

120. *Id.*

121. GENERAL ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL COMMITTEES (Dec. 19, 1997).

122. *Id.*

123. *GAO Shelves Demographics Survey*, *supra* note 8.

124. *Id.* The GAO claimed it was "financially infeasible" to complete the survey with so few participants. *Id.* The GAO has until January 1, 1999, to present a report of the findings to Congress. 104 P.L. 191, 110 Stat. 1936, 2053 § 301(l) (1996).

125. WESTAT, *supra* note 8, at 2.

126. GENERAL ACCOUNTING OFFICE, *supra* note 121.

enrollment has been lower than expected.[127] These reasons include findings that the commissions to insurance brokers and agents are lower on qualified high-deductible insurance; more time is required to educate consumers about the product than traditional indemnity insurance programs because of the complexity of MSAs coupled with high-deductible insurance; and the fact that this is a demonstration program.[128] In spite of the slow initial enrollment, the survey indicated that sales may be picking up.[129] The survey also noted that insurers had responded quickly, often with little market research, making qualified plans available in all states.[130] Interestingly, the survey found that the target market was more highly compensated persons, such as the partners in large law firms.[131] This finding suggests that adverse selection may be a real possibility, particularly in light of the targeted marketing of qualified plans.

However, since the remainder of the study is not being conducted at this time, it is not currently possible to tell what the effects actually are. One of the reasons that individuals may be reluctant to participate is that this is a demonstration program. Therefore, if Congress decides to allow tax-preferred MSAs on an unlimited basis, participation could dramatically increase. This could result in unforeseen problems, unless the study is completed and deals with all possible negative effects that MSAs may have on the traditional health insurance market.

I. Singapore's Experience with Mandatory MSAs for All Citizens

MSAs are not completely untried. In addition to being offered, without tax benefits, by some larger companies,[132] they have been used in Singapore for a number of years.[133] However, Singapore's program is substantially different—all workers must participate.[134] In spite of this important difference, and even without taking into

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127. WESTAT, *supra* note 8, at 3.

128. *Id.*

129. *Id.* at 17.

130. *Id.* The study found that many companies had simply modified existing plans to meet the requirements of the demonstration program, which allowed quick entry. *Id.* The study also found that some of the plans being marketed as qualified plans appeared not to meet the requirements set out in the program. *Id.* In particular, the study found that many of the plans had embedded deductibles, which the IRS ruled would not qualify for tax preferred status. *Id.*

131. *Id.* at 8-10. The study noted that although they might seemingly not qualify because of the size of the organization they are eligible because for tax purposes they are treated as self-employed. *Id.*

132. *See supra* notes 95-100 and accompanying text.

133. Hsaio, *supra* note 74, at 262.

134. *Id.*

account possibly substantial cultural differences, examining Singapore's experience may be instructive.

To combat the rising costs of health insurance, Singapore created a new insurance program in 1984, which makes use of what are called Medisave accounts.[135] Over time it became apparent that additional coverage was needed for longer-than-average hospital stays.[136] As a result, the government created an optional insurance pool that pays for hospitalization costs for each hospital stay that is longer than average.[137]

Contributions to Medisave are mandatory for all workers.[138] Contributions are split between the employer and the employee and range from six to eight percent of an employee's salary.[139] The Medisave account, like an MSA under the demonstration program here, is available to pay for medical expenses.[140] The funds in the Medisave account may be used for the worker/account holder's medical expenses, or those of a family member of the worker/account holder.[141] Unlike the HIPAA's demonstration program, a Medisave account is created for all workers and contributions must be made by all employers and employees, regardless of whether the worker elects to purchase the optional catastrophic insurance.[142]

Although Singapore's average length of stay and type of treatment are comparable to those experienced by other countries,[143] these plans have not been entirely successful in stemming the increase in health

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135. *Id.* at 261. These accounts are similar to the MSAs being discussed throughout this Comment. Originally, these accounts were the sole insurance Singapore's citizens had; Medisave was not coupled with high-deductible insurance at the outset. *See also* GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 598-605; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at Appendix B, 34-37; *and* Thomas A. Massaro and Yu-Ning Wong, *Positive Experience with Medical Savings Accounts in Singapore*, 14 HEALTH AFF. 267, 267-72 (1995) (discussing Singapore's experience with Medisave).

