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ARCHER MSA EXPANSIONS COULD DRIVE UP HEALTH INSURANCE PREMIUMS AND CREATE NEW TAX SHELTER

by Iris J. Lav

Summary

Few would propose a tax cut for the affluent paid for with increased health insurance premiums on the sick. That is the probable consequence, however, of a proposal to expand Medical Savings Accounts (MSAs) that Representative Bill Archer recently has named as one of his top priorities for passage this year. Representative Archer hopes to attach the provisions to other legislation moving at the end of the session.¹

The new Archer proposal would dramatically expand an MSA demonstration project that Congress established in 1996 and that is scheduled to end this year. In general, the proposal would permit universal access to MSAs and remove a number of safeguards included in the demonstration project. These proposed expansions are identical to MSA provisions included in the version of the Patient's Bill of Rights passed by the House of Representatives last year.

- The Archer proposal seeks major expansions of MSAs, including universal access, despite the fact that the General Accounting Office's report on the current demonstration finds evidence that MSA availability encourages "adverse selection" in insurance markets. Adverse selection is a circumstance in which healthy and less healthy segments of the population become segregated in different types of insurance plans. When adverse selection occurs, health insurance premiums rise for the less-healthy individuals (because they are no longer pooled with the healthier individuals), and the resulting increase in costs may cause some individuals to lose insurance coverage because it becomes unaffordable for them.
- If MSAs are expanded from the current limited demonstration to universal access, it is highly likely that the types of problems the GAO found during the demonstration period would become widespread and result in substantially higher premium costs for conventional insurance.

Premiums for conventional insurance would be higher because of the effect of MSAs on the insurance market, the phenomenon known as adverse selection.

¹ Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the MSA-holder's insurance policy.

- Adverse selection would occur because substantial numbers of young, healthy people with low medical costs would choose to use the high-deductible insurance policies and MSAs and thereby to retain their unspent dollars in their own accounts. This would leave people who are less healthy and have higher medical costs in conventional, low-deductible health insurance plans.
- Such a division of the market would drive up the cost of low-deductible insurance for the less healthy segments of the population who most need it. Research conducted by the Urban Institute, RAND, and the American Academy of Actuaries suggests that premiums for conventional insurance could *more than double* if MSA use becomes widespread. According to the American Academy of Actuaries, “The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women.”²

When Congress was debating MSAs in 1996 as part of its deliberations on the Health Insurance Portability and Accountability Act, there was concern about the effects that widespread adverse selection could have on the insurance market. Accordingly, Congress allowed MSAs only as a limited demonstration policy so it could secure more information on this matter. The demonstration period is scheduled to expire at the end of this year, but limited use of MSAs during the demonstration period has made it impossible to conduct the comprehensive evaluation of MSAs the 1996 law envisioned. Despite the absence of information indicating that MSAs would not cause serious problems, the Archer proposal would make MSAs universally available and relax a number of other safeguards in the 1996 demonstration design. Any negative consequences MSAs may have for the insurance market consequently could become pervasive and difficult to reverse.

- Evidence suggests adverse selection in the usage of MSAs already is occurring under the demonstration project. A survey of insurers offering MSA plans notes that “Insurers expect relatively better health status and lower service utilization by enrollees selecting high-deductible plans and *price their products accordingly.*” [Emphasis added.] In other words, the insurers can afford to set lower premiums for insurance policies used with MSAs, because they know it will be healthier people who are attracted to using MSAs. This survey of insurers was conducted by Westat under contract with the General Accounting Office in partial fulfillment of the terms of the demonstration project Congress established in 1996.

² American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues, May 1995*, p. 23.

- The Archer proposal would make the accounts universally available. If MSAs become widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.

In addition, the changes in the Archer proposal could create a major new tax shelter. The tax shelter would come about because of the similarities between MSAs and Individual Retirement Accounts. Under current law, married taxpayers who are covered by an employer-sponsored pension plan may deduct from their income up to \$4,000 a year for deposits to an IRA if their income is below \$62,000. By 2007, they will be able to make such deposits if their income is below \$100,000.³ Earnings on funds deposited in an IRA compound free of tax; no tax is due on either the deposits or the earnings until funds are withdrawn after retirement (or for a limited number of other purposes).

