REPORT OF THE COUNCIL ON MEDICAL SERVICE

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Subject: Establishing Multi-Year Mutual MSA Trust Accounts

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At the 2002 Annual Meeting, the House of Delegates adopted as amended Resolution 141, which calls on the AMA to study the viability and usefulness of multi-year aggregated medical savings accounts (MSAs). The Board of Trustees referred the requested study to the Council on Medical Service for a report back at the 2003 Annual Meeting. This report, which is provided for the information of the House, presents an overview of MSAs, describes the major problems facing the Medicare and Medicaid programs, summarizes early studies of the impact of MSAs on aggregate health spending, describes the merits of multi-year mutual MSA trust accounts and how they might be used to address the problems of Medicare and Medicaid, and reviews relevant AMA policy.

MEDICAL SAVINGS ACCOUNTS

MSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a personal savings account to be used only for qualified medical expenses. Properly structured MSAs provide affordable protection against high medical costs and greater patient control over use of health services. Patients with MSAs have incentives to utilize health care in a cost-conscious manner because they spend from their own accounts and/or out-of-pocket before meeting the deductible, and because unspent account balances accumulate and accrue interest from year to year. High deductibles keep premiums low, making MSAs more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little to no cost sharing for in-network services and limits on total out-of-pocket costs.

Although MSA products have been available in some states since the 1980s, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a five-year national demonstration of MSAs, extending the tax advantages of traditional employment-based health insurance to MSAs. HIPAA also imposed numerous rigid, complex rules regarding eligibility, benefit design, and account contributions. These constraints hampered enrollment and discouraged insurers and insurance brokers from investing in product development and marketing. Despite these obstacles, roughly 80,000 households or individuals have enrolled in HIPAA-qualified MSAs (Internal Revenue Service Announcement 2002-90, September 2002), and some large employers choose to offer non-qualified MSAs despite the fact that they do not receive federal income tax relief. Although overall enrollment has been low, the majority of MSAs have been issued to households of two or more, 50% to families with children (Bunce, Cato Institute, August 2001). In addition, MSAs have expanded coverage to a greater-than-expected number of previously uninsured individuals and families. In 2001, nearly 75% of those with HIPAA-qualified MSAs were previously uninsured (IRS Announcement 2002-90, September 2002). Finally, MSAs seem to have achieved cost-containment goals, saving both enrollees and employers on total premium and out-of-pocket expenditures (Bond et al., 1996).

Legislation passed in 2001 and 2002 renewed the MSA demonstration through the end of 2003. (Previously enrolled individuals may continue to have MSA coverage and make contributions after 2003 even if the program is not extended further.) MSA supporters have sought additional legislation to eliminate many of the restrictions facing MSAs. Current Congressional and Bush Administration proposals seek to make MSAs permanent, eliminate eligibility restrictions, and allow more flexibility in benefit design and account contributions.

CURRENT PROBLEMS WITH THE MEDICARE AND MEDICAID PROGRAMS

Serious flaws exist in the design of the Medicare program that, in the short term, impose significant financial hardships on many Medicare beneficiaries, and, in the long term, threaten the future viability of the Medicare program. Medicare's cost-sharing requirements potentially require a beneficiary to pay more than $35,000 per year out-of-pocket if he or she does not have private supplemental insurance or Medicaid. Medicare and Medicaid's price controls are forcing physicians to reduce the resources available to provide patient services because payments are not keeping up with costs. Increasingly, Medicare and Medicaid beneficiaries are encountering restricted access to care, particularly for certain medical specialties and in certain geographic areas. Compared to the private market, Medicare is slow to provide coverage for new technologies, treatment modalities, and diagnostic techniques, even when such approaches are cost effective. For example, when Medicare was enacted in 1965, prescription drugs constituted a small part of medical expenditures, whereas pharmaceuticals now represent a major therapeutic approach to disease, as well as a substitute for many surgeries and hospitalizations. Nonetheless, Medicare does not generally cover prescription drugs. Like Social Security, both Medicare and Medicaid are pay-as-you-go social programs. With demographic shifts, the ratio of workers to non-workers is declining, eroding the tax funding for such programs. In the absence of substantive reforms, pay-as-you-go social programs will consume more than three-quarters of the federal budget by 2030.

Many proposals to reform federal social programs emphasize greater reliance on private markets, individual choice, and incentives such as defined contributions to encourage cost-conscious choices. Such reforms are designed to reconfigure beneficiary cost-sharing, create competitive pricing, expand benefit design options, relieve the regulatory burden on physicians and providers, and ensure long-term financial solvency. A gradual shift to a system of private savings (i.e., "prefunding") with individual investment choices has been proposed to assure the sustainability of both Medicare and Social Security. In 1999, the Medicare+Choice program expanded beneficiary choice of private plans and introduced incentives to choose cost-effective plans. The Medicare+Choice program created the possibility of Medicare MSAs, though to date no such plans have been established. In addition, there have been occasional proposals for Medicaid MSA demonstrations in several states, though no such plans appear likely to materialize in the foreseeable future.