136. Hsiao, *supra* note 74, at 262.

137. Massaro & Wong, *supra* note 135, at 267.

138. Hsiao, *supra* note 74, at 261. However, participation in the catastrophic insurance is optional. *Id.* at 262.

139. *Id.* at 261. To a certain extent, this insurance is similar to the high-deductible plan that is discussed in this Comment, except that Singapore's insurance insures on a per hospitalization incident, while the United States' demonstration program insures based on an annual deductible. Singapore's insurance fund is called Medishield. *Id.* at 262.

140. *Id.* at 261.

141. *Id.*

142. *Id.* at 261-62.

143. Massaro & Wong, *supra* note 135, 268-69.

care costs.[144] Singapore's health care costs have increased at a rate slightly above the rate of increase in its gross domestic product.[145]

It is not clear, however, whether similar programs elsewhere will experience the same or similar results.[146] There are major differences between the cultures of the United States and Singapore that may affect the results,[147] particularly the differences in the respective savings rates and the citizens' education about, and interest in, preventive health care.[148]

Additionally, Singapore's Medisave program is substantially different from the MSA demonstration program that Congress has adopted in that Singapore's program is mandatory for all workers.[149] On the other hand, the United States' MSA demonstration program allows only some people to participate, and participation for those who are eligible is completely optional. Also, Singapore's optional catastrophic insurance coverage is per hospitalization, and both incidental expenses and outpatient treatment are completely excluded.[150] Under the United States' MSA demonstration program, the high-deductible plans have a large annual deductible that applies to inpatient and outpatient treatment, as well as to many incidental expenses.

The differences between the two types of insurance may create very different incentives. Under Singapore's program there is a financial incentive to have a low number of treatment episodes, regardless of their total cost.[151] However, under the United States' MSA demonstration program, once the deductible and out-of-pocket limits have been reached, the financial incentive to keep health care costs down disappears because the high-deductible insurance will pay all covered expenses.[152]

But despite both the program and cultural differences, it may be instructive that Singapore has not experienced a reduction in overall health care costs. Because participation in Medisave is mandatory for all workers in Singapore and health care costs have not been reduced, as the AAA and RAND simulations suggest may be possible for the

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144. Hsiao, *supra* note 74, at 264.
145. *Id.* at 265.
146. *Id.* at 264. *See also* Massaro & Wong, *supra* note 135, at 271.
147. Hsaio, *supra* note 74, at 266.
148. *Id.*
149. *Id.* at 261.
150. *Id.* at 262.
151. *See* Massaro & Wong, *supra* note 135, at 270.
152. *Id.*

United States with MSAs, the question arises whether any benefit will likely result from the allowance of tax-preferred MSAs. The fact that a mandatory program has not reduced health care costs suggests that an optional allowance, which simulations predicted could even raise costs, may not create the reduction in health care costs that proponents claim it will.

III. MEDICAL SAVINGS ACCOUNTS, HEALTH POLICY, AND THE TAX CODE

While debate whether to expand, continue to allow, or eliminate a tax-preferred treatment for MSAs continues,[153] the real issue is much more basic. The real issue is what role the tax code should play in the development of health policy, and further, how the tax code should be used to affect health policy.

A. *Health Policy Issues*

The government may want to encourage the private purchase of health insurance for several reasons, including reduction of overall health expenditures and reduction of the government's cost of health care.[154] One way the government can encourage private purchase of health insurance is through the tax code.

The pressure to reduce government spending creates a strong incentive for government to encourage people to obtain private health insurance. Increased purchase of private health insurance distributes the cost of health care more evenly throughout society and places less of the burden on the government's shoulders.[155] However, if the private purchase of health insurance is to be encouraged through the

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153. *See infra* note 203.

154. Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer Sponsored Health Insurance*, 1995 B.Y.U. L. REV. 1229, 1231 (1995) (advocating that the current tax treatment of health insurance be redesigned, allowing everyone a tax deduction for the purchase of health insurance, rather than only allowing deduction and exclusion from income for employer provided health benefits). The author includes as reasons for a redesign that the government may wish to encourage the purchase of private health insurance, a more equitable distribution of health care costs to recipients, and a reduction of forced poverty because of catastrophic illness. *Id.*

155. *Id.* at 1230, 1235. Health care is often seen as a right in this country and to some extent everyone has access to health-care services. *Id.* at 1232 (discussing forms of access that are available even to the uninsured). However, in many instances, only emergency health care is available to an indigent or low-income person. *Id.* This is not economically efficient. Emergency care for uninsured and indigent persons is paid for by some combination of depleting the person's assets, using Medicaid and other public funds, and passing the cost on to other consumers. *Id.* at 1230, 1234.

use of taxation and spending policies, the question becomes how this should be accomplished.

Providing favorable tax treatment for MSAs is one means that has been suggested to reduce the overall costs of health care throughout the economy.[156] The argument is that consumers spending their own money will become more conscious of the actual cost of health care. This will encourage more thoughtful spending, resulting in reduced overall health care costs.[157] However, whether consumers have sufficient ability to gather information on prices, or the bargaining power to affect prices enough to cause any real cost reduction to occur, has been questioned.[158]

Most people would agree that a program that increases cost consciousness and encourages thoughtful spending, resulting in an overall cost reduction, creates a social benefit. Therefore, if MSAs accomplish what proponents claim they will, it may be sound policy to encourage a reduction in health care costs through the use of tax-preferred MSAs. However, before deciding whether MSAs, coupled with high-deductible insurance, are a form of health care coverage that should be encouraged by the use of favorable tax treatment, there are a number of risks that should be considered.

First, although in theory an employer will place the savings that result from purchasing high-deductible insurance in the MSA, there is no requirement that the employer do so. Additionally, it is possible that the employer will not experience savings as great as the increase in the deductible.[159] Therefore, a person with an MSA could face much higher expenses that would have to be paid out of after-tax income than were possible under a traditional insurance plan or HMO if the employer chooses not to make a contribution equal to the difference in deductibles.[160]

The potential increase in out-of-pocket expenses with a high-deductible plan may create a particularly severe hardship for low-wage earners. A low-wage earner probably cannot afford this increase in out-of-pocket expenses or to make contributions to an MSA. Further,

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156. *See supra* notes 71-73 and accompanying text.

157. GOODMAN & MUSGRAVE, PATIENT POWER, *supra* note 19, at 249-51; GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 22-23.

158. Hsiao, *supra* note 74, at 260.

159. AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 9-10. This may not be true if the business is located in a region such as California with high health insurance costs. *See, e.g.*, GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE COSTS, *supra* note 15, at 10.

160. *See supra* note 54 and accompanying text.

if the employer makes only a small contribution each year, this problem may be exacerbated because the employee cannot make a contribution in the same year that the employer makes a contribution.[161]

Second, because of the increase in deductible without a requirement that the employer contribute to the MSA, some people may be left with inferior coverage relative to their previous coverage. As noted above, even if all the savings from the purchase of high-deductible insurance policies are placed in the employees' MSAs, the savings relative to a traditional insurance plan or HMO may not equal the increase in the deductible unless the employee and employer are located in one of the more expensive areas for insurance, such as California.[162]

Because an employer is not required to make any contribution whatsoever to the MSA, an employee may have a much greater risk and no means to pay the higher deductible. This could result in more people spending down their assets in order to qualify for publicly-assisted health care such as Medicaid, resulting in increased public costs in the form of lower individual economic worth and higher public health care payments.[163] These risks seem contrary to the HIPAA's goal of increasing the affordability of health insurance.

The current use of tax policy to provide an incentive for the formation of MSAs is misguided because of the lack of available information regarding the potential harms. The risk of adverse selection and reduction in coverage for some currently insured people makes it possible that the intended reductions in the costs of health care to society and the government may not occur. However, because this is only a demonstration program, it can be terminated if the actual effects are negative.