Taxpayers with incomes above these limits who have pension coverage under employer-sponsored plans are not eligible to use deductible IRAs. When IRA policies were revised in 1986 and again in 1997, Congress determined that such income limits were appropriate largely because the evidence indicates that higher-income individuals can and will save without a taxpayer subsidy; giving high-income taxpayers a tax subsidy for saving is not an efficient use of government funds.

Nevertheless, MSAs could be used by high-income taxpayers as a means to circumvent the income limits that govern tax-advantaged deposits to Individual Retirement Accounts. Under the proposed MSA expansion, *all* high-income taxpayers who choose to use MSAs would be allowed to make tax deductible deposits, and the earnings on these MSA deposits would compound free of tax. Like funds deposited in an IRA, funds on deposit in an MSA may be invested in stocks, bonds, or similar types of assets. MSA deposits and earnings are never taxed if MSA funds are used to pay medical costs. Moreover, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits over a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

The Westat survey of MSA insurers indicates that the market may indeed be developing in this manner.

³ Single taxpayers with incomes below \$42,000 may deduct up to \$2,000 a year. These income limits apply for tax year 2000; the limits are increasing gradually though 2007 under legislation enacted in 1997.

- According to the Westat survey, “Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnership firms, and association groups.”
- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: “The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers’ perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses.”
- Universal availability of MSAs, along with other changes in the proposal such as larger allowable deposits into MSAs, would likely accelerate this trend.

The Archer proposal also includes a provision that deals with employer and employee contributions to MSAs. This provision would undermine the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The Archer proposal would allow both employees and employers to make deposits to an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income. Most lower-paid staff would not be able to afford substantial additional contributions and, because they generally are in lower tax brackets than better-paid employees, would get less subsidy for making their own deposits.

The Medical Savings Account expansions proposed by Representative Archer and included in the House-passed Patients’ Bill of Rights represent a dramatic departure from the current design of MSAs that would likely have adverse consequences for health care consumers. They carry the strong potential to drive up the cost of comprehensive, conventional insurance to the point where many Americans, including those most in need of health services, cannot afford to buy coverage. Moreover, the expansions would significantly increase the appeal of MSAs as a tax shelter for higher-income individuals, further compounding the risk of triggering adverse selection in the health insurance marketplace.

The MSA Demonstration

The bipartisan Health Insurance Portability and Accountability Act of 1996 established a demonstration to test and evaluate Medical Savings Accounts, which are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. The demonstration was designed to provide information about the effects of MSAs on workers, employers, and insurers and to do so without creating widespread, irreparable harm to the participants or the insurance market as a whole. Participation in the demonstration was limited to no more than 750,000 participants who are either employees of small businesses (businesses with 50 or fewer employees) or self-employed individuals. In addition, a number of the rules governing use of MSAs during the demonstration were designed to assure that these tax-advantaged savings accounts were used largely for the purpose of obtaining medical care and would not become a general-purpose tax shelter. The demonstration is scheduled to run through December 31, 2000.

The legislation required an evaluation to determine the effects of MSAs on the insurance market and on consumers. Among other issues, the evaluation was to study the extent to which MSAs fostered “adverse selection” — a situation in which younger and healthier individuals find MSAs financially advantageous and choose MSAs while older and less healthy individuals remain in conventional insurance. The evaluation also was to study the effect of MSAs on health care costs, including any impact on the premiums of individuals with comprehensive coverage. The intention was that Congress would be able to examine the results of the evaluation and, on the basis of those results, determine future policy regarding MSAs.

Few consumers, however, have chosen to use MSA during the demonstration period; fewer than 75,000 policies were sold through 1998. As a result of the light usage, a full evaluation of the effects of MSAs could not be conducted. One portion of the evaluation was completed — a survey of insurers, which was conducted by Westat under contract to the General Accounting Office.

MSA proponents attribute the lack of popularity of MSAs during the demonstration period in part to various safeguards included in the demonstration legislation that were intended to prevent abuse of the accounts. Almost as soon as the demonstration was put in place, bills were introduced in Congress to relax the safeguards.

Another possible interpretation of the sparse usage of MSAs during the demonstration project is that MSAs are not attractive as a health insurance product per se and can gain acceptance only if MSA policies allow substantial abuse of the accounts as tax shelters. The provisions now being considered in conference would remove many of the anti-abuse protections while also making MSAs universally available.

MSAs and Adverse Selection

A major concern is that universal access to MSAs would trigger widespread adverse selection in the insurance market. Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of engendering this type of effect.

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for other purposes.