Separate reports before the House of Delegates at this meeting address restructuring Medicare in the short term (Council on Medical Service Report 9, A-03) and medical care for patients with low incomes (Council on Medical Service Report 8, A-03).

THE MILLIMAN AND ROBERTSON STUDIES

In 1993, the actuarial consulting firm of Milliman and Robertson, Inc. released a study commissioned by the Council for Affordable Health Insurance (CAHI) entitled "The Financial

Impact of Medical Savings Accounts on Health Care Spending and the Federal Budget" (Litow, October 1993). The study was issued prior to 1996 when HIPAA established the MSAs demonstration, and provided support for changing federal law to permit tax-preferred MSAs. It used a computer simulation model to estimate the impact of offering MSAs without eligibility restrictions to those under age 65 in private markets and requiring MSA enrollment for all non-institutionalized, under age 65 Medicaid beneficiaries.

Based on assumptions of a 65% participation rate in the private market and 100% Medicaid participation, the model projected savings of $588 billion (in 1992 dollars) over five years. These savings represent a 22% reduction in aggregate health spending among the non-institutionalized, under age 65 population. Forty percent of the projected savings were due to reduced health care spending resulting from individuals' financial incentives to use health care more prudently. About a third of the projected savings were in the form of individuals' accumulated account balances. (It was assumed that 20% to 40% of MSA deposits remain at year's end.) Further savings were attributable to reduced medical inflation – from 13% to 10% annually – and lower administrative costs due to direct payment of bills by patients and reduced need to submit and review insurance claims. The net effect on federal tax revenues was estimated to be minimal. Reduced tax revenues from tax-deductibility of MSA account deposits were roughly offset by lower government spending due to reduced medical inflation and increased tax revenues due to secondary effects of increased corporate profits and wages.

Medicaid expenditures alone were projected to go down by 25% despite the assumption that Medicaid price schedules would be eliminated. As in the private market, individuals would consume fewer services, use services in a more appropriate and cost-effective manner (e.g., shifting from emergency room care to office visits), and face lower prices due to reduced inflation.

The study also estimated that unrestricted availability of MSAs would reduce the number of uninsured by nearly half for two reasons. First, MSAs would be more affordable than other forms of insurance, allowing more people to obtain coverage. Second, those who would otherwise lose coverage could use accumulated balances to pay premiums. Those who lose coverage and choose not to purchase another insurance policy would still have any accrued balances available to pay for health care. To the extent that the newly insured consume more health care upon obtaining MSAs, health care costs increase, but this increase is swamped by the savings generated by the rest of the population.

A subsequent report by the National Center for Policy Analysis (NCPA) was based on further Milliman and Robertson analysis ("Saving the Medicare System with Medical Savings Accounts," NCPA Policy Report No. 199, September 1995). This study examined the effect of offering Medicare beneficiaries defined contributions toward private insurance, including MSAs. Like the CAHI report, the NCPA report was issued prior to the enactment of both HIPAA-qualified MSAs and the Medicare+Choice program. The analysis showed that the most cost-effective way to control Medicare spending would be to combine MSAs with managed care catastrophic policies. From the beneficiary's point of view, an MSA would eliminate the need for medigap coverage; put a cap on out-of-pocket health care expenses; and be used for medical expenses not covered by traditional Medicare, such as pharmaceuticals, eyeglasses, or hearing aids. Elimination of first-dollar coverage provided by medigap policies, along with MSA incentives to utilize care prudently, would reduce health care spending considerably. Based on the assumption of 100% MSA

enrollment by elderly and non-elderly disabled Medicare beneficiaries, the analysis concluded that the federal government would save about $200 billion (in 1994 dollars) over seven years.

Two additional Milliman and Robertson studies focused exclusively on Medicaid MSAs (Litow, "The Potential of MSAs with Medicaid," July 1995, and Litow and Muller, "Alternatives for Using MSAs with Montana Medicaid," August 1996). Both studies assumed 100% MSA participation by Medicaid beneficiaries, looked only at effects after one year, ignored potential savings through reduced administrative costs, and assumed that individuals kept only a portion (e.g., 20%) of unspent account balances at year's end. Because individuals faced incentives to "use-it-or-lose-it", the programs studied might be more accurately described as flexible spending accounts (FSAs) than MSAs. In any case, the FSA program design lowered the studies' savings estimates compared to savings under true MSAs. The studies estimated reductions in total health spending among Medicaid beneficiaries between 6% and 18%. The studies also noted that only a portion of reduced spending represents savings to the government.

MULTI-YEAR MUTUAL MSA TRUSTS

Based on the Milliman and Robertson analyses, the proposal to which Resolution 141 (A-02) refers was developed by an AMA member physician. The proposal seeks to establish five-year mutual MSA trust accounts, which are intended to generate savings sufficient to fund Medicare and Medicaid. According to materials provided to the Council on Medical Service, the proposal appears to include the following elements:

- Anyone would be allowed to establish an MSA (in contrast to existing HIPAA restrictions), including Medicaid and Medicare beneficiaries.

- Participation would be on a voluntary basis, but participants would be required to make a five-year commitment to the program, during which time they must make annual MSA account contributions of approximately $2,500 for individuals or $3,500 to $4,000 for families.

- Enrollment would be offered to uninsured patients presenting at physicians' offices or hospitals.

- Participants would pay for both high-deductible insurance premiums and MSA account deposits with pre-tax dollars (i.e., these expenditures would be tax exempt or, equivalently, tax deductible).

- Participants' MSA account deposits would be pooled into a mutual trust fund.

- The five years of interest earnings on the pooled trust fund would be used to finance Medicare and Medicaid.

- After five years, unspent account balances and subsequent interest earnings would revert to individual accounts, with participants collecting interest on account balances.

- After five years, a participant would have the option of rolling over a portion of account balances into an individual retirement account (IRA). No more than one year of contribution could roll over to an IRA per year.

- A government board would provide oversight of the program.

The analysis accompanying the proposal is based on the assumption that at least half of the population would choose MSAs. Employers and employees would pay premiums and make account contributions, and tax credits would be used to fund MSAs for low-income individuals. It is also assumed that each participating individual or family would deposit $3,500 to $4,000 each year into their MSA accounts regardless of previous health care expenditures or account balances. Although the proposal suggests using the five years of pooled trust fund interest to fund Medicare and Medicaid, elsewhere the analysis suggests that the full amount of savings attributable to MSAs – including individual account balances – would be available to fund these programs, as well as medical research and graduate medical education. Extrapolating from the Milliman and Robertson analyses, the proposal estimates cost savings from MSAs to be approximately one trillion dollars out of a total 1.5 trillion dollars in national health expenditures (Centers for Medicare and Medicaid Services, 2002).

RELEVANT AMA POLICY

MSAs

Extensive, longstanding AMA policy supports promotion and expansion of MSAs (Policies H-165.869, H-165.920, H-180.957, H-165.863, H-185.982, H-165.879, H-270.969, and H-165.858, AMA Policy Database). The AMA supports MSAs as a means of increasing patient choice of both coverage and physicians, as well as a means of promoting individual cost-consciousness in the utilization of health services. Policy H-165.920(7) supports legislation allowing the tax-free use of MSA accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. Policy H-165.869(3) closely parallels current legislative proposals to expand MSAs by seeking to repeal MSA demonstration status, eligibility restrictions, and numerous other legislative constraints on MSAs.

Medicare and Medicaid Reform

Since 1987, the AMA has proposed transformation of Medicare into a fiscally solvent program, as reflected in numerous AMA policies (Policies H-165.987, H-165.890, H-330.998, H-165.966, and H-330-990). Policies H-165.987 and H-165.890 advocate that the current Medicare program be replaced with a self-funded, privatized approach to financing health care that includes defined contributions toward the purchase of private coverage, increased beneficiary choice, market competition instead of price controls, and equitable means testing provisions. These policies also advocate combining all cost-sharing requirements into a single deductible in order to eliminate the need for Medigap coverage, maintain beneficiary financial protection, and reduce Medicare program costs resulting from Medigap-created first-dollar coverage of services. Policy H-165.987 also supports the use of accumulated MSA account balances to fund post-retirement medical care. Policies H-165.872 and H-165.868 advocate that Medicare coverage of pharmaceuticals be addressed in the broader context of transforming Medicare into a fiscally solvent program. An

extensive body of AMA policy calls for additional changes to Medicare, such as reform of physician payment methodology and reimbursement levels, reduction of burdensome regulations, and legalization of private contracting between beneficiaries and physicians (Policies H-400.960, H-330.932, H-385.961, H-180.973, and H-335.984).

AMA policy calls for reforming Medicaid in conjunction with Medicare reform, in order to ensure that delivery of financing of care through both programs result in appropriate access and level of services for patients (Policy H-290.982[1]). Numerous policies call for adequate funding of the Medicaid and State Children's Health Insurance Programs (Policies H-290.982[2], H-165.895[1d], H-290.997[5], H-290.980, and H-290.989).

Choice

For at least two decades, the AMA has advocated expanded freedom of patient choice of both physicians and health plans, as well as pluralism in health care delivery systems, health plan type, financing mechanisms, and third-party payment methodologies (Policies H-165.920, H-165.881, H-160.997, H-165.895, H-165.913, H-385.987, H-385.989, and H-385.990). Similarly, Policy H-160.997 calls for a multiplicity of practice options, maximum professional independence, and freedom of choice for both physicians and patients. AMA policy has historically favored free market activity over mandates imposed on patients, physicians or insurance plans (e.g., Policies H-165.920[15] and H-390.961). Policy H-180.978 expresses a preference for allowing insurance markets to operate freely rather than under government mandates and controls. Policy H-165.944 specifically states that there should be no preferential treatment by government that gives a competitive advantage to any form of health insurance or health care delivery organization. Policy H-290.982[3] calls for a pluralistic approach to Medicaid health care financing and delivery including but not limited to MSAs. Finally, Policy H-165.920[17] supports providing coverage to the uninsured through refundable, advanceable tax credits inversely related to income to be used toward the individual's choice of health plan.

DISCUSSION

The AMA and the Council are strongly supportive of MSAs. However, the Council finds a number of difficulties with the analysis underlying the proposal for multi-year mutual MSA trusts, and with the proposal itself. Nearly a decade has passed since the publication of the Milliman and Robertson studies. During this time, the enactment of HIPAA has made tax-advantaged MSAs available to a limited number of people, and the Medicare+Choice program has cleared the way for the establishment of Medicare MSAs. HIPAA imposed numerous eligibility and benefit design constraints that could not have been anticipated by the Milliman and Robertson analyses, but that have hampered MSA enrollment, marketing, and product development. MSA experience in the Medicare+Choice program has also been disappointing, as no Medicare MSAs have been established to date.

Were existing constraints imposed by HIPAA on MSAs to be removed, it is still doubtful that voluntary enrollment in MSAs would approach the 65% participation rate assumed by Milliman and Robertson – a participation rate that assumed compulsory participation by Medicaid beneficiaries. Given that participation would be voluntary, that participants could spend down account balances for medical purposes during the initial five-year period, and that participants could start to opt out of the program after five years, the proposal represents an unstable funding

mechanism. Under voluntary participation, there is probable selection bias between early adopters and those who join later, the former being, on average, healthier and better able to spend prudently. In addition, interest rates have fallen drastically since the Milliman and Robertson analyses were conducted, calling into serious question the validity of the projections upon which the proposal is based. The Council believes that more up-to-date analysis would yield less optimistic results than the Milliman and Robertson studies, but that the analysis would still corroborate findings that MSAs have the ability to reduce health expenditures at the individual and aggregate levels, and to reduce the number of uninsured.

Even if the multi-year MSA trust proposal were to be modified to reflect updated analysis, the Council would still have serious objections to key elements of the proposal. Foremost is the requirement that individuals forfeit account balance earnings for a period of five years – a requirement that amounts to a substantial tax on households and individuals. The fact that account balance interest earnings are appropriated by the government would alter incentives for individuals to participate. Even without the 100% tax on interest earnings, potential participants would be daunted by the requirement to deposit $2,500 to $4,000 each year, particularly given that accumulated balances could far exceed the amount needed to meet the high deductibles of catastrophic policies. Low-income individuals and families would find it especially onerous to meet annual deposit requirements, particularly since they derive relatively little benefit from the tax exclusion of premium expenditures and account deposits.

Even if estimated cost savings from MSAs were to approach the amount envisioned in the proposal (approximately one trillion dollars, or two-thirds of total national health expenditures), much of the savings would not be available to fund federal programs. It is true that reduced health care spending by Medicare and Medicaid beneficiaries, reduced medical inflation, and reduced administrative costs within federal programs would ease the financial strain on these programs. However, the majority of savings estimated by Milliman and Robertson are comprised of private sector reductions in health care spending and administrative costs, and privately owned principal in MSA accounts, and thus would not be directly available to finance federal programs.

In addition, as noted earlier, promoting MSAs above other forms of health insurance is contrary to the AMA's support for expanded individual choice of health plans, free market competition, and a pluralistic approach to health care financing. In contrast to the AMA reform proposal, the multi-year mutual MSA trust proposal does nothing to expand choice or dismantle the current inequitable tax treatment of health insurance expenditures. As in the current system, the tax incentive to participate in the MSA program would be the exclusion of health insurance expenditures and MSA account deposits from taxable income. In contrast to refundable tax credits that are inversely related to income as proposed by the AMA, the tax exclusion disproportionately benefits households in upper tax brackets, rather than those most in need of assistance obtaining coverage. For all of these reasons, the Council is unable to support the multi-year mutual MSA trust account proposal at this time.

References for this report are available from the AMA Division of Socioeconomic Policy Development.