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161. See I.R.C. § 220(b)(5) (West Supp. 1997).

162. *See, e.g.*, AMERICAN ACADEMY OF ACTUARIES: COST IMPLICATIONS, *supra* note 24, at 8-9; Goodman & Musgrave, Controlling Health Care Costs, *supra* note 15, at 9-10.

163. *See generally* Joondeph, *supra* note 154, at 1236-38 (discussing these risks in the context of people who do no not have insurance; however, this is analogous to the situation of having inadequate insurance). *See also* JOSEPH A. PECHMAN, FEDERAL TAX POLICY 5-7 (1987) (discussing equity and efficiency as primary goals of tax policy).

B. *Tax Policy and the Medical Savings Account Demonstration Program*

Equity, simplicity, and efficiency have been enunciated as primary goals of federal tax policy.[164] The Medical Savings Account provision fails to meet each of these goals to some extent. As enacted, this provision will create both horizontal and vertical inequity, will require complex reporting and record keeping, and, at least in most respects, will be economically inefficient.

1. Equity

There are two components to equity: vertical equity and horizontal equity. Vertical equity refers to situations in which individuals with higher incomes pay proportionally higher taxes. Horizontal equity refers to situations in which similarly situated individuals are treated similarly.

a. *Vertical Equity*

Vertical equity is a feature of a progressive tax system. It requires that those with higher incomes who can afford to pay more should pay more in taxes than those with lower incomes; that is, individuals with greater earnings ought to pay proportionally more than individuals with lower earnings.[165]

As designed, the MSA provision is vertically inequitable. This provision is a tax expenditure, which by definition is vertically inequitable.[166] The effects of this provision on people with greater earnings will differ from the effects on those people with lesser earnings in terms of tax paid. The difference will be similar to that resulting from IRAs, which are another tax expenditure.[167]

Assuming no contributions to the MSA by the employer, individuals with higher earnings will have greater ability to make the maximum contribution to their MSA than will those with lower

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164. *See* Donna M. Byrne, *Progressive Taxation Revisited*, 37 ARIZ. L. REV. 739, 747 (1995). However, in some discussions as many as seven categories of analysis have been articulated. *Id.* (citing Joseph T. Sneed, *The Criteria of Federal Income Tax Policy*, 17 STAN. L. REV. 567, 568 (1965)).

165. PAULY, *supra* note 79, at 5.

166. Tax expenditures, because of marginal tax rates, are vertically inequitable. Tax expenditures result in greater tax benefit to higher income levels than lower, the opposite of vertical equity's requirement. *See* JOSEPH M. DODGE, THE LOGIC OF TAX: FEDERAL INCOME TAX THEORY AND POLICY, 293-95 (1989).

167. PAULY, *supra* note 79, at 11-12.

earnings. Therefore, those with higher earnings will have a greater opportunity to experience the tax benefits available under this provision than will those with lower earnings. As noted previously, where an employer funds an MSA, some individuals have claimed they are more likely to use some services, such as preventive care, because the money was available in the MSA.[168]

Additionally, the requirement that comparable contributions be made on behalf of highly-compensated employees to those made on behalf of nonhighly-compensated employees does not deal with the vertical inequity arising between those who work for companies that have mostly highly-paid employees compared to a company where almost everyone works for minimum wage. Moreover, employers of more highly-compensated workers may be more willing to make contributions to an MSA than are employers of lower-paid workers. To some extent, this is dealt with by the requirement that employers make comparable contributions to all employees' MSAs.[169]

The vertical inequity might be reduced by adopting a tax credit that would entitle each individual to a maximum credit amount.[170] Another possible means of reducing the vertical inequity might be to limit the deduction to the amount of the deductible, with further deductions allowed for contributions only after MSA funds are used for qualified health care expenses. This would eliminate the possibility of people with higher incomes using an MSA simply as a tax-free means of accumulating savings.

b. *Horizontal Equity*

This provision will also result in horizontal inequity. Horizontal equity requires that individuals who are in similar economic situations be treated similarly and subject to similar taxes.[171]

This provision is horizontally inequitable because only people who are employed by small businesses or are self-employed may participate in this program; people employed by businesses with more than fifty employees are not eligible.[172] Therefore, this provision gives preference to some, but not all, people who are economically similarly situated, making a distinction based solely on the size of their place of

168. *See infra* note 203 and accompanying text.

169. *See* I.R.C. § 4980E(d) (West Supp. 1997).

170. *See* Mark V. Pauly & John C. Goodman, *Tax Credits For Health Insurance and Medical Savings Accounts*, 14 HEALTH AFF. 126, 130-31, (1995). *See also* PAULY, *supra* note 79, at 19-20.

171. PAULY, *supra* note 79, at 5.

172. I.R.C. §§ 220(c)(1)(A)(iii)(I)-(II).

employment. This results in a situation that is not horizontally equitable.

To eliminate the horizontal inequity that the MSA provision creates, everyone, regardless of the size of their employer, would have to be able to participate in the demonstration program, although the total number of participants could still be limited.[173] This should make the demonstration program and the study more representative of the actual selection of MSAs while increasing the horizontal equity.

A final possible solution would be to allow a tax credit to everyone who had some minimal form of health insurance.[174] This would increase the equity of the tax treatment of insurance.[175] However, this would entirely change the tax treatment of insurance. A more limited version of this approach would be to give a tax credit only to participants of this demonstration program, and only if certain criteria in terms of policy type and contribution amount were met.

2. Simplicity

The features of this provision are unnecessarily complex and defeat the goal that the tax system, which necessarily is somewhat complex, be kept as simple as possible. Complex formulas are used to determine whether, and under what circumstances, contributions may be made and whether new MSAs may be created each year.

Each year, all MSA trustees must report to the IRS the number of MSAs that have been formed.[176] The IRS must then determine if the annual ceiling[177] or overall ceiling[178] has been reached. If no further MSAs may be created, the IRS must issue a notice.[179] Further, accounts do not have to be applied for, or registered with, the

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173. It has also been argued that MSAs are more horizontally equitable than traditional employer provided health care. *See* PAULY, *supra* note 79, at 19.

174. The idea of a tax credit for health insurance, rather than the current system of deductions for the full amount of employer-provided insurance has been advocated as a means of making the health insurance tax incentive system more equitable. *See* PAULY, *supra* note 79, at 19-21.

175. *Id.*

176. I.R.C. § 220(j)(4).

177. Annual caps are set out *supra* note 5.

178. As previously noted, the overall ceiling is 750,000. I.R.C. § 220(j)(2). *See* I.R.C. § 220(j)(4)(A) (requiring the trustee to report number of MSAs annually by August 1). *See also* I.R.C. § 220(j)(5) (requiring that the Secretary determine whether the limit has been reached by October 1).

179. I.R.C. § 220(j)(5).

IRS before they are opened.[180] However, an MSA may be opened until a notice has been issued that enrollment has been cut off.[181]

By changing the restrictions on MSAs, this provision could be greatly simplified. Rather than have a limit on the number of MSAs that can be created, it could have a durational limit on the tax preference. The program could be opened up to anyone who wants to participate, regardless of the size of the employer. This would reduce the amount of tracking that is necessary. However, a durational limit could increase the risks and costs to consumers who choose to switch to MSAs. It might reduce the number of people willing to participate in the demonstration program because Congress could decide not to continue the preferential tax treatment of MSAs at the end of the program. Participants in the program could then be forced to switch insurance again. This problem, and its possible solutions, is further discussed in Part IV.

A second possible simplification would be to eliminate or simplify the formulas used to determine the number of accounts that can be opened. The total number of participants could be limited and enrollment would end at the time that limit was reached. This would eliminate the annual caps. One way to accomplish this would be to require either that the MSA holder apply to participate or that the MSA trustee report each MSA which is opened.

A third possible simplification would be to simplify the rules regarding who can make contributions and how much their contributions can be. The contribution limit could be made a flat dollar amount, rather than a percentage of the deductible that depends on whether it is an individual or family MSA. This contribution limit would then be the only limit. Contributions would be allowed from either the employee, the employer, or both, so long as the dollar limit is not exceeded, as there is no apparent reason for this limitation.

Adopting any or all of these changes would increase certainty for MSA holders and potential MSA holders. Further, the changes would simplify administration of this program.

3. Efficiency

Finally, in most senses, this provision also fails to meet the goals of efficiency. Although efficiency may be defined in many ways, it is difficult to find a definition that would consider this program to be efficient. The only exception is that MSAs may reduce the administra-

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180. I.R.S. Notice 96-53, 1996-2 C.B. 219.

181. *Id.* at 220.

tive costs of insurance.[182] However, the reduction in administrative costs of insurance may be offset by the burdens of record keeping and reporting required of the trustee.

Because the number of accounts allowed to be created is limited and because of the nature of the study to be done, there is a great deal of record keeping required. Such record keeping will be costly. As part of the record-keeping requirements, both the employee and the trustee must file reports with the IRS. The employee must report the dollar amount of contributions to an MSA, whether made by the account holder or by the employer.[183] The employee must also keep records of distributions for qualified medical expenses as well as report any distributions that are not for qualified medical expenses.[184]

Although the trustees have lower record-keeping and reporting requirements, even for them the requirements are not insubstantial. The trustee must report the number of MSAs,[185] the name of the account holder, the amount of contributions,[186] and the amount of distributions from the MSA.[187] The trustee must also provide the account holder with a 1099-MSA, a copy of which goes to the IRS, that shows distributions from the MSA.

While some cross checks are probably necessary, there appears to be excessive redundancy in the reporting requirements. However, in spite of some redundancies and the requirement that trustees report on distributions, trustees do not determine whether expenses are qualified medical expenses or even identify the purpose of the distribution.[188] It seems unnecessary and inefficient to require the employee and the trustee to provide so much of the same information to the Internal Revenue Service.[189] For example, the information on the 1099-MSA

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182. It has been estimated that these accounts, by allowing the patient to pay for small medical bills without the doctor or health care provider having to complete claim forms, which then have to be reviewed and paid by the insurance company, would substantially reduce the costs of administration of insurance. One estimate of the savings that might be realized is a savings of $33 billion per year. GOODMAN & MUSGRAVE, CONTROLLING HEALTH CARE, *supra* note 15, at 25-27. It seems reasonable to hypothesize that self-administered MSAs would result in lower administrative costs for smaller claims. However, it would not eliminate all administrative costs.

183. Contributions are deductible if made by the employee, I.R.C. § 220(a); if made by the employer, contributions are excludable from income, I.R.C. § 220(b)(5).

184. The account holder must determine whether the distribution was for a qualified medical expense. I.R.C. § 220(d)(2); I.R.S. Notice 96-53, 1996-2 C.B. 219, 222.

185. I.R.C. § 220(j)(4)(A). This report is made on form 8851.

186. This report is made on form 5498-MSA.

187. This report is made on form 1099-MSA.

188. I.R.S. Notice 96-53, 1996-2 C.B. 219.

189. However, double reporting is common. For example, the information provided to the IRS by an employer on a W-2 form is also provided by the employee when filing a federal income

(distributions) and the 5498-MSA (contributions and other information), both of which are filed by the trustee, overlap to a large extent. Additionally, the overlap with the information provided by the employee is also substantial.

This inefficient use of resources might be cured by lessening the administrative burden on everyone, including employees, trustees, and the IRS. One way the administrative burden might be lessened is to reduce some of the redundant reporting.[190] Although trustees are required to make a report of the distributions,[191] trustees are not required to track expenditures.[192] However, at least some verification of the propriety of expenditures should be required. Otherwise, the only way that improper withdrawals will be discovered is during an audit. This could either increase audit costs or allow people to get away with improper spending of before-tax dollars. Both options are inefficient as to the collection of revenues and reduction of administrative costs. However, if trustees were required to track distributions and determine whether they were used for qualified medical expenses some or all of the potential reduction in administrative costs would be lost. Further, this should not increase the administrative burden because a record of expenditures will have to be maintained to determine when the high deductible has been reached.

As a result of the preferential tax treatment that MSAs are given, millions of dollars of revenues will be forgone each year. The Joint Committee on Taxation estimated that the cost, in forgone revenues, will exceed $134 million in 1997, increasing to $399 million in 2001.[193]

Giving these MSAs tax-preferred treatment is economically inefficient, using a Pareto optimal definition of efficiency.[194] The forgone revenues will result in a lessened ability of the government to

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tax return.

190. Prospective Collection; Comment Request for Form 1099-MSA, 62 Fed. Reg. 2439 (1997). Prospective Collection; Comment Request for Form 5498-MSA, 62 Fed. Reg. 2440 (1997). The Department of the Treasury estimates that the 8851 reporting, record keeping, and compilation will take a total of 1,540,000 hours; the estimated time necessary for record keeping and completion of the 1099-MSA is a total of 45,000 hours per year; and the estimated time required for record keeping and completion of the 5498-MSA is 60,000 hours. Submission to OMB for Review; Comment Request, 62 Fed. Reg. 10,623 (1997).

191. Form 1099-MSA.

192. I.R.S. Notice 96-53, 1996-2 C.B. 219.

193. JOINT COMMITTEE ON TAXATION, 104th CONG., COMPARISON OF ESTIMATE BUDGET EFFECTS OF THE REVENUE PROVISIONS IN H.R. 3103, THE "HEALTH COVERAGE AVAILABILITY AND AFFORDABILITY ACT OF 1996" (Comm. Print 1996).

194. Pareto optimal efficiency occurs when no one individual can be made better off without making someone else worse off. *See, e.g.*, Byrne, *supra* note 164, at 750-52.

fund other programs. However, the actual extent of the inefficiency is uncertain because it is not clear which programs would lose, or not receive, funding because of the foregone revenues. Therefore, although some people may be better off with an MSA, others would be worse off because spending will have to be reduced, taxes raised, or the deficit increased to compensate for the forgone revenues.[195]

IV. Changes in the MSA Program to Further Health Policy Goals Through the Tax Code

Because this demonstration program does not meet the goals of either health or tax policy, the tax preference granted by this demonstration should either be eliminated or redesigned. The effects on revenue collection by the federal government, the effects on health insurance overall, and the effects on particular forms of health care, such as preventive care, could be evaluated more validly by changing the parameters of the study.

The availability of MSAs needs to be expanded, at least as to the status of the participants and perhaps as to the allowable number of participants, to allow the study to accurately demonstrate the effects of a tax-preferred MSA on the traditional health insurance market. Enrollment needs to be open to everyone, including people employed by larger businesses, to allow a more accurate determination of the actual incidence of the selection of MSAs coupled with high deductible health insurance.

Moreover, the overall cap on participants should be increased to a number that would allow a determination, with some degree of accuracy, of whether and to what extent adverse selection would result. In raising the overall cap, a geographic distribution limit on enrollment might significantly assist in obtaining accurate findings regarding selection and adverse selection. However, geographic limits might present political difficulties that could prevent creation of such a program. But if such a limit is used, areas that are economically and demographically similar could be compared. This would allow a more accurate determination of the effects of MSAs on traditional insurance.

At the end of the study, if Congress determines that MSAs have a detrimental effect on the health insurance market overall, Congress could discontinue the preferential tax treatment altogether. People with MSAs could be forced to return to the traditional health insurance market. However, this risk is not as burdensome as it might seem.

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195. DODGE, *supra* note 166, at 290-92. *See also* PAULY, *supra* note 79, at 3.

Since this is a demonstration program, people should be aware of this possibility when making the initial selection of an MSA.[196]

Although there is a risk that people forced back into the traditional market will be unable to obtain replacement insurance because of preexisting conditions, this risk exists any time insurance is changed. This was a primary concern of the HIPAA's attempt to eliminate "job lock."[197] If the tax-preferred treatment of MSAs is terminated at the end of the program, Congress could use some of the same techniques to insure that people who had selected MSAs would be able to obtain new insurance without unduly burdensome waiting periods and exclusions. If it so chooses, Congress could also limit the costs associated with switching insurance due to preexisting conditions and waiting periods.

A broader alternative to the current treatment of health insurance generally is to provide tax credits for all taxpayers with insurance, rather than allowing full tax deductions only for employer-provided health care and only lesser deductions for self-employed people and individuals.[198] This would further the basic goal of encouraging wiser use and lower health care expenditures.[199] Tax credits, instead of a deduction by the employer and exclusion from income by the employee, would remove current incentives to overinsure and overspend on health care by redistributing the tax incentives.[200] This would result in greater equity in taxation and greater efficiency in the level of health care purchased, because the improper incentives that currently exist would be substantially removed.[201] A uniform tax credit would allow individuals to select the type of health insurance they feel is most economically efficient for them.[202] However, this would be a much broader change and would affect the treatment of all health insurance, not just MSAs.

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196. The survey of insurers noted that this is one of the factors that may be contributing to the slower-than-expected sales of MSAs. *See* WESTAT, *supra* note 8, at 8-10.

197. Nichols, *supra* note 111, at *5. Job lock is created by an inability to either take health insurance with the employee or to obtain new health insurance because of preexisting conditions.

198. *See* PAULY, *supra* note 79, at 19-22; Pauly & Goodman, *supra* note 170, at 126-39; and David B. Kendall and Mark V. Pauly, *Health Care Reform Starts with Tax Reform*, WALL ST. J., June 10, 1996, at A18.

199. *See* PAULY, *supra* note 79, at 19-22; Pauly & Goodman, *supra* note 170, at 126-29.

200. Pauly & Goodman, *supra* note 170, at 126-29.

201. *Id.* at 130-32.

202. *Id.*

CONCLUSION

MSAs may or may not have harmful effects on the traditional health insurance market. Until the impacts of MSAs are clearer, Congress should find a more equitable and certain method of testing the effects MSAs will have on traditional health insurance markets and health care costs. If Congress is not willing to create a truly representative demonstration program, Congress should not allow the creation of these accounts because of the risk of an adverse impact on the traditional insurance market. Congress should either completely abandon the idea of MSAs until more is known about their actual effects or change the demonstration program so that it will be more representative of the actual effects that MSAs will have.

Because of the way this program is designed, it is possible that any negative effect of allowing preferential tax treatment of MSAs will not be realized or will be so muted that it will not appear as significant as it really is. This could result in an ill-advised, or at least not fully advised, increase in the availability of a tax-preferred status for MSAs. If the demonstration program is continued, it should be opened up to everyone—employees of large and small businesses, governmental employees, and self-employed people.[203]

A control group should also be required to help determine what changes occur in the health-care and insurance markets that is not affected by MSAs so that changes that are not produced by MSAs will not be attributed to them. The simplest way to do this, in spite of potential political difficulties, would be to place geographic limits on the study and then compare similar areas.

Also, the duration of the study should be increased to allow the long term effects of MSAs to be observed. However, the number of MSAs available could continue to be limited. Changing the study parameters is necessary so that it will show the actual effects MSAs will have.

At a minimum, this program should be redesigned so that it will provide valid information regarding the effects MSAs have on the insurance market and overall health care costs. Furthermore, a more complete study of the effects of MSAs needs to be done, regardless of whether it is cost effective given the number of current account

203. To some extent the availability of MSAs has been expanded, as they are available, also on a demonstration basis, to Medicare recipients. Also, bills have been introduced to remove the caps, H.R. 1743, 105th Cong., 1st Sess. (1997), and to allow MSAs for federal employees, H.R. 1574, 105th Cong., 1st Sess. (1997).

holders. Once such a study is completed, it will be possible to determine whether widespread availability of tax preferred MSAs will affect the traditional health insurance market and health care costs in a positive or negative way. If Congress is unwilling to redesign the program so that it will yield accurate study results, the program should be terminated.