Medical Savings Accounts

CENTER ON BUDGET
AND POLICY PRIORITIES

August 18, 1994

TO: Members of Congress and health care L.A.s
FR: Ellen Nissenbaum
RE: Medical Savings Accounts and Health Care Reform

Most of the major health care proposals under consideration include provisions allowing individuals to establish special Medical Savings Accounts (MSAs), yet these provisions have received little careful analysis or attention. This important issue is likely to be debated on the Senate floor and eventually in conference. I have enclosed the Center's new report on the issues involved in MSAs.

The paper discusses some of the hidden dangers of including MSAs in health care reform legislation. It addresses both MSAs to which individuals would contribute and those designed to accept contributions from employers. Although these two models of MSAs present somewhat different problems, both could result in increased health care costs (regardless of the presence of an employer mandate) and could jeopardize efforts to achieve universal health care coverage.

The analysis examines how benefits of individual contribution MSAs would flow overwhelmingly to upper-income taxpayers much like individual retirement accounts did before their use was limited to moderate-income taxpayers in 1986. In addition, MSAs are likely to produce large revenue losses over time.

Various health care proposals include some form of an MSA. The Gephardt and Rowland-Bilirakis bills would establish MSAs that would only accept contributions from employers. The Michel and Dole-Packwood bills would establish MSAs to which either individuals or employers could contribute. The Mitchell bill does not create MSAs.

Support for this analysis was provided by the Henry J. Kaiser Family Foundation, which is not affiliated with Kaiser Permanente or Kaiser Industries.

We hope you find this information useful. Please contact Iris Lav or David Super for further information.

---

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056
Robert Greenstein, Executive Director

The New York Times
New York, New York
August 16, 1994

Don't Be Seduced by Medisave

Medisave, the proposal for medical savings accounts, is a bad idea that has crept into the health-care bills proposed by the Democratic leadership in the House and by Bob Dole, the minority leader, in the Senate. Medisave would allow people to save money by purchasing health insurance policies with very high deductibles and then invest the savings in tax-free accounts.

Advocates say Medisave can help control health-care costs through consumer choice rather than heavy-handed government regulation. Catastrophic coverage requires consumers to pay ordinary medical bills out of pocket, leaving insurance to pick up only large bills that exceed an annual threshold of, say, $3,000. That, according to advocates, will compel consumers to monitor physician and hospital fees carefully. But what advocates do not say is that Medisave would hurt the poor and the chronically ill and inadvertently disrupt private insurance markets.

Medical savings accounts would attract the rich, because they get the biggest benefit from tax-free investments. And the accounts would attract healthy people because they would not expect to spend much money out of pocket for health care. But as healthy people gravitate toward catastrophic coverage, the pool of applicants for regular coverage would consist increasingly of people who are more chronically ill and more costly to insure; that would drive premiums higher.

The problem grows worse under health-care reform. Every bill would require health plans to cover nearly any applicant at rates that would not vary with their medical condition. The combination of Medisave and reform invites a scheme: healthy people buy catastrophic policies until they become sick or pregnant; then they switch to ordinary coverage. The scheme would destroy the elementary need of insurers to charge healthy customers premiums when they are well to cover their costs when they get sick.

Medisave will not work for another reason. Most health-care costs are accounted for by patients who exceed the $3,000 annual threshold. If these high-cost patients own fee-for-service policies, they lose any reason to search for low-cost providers. Studies show that surgical costs among comparable hospitals can vary by tens of thousands of dollars; under catastrophic coverage, patients will lose incentive to reward hospitals that charge low fees. Catastrophic coverage can also drive consumers away from low-cost primary care, which would come out of their pockets, toward high-tech, costly fixes when they let a preventable problem fester.

Medisave advocates are correct when they say consumer choice can help control costs. But the choice that consumers — rich and poor, healthy and sick — should have to make is between standard packages of benefits. That way health plans would be forced to attract applicants by offering high-quality care and attractive prices — rather than picking off low-risk applicants with catastrophic policies and leaving the high-cost patients for some other plan to cover. Medisave is a needless payoff to rich families and a body blow to market reform.

CENTER ON BUDGET AND POLICY PRIORITIES

FOR IMMEDIATE RELEASE:
Thursday, August 11, 1994
(Revised August 18, 1994)

CONTACTS: Iris Lav
Art Jaeger
(202) 408-1080

SPECIAL MEDICAL SAVINGS ACCOUNTS COULD JEOPARDIZE UNIVERSAL COVERAGE AND PUSH UP HEALTH COSTS, ANALYSIS SAYS

Little-noticed provisions allowing individuals to set up special Medical Savings Accounts — included in several of the health reform bills now before Congress — could jeopardize the goal of universal or near-universal coverage and push up health costs for families, employers, and government, according to an analysis issued today by the Center on Budget and Policy Priorities.