On the other hand, older and less healthy people who judge they are likely to incur significant health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers who will retain conventional insurance if MSA use becomes widespread could incur much-higher average health care costs than the larger pool of workers who are covered by conventional insurance today. To accommodate those higher average health care costs, the premiums charged for conventional insurance policies would have to increase, perhaps dramatically.

Research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much as a four-fold, depending on the degree of adverse selection that MSAs trigger in the insurance market.⁴ At those increased premium rates, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and also that the resulting decline in the market for conventional insurance would lead some insurers to cease selling it.

⁴ Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

Provisions in the Archer proposal and the House-passed Patients' Bill of Rights

Both the Archer proposal and the House-passed Patients' Bill of Rights (H. R. 2990) would end the MSA demonstration. They would open up MSAs to use by all individuals and employees, removing the numerical cap on participation and eliminating the sunset date for MSAs contained in current law.

- Universal availability for MSAs would mean that any negative consequences that MSAs may have for the insurance market could become pervasive and difficult to reverse.
- The available evidence from the survey of insurers conducted under the demonstration project suggests that insurance companies set premiums for MSAs based on the assumption that adverse selection will take place. According to the report, "Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans....*Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly.* Insurers confirmed this conclusion in the survey."⁵ [Emphasis added.]

The Archer proposal and H.R. 2990 also would increase the maximum amount allowed to be deposited each year in the tax-advantaged Medical Savings Accounts. The current demonstration project places strict limitations on such deposits to prevent use of MSAs as general-purpose tax shelters.⁶

- MSAs are similar to conventional Individual Retirement Accounts: contributions are deductible from income, and tax is deferred on the amounts the accounts earn. While deposits and earnings are never taxed if MSA funds are used to pay medical costs, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits for a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

⁵ U.S. General Accounting Office, Medical Savings Accounts: Results From Surveys of Insurers, December 31, 1998, GAO/HEHS-99-34, Appendix, p.14.

⁶ For individuals, the maximum amount that can be contributed annually under current law is 65 percent of the insurance policy's deductible amount; for family coverage, it is 75 percent of the deductible amount. The House and Senate bills would allow annual contributions equal to the full deductible amount.

- MSAs differ from IRAs in one key respect — there are no income limits on MSAs that prevent wealthy people from using them as tax shelters. As a result, opening up MSAs to all individuals and increasing the amounts that may be deposited in them, as the proposed legislation would do, would enable high-income taxpayers who cannot use IRAs because of the income limits to begin using MSAs as significant tax shelters.
- When the MSA demonstration was established, a number of financial experts pointed out the possibilities for use of the accounts as tax shelters. An Associated Press article cited Eclipse MediSave America Corp., an MSA servicing company, as having calculated that “a family making \$3,375 annual MSA contributions (the maximum allowed under federal guidelines), and earning 8 percent interest a year could accumulate \$1.4 million in the account over 45 years. Even if they withdrew \$1,000 a year, they still would accumulate \$991,000.”⁷ The family would have accumulated these amounts tax-free. A *New York Times* article at that time included an example of a relatively well-off MSA holder who chose to pay medical expenses with other funds, leaving his MSA deposits to grow tax-free.⁸
- The Westat Report indicates the MSA market may indeed be developing in this way. According to the survey, “Insurers reported targeting some segments of the insurance market [for MSAs], including highly-paid professionals, farmers and ranchers, partnership firms, and association groups.”
- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: “The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers’ perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses.”⁹

Finally, both the Archer proposal and H.R. 2990 include changes that would circumvent the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

⁷ Associated Press release by Vivian Marino, August 15, 1997.

⁸ Margaret O. Kirk, “Medical Accounts: Mixed Reviews,” *The New York Times*, July 5, 1998.

⁹ U.S. General Accounting Office, *Medical Savings Accounts: Results From Surveys of Insurers*, December 31, 1998, GAO/HEHS-99-34, Appendix, pp. 15-16.

- Under the MSA demonstration now underway, deposits can be made in an MSA account either by an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.
- The House bill would allow both employees and employers to make deposits in an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income, but most lower-paid staff would not be able to afford substantial additional contributions.

Together, these provisions would greatly increase the potential for abuse of MSAs and use of the accounts as a tax shelter. These changes would make MSAs substantially more attractive and lead to much more widespread use by healthy, wealthy individuals. As a result, these expansions greatly compound the risk that MSAs pose to health care consumers, particularly those in need of comprehensive, affordable health care coverage.