The proposals for tax-advantaged Medical Savings Accounts are found in different forms in several Senate bills and, in yet another form, in the House leadership bill. Although the leadership bill now on the Senate floor does not include an MSA provision, an amendment providing one may be offered during the debate.

According to the analysis by the nonprofit research organization, MSAs in plans without employer mandates are likely to benefit high-income taxpayers disproportionately. In this way, these MSAs are similar to individual retirement accounts before their use was limited to moderate-income taxpayers in 1986. But with or without mandates, the analysis found, MSAs threaten to push up health care costs.

Under all the MSA plans, individuals with catastrophic health insurance could deposit part of their income in special accounts without paying tax and use the money to help meet their deductible or other health care costs. Many proposals also would allow withdrawal of funds for non-health care purposes, subject in some cases to a modest tax penalty.

While on the surface these proposals have some appeal, the analysis said they pose serious problems. If younger, healthier people elect a combination of catastrophic coverage and an MSA — in the hopes of keeping their unspent deposits as tax-advantaged investments — the pool of those covered by comprehensive health plans will become older and sicker, pushing up the cost of these plans, the analysis found.

'Gaming' the System Could Increase Costs

According to the analysis, people also are likely to "game" the system by using MSAs to accumulate tax-advantaged savings when they expect low health costs and shifting to comprehensive coverage when they anticipate higher costs.

"Gaming" could result, the analysis said, because most pending health care reform plans do not include "pre-existing condition" provisions that prevent switching from minimal to higher

— more —

coverage. Without such barriers, individuals would be free to choose catastrophic coverage when they are healthy and switch to comprehensive coverage when they begin a family or face surgery.

The result would be upward pressure on the price of comprehensive insurance plans, which would increase the cost to employers and families for premiums and to the federal government for health care subsidies for low-income families, the analysis said.

'Individual-Deposit' MSAs Create High-Income Tax Breaks

MSA proposals fall into two general categories, but both are tied to use of catastrophic health care plans, or insurance coverage that carries a high yearly deductible.

The proposals found in most health reform bills that do not include mandates requiring employers to contribute to health insurance for their employees allow taxpayers to make MSA contributions up to an annual ceiling and to deduct those amounts from their income for tax purposes. Several Senate bills fall into this category.

Most of these proposals require MSA funds to be used for expenses that count toward a deductible under catastrophic insurance plans. Some also permit use of the money for other medical expenses that might not be covered under the plans, such as eye and dental care. Some proposals also allow deposited funds to be used for any purpose after the employee reaches a specified age.

MSA funds used to pay permitted types of medical bills are never taxed. A taxpayer in the highest income tax bracket would save nearly $700 in federal taxes for every $1,000 spent on medical care under an "individual-deposit" Medical Savings Account. Funds withdrawn for non-permissible purposes are taxed as income when withdrawn and also are generally subject to penalties. According to the analysis, however, taxpayers who withdraw funds for non-permissible purposes can still come out ahead, even after paying the taxes and penalties. As a result, high-income taxpayers who expect to remain healthy can use this form of MSA to accumulate savings at reduced tax rates.

Under an "individual-deposit" plan offered by Senator Phil Gramm (R.-Tex.), the analysis added, the net value of $3,000 of gross income after five years in the MSA would be nine percent more than $3,000 of gross income saved in the traditional way. This assumes the taxpayer is in the 36 percent federal income tax bracket and a seven percent state income tax bracket and that the account earns only a minimal three percent rate of interest. The Gramm plan allows taxpayers to use MSA deposits for any purpose without penalties, so long as the there is enough left in the account to cover the yearly insurance deductible.

If held for 20 years, the $3,000 MSA deposit under the Gramm plan would have a net value nearly a third greater than a deposit that did not enjoy such tax advantages, the analysis added. And if the interest rate were five percent rather than three percent, the MSA deposit

made under the Gramm plan after 20 years would be worth 50 percent more than the deposit lacking such tax advantages.

Other "individual-deposit" MSA proposals have more restrictive provisions that would lessen the value of MSAs for investment purposes, but they would not eliminate the tax advantages altogether, the analysis said. As a result, high-income taxpayers could still use the accounts as a tax-advantaged way to accumulate savings.

"Individual-deposit MSAs generally would afford a substantial new tax break to healthy, high-income people that would be unavailable to the vast majority of moderate-income families that fall in the 15 percent tax bracket," the analysis concluded, adding that the tax break would have no value at all for poor families that do not pay taxes.

"In this respect, MSA usage is likely to be similar to usage of Individual Retirement Accounts before IRA use was limited to low- and moderate-income taxpayers in the Tax Reform Act of 1986," the analysis said. Before 1986, it noted, 82 percent of IRA deductions were taken by the one-third of individuals with the highest incomes.

Also, the analysis said, since virtually all those who would benefit can afford excellent health insurance under the current system, "individual-deposit" MSAs are not likely to contribute to the goal of making affordable health care coverage available to every American. Rather, it said, they are likely to make the goal harder to reach by driving up the cost of comprehensive health insurance.

'Employer-Deposit' MSA Provide Tax-Advantaged Savings

Bills proposed by Representative Gephardt and by Representatives Rowland and Bilirakis would create MSAs that would only accept contributions from employers. Under these proposals, employers could offer a combination of an MSA and a high-deductible insurance plan as an alternative to comprehensive insurance coverage. Employers are required to spend the same amount per employee regardless of which option is chosen.

Under the "employer-deposit" MSA in the House leadership's health reform plan, deposited funds must be used for health care costs or remain in the account until the employee reaches age 59½. Under the Rowland-Bilirakis bill, unspent funds would be retained until the employee reached age 65. At that point, they become available for any purpose without penalties. For employees who are relatively healthy and accumulate balances in their accounts, the "employer-deposit" MSA provides tax-advantaged retirement savings. Less healthy employees, however, are likely to find the combination of catastrophic insurance and an MSA inadequate to meet their health care needs, the analysis found.

Because the employer rather than the employee makes the deposits, "employer-deposit" MSAs would avoid the potential for large federal and state revenue losses. Like "individual-deposit" MSAs, however, they would create incentives for gaming the system that ultimately would

lead to increased costs for health insurance. For example, the analysis found, a young, single person whose employer deposits $2,500 annually in an "individual-deposit" MSA and who withdraws no funds for medical expenses would accumulate $28,000 over 10 years. If the same person took $2,500 of earnings, paid taxes on it, and saved the after-tax earnings each year for 10 years, the accumulation would be only $16,600.

"There would be strong incentives to accumulate tax-advantaged savings at times when few health care expenses are anticipated," the analysis said. When high medical expenses became more probable, the individual could simply switch to comprehensive coverage and keep the MSA accumulation as savings.

If the concentration of less-healthy workers in comprehensive plans drove up premiums for that type of coverage, the analysis said, employers would face increased costs for all types of health coverage. Under the Democratic leadership bill, for example, employers would pay 80 percent of the increased cost of comprehensive plans for their employees. Even if the cost of covering employees under catastrophic plans did not increase, employers would still have to make larger payments into MSAs for their employees with catastrophic/MSA plans in order to comply with the requirement that the same amount per employee is spent regardless of which option is chosen. Under the Rowland-Bilirakis bill, either employers or workers would have to absorb the additional costs.

In addition, the analysis said, families would face increased costs for their share of comprehensive insurance premiums, and the federal government would pay more for subsidizing low-income households that buy insurance and small businesses that must provide insurance for employees. These added costs would require implementing other measures to hold down costs to avoid swelling the deficit. For example, under the Rowland-Bilirakis bill, these added costs could trigger reductions in eligibility for premium subsidies, leaving more people uninsured. Under the Democratic leadership bill, payments to providers could be cut.

No Good Way to Design MSAs

"There does not appear to be a way to design an MSA that is not detrimental to the goal of achieving universal or near-universal health care coverage at a reasonable cost," the analysis concluded. "The ultimate cost of allowing Medical Savings Accounts, with or without employer mandates, is likely to be fewer benefits with higher co-payments in comprehensive insurance plans used by middle- and lower-income families. In addition, in the absence of an employer mandate, a lower proportion of the population is likely to be covered by adequate health insurance — since increased cost of comprehensive insurance would lead some employers to drop insurance coverage, and a scale-back of subsidies would cause some low-income families to fail to purchase health insurance."

The Center on Budget and Policy Priorities conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting low-income Americans. Support for this analysis was provided by the Henry J. Kaiser Family Foundation. The foundation is not affiliated with Kaiser Permanente or Kaiser Industries.

CENTER ON BUDGET AND POLICY PRIORITIES

MEDICAL SAVINGS ACCOUNTS IMPEDE UNIVERSAL COVERAGE

by Iris J. Lav

Overview

A number of health care reform bills include provisions for tax-advantaged Medical Savings Accounts. All of these bills tie use of such accounts to catastrophic health care coverage — that is, a health insurance plan that carries a high yearly deductible amount. Funds placed in a medical savings account may be used to pay health care costs that count toward the insurance deductible. Under some bills, funds placed in an MSA also may be used to pay other health care costs.

On the surface, MSAs have appeal. An MSA can enable people who are young and healthy, along with people who have enough discretionary income to set aside for contingencies, to feel they are keeping their own money rather than contributing it to insurance company profits. In addition, proponents of injecting more free-market discipline into health care believe that consumers can be made more price-sensitive — and will consume fewer health care services — if they pay medical bills out of their own accounts.

Nevertheless, there are serious problems with MSAs. These problems greatly overshadow their surface appeal. Whether used with or without an employer mandate, MSAs are likely to jeopardize the national goal of achieving universal health care coverage at a reasonable cost.

If younger, healthier people choose catastrophic insurance with MSAs in the hope of keeping their unspent deposits, the pool of people covered by comprehensive health insurance will tend to be older and sicker. Since most of the health care reform proposals allow free movement among health insurance plans, without regard to pre-existing conditions, people are likely to "game" the system. People would be able to use MSAs to accumulate tax-advantaged savings at times when they expect low health care costs and then shift into comprehensive health care plans at times when they anticipate high health care costs, such as when beginning a family or needing surgery. As a result, the price of a basic comprehensive health insurance plan will be higher than it would be if all people participated in a comprehensive plan.

Financial support for the work of the Center on Budget and Policy Priorities in preparing this report was provided by a grant from the Henry J. Kaiser Family Foundation. We are grateful for their support.

777 North Capitol Street, NE, Suite 705, Washington, DC 20002 Tel: 202-408-1080 Fax: 202-408-1056
Robert Greenstein, Executive Director

The upward pressure on the price of a comprehensive insurance plan would increase the cost to employers and families for premiums and to the federal government for subsidies. In addition, if individuals are permitted to deposit funds into the MSA in addition to, or instead of, employers, MSAs can be used in part as a new, non-productive tax break; this could increase the federal deficit and cause revenue losses for many states. Several pending health care reform proposals would create MSAs of this type. Like Individual Retirement Accounts before their use was limited by the Tax Reform Act of 1986, MSAs are likely to yield large revenue losses that disproportionately benefit high-income taxpayers.

'Individual-Deposit' and 'Employer Deposit' MSAs

It is useful to distinguish two broad types of proposals, both of which are called Medical Savings Accounts. The two types of proposals have somewhat different policy implications. One type may be called "individual-deposit" MSAs, while the other may be called "employer-deposit" MSAs.

'Individual-Deposit' MSAs

"Individual-deposit" MSAs — such as those proposed by Senators Phil Gramm, Bob Dole, and John Chafee and also in two separate proposals by Representative Bob Michel — are included in bills that do not require employers to contribute to health insurance for their employees. Under these proposals, qualified taxpayers (either directly or through their employers) are allowed to contribute yearly amounts to an MSA, up to a specified ceiling. To be qualified, taxpayers must have insurance coverage through a catastrophic plan.

Contributions to "individual-deposit" MSAs may be deducted on an individual's income tax when determining adjusted gross income, which means they may be deducted whether or not the individual itemizes other deductions. If MSA contributions are withheld from income by an employer, the withheld amount also is not counted as wages or salary for purposes of computing income or FICA (Social Security and Medicare) taxes. In some proposals, contributions made by a self-employed individual or person whose employer does not provide insurance are similarly exempt from income and FICA taxes.[1]

---

[1] The Dole bill allows individuals to make deposits in MSAs if they are not eligible to participate in an employer-subsidized health plan or do not receive employer contributions to a medical savings account. If an employer does make contributions for an employee to an MSA, the MSA deposits are tax-free to the extent they do not exceed the difference between the premium cost of the catastrophic plan the employer

(continued...)

Most of the proposals require persons holding MSAs to use funds in an MSA account to pay medical expenses that count toward the deductible amount of their catastrophic insurance. Individuals who incur such expenses but do not reimburse themselves from their MSAs are subject to a tax penalty. Some proposals, however — such as Senator Gramm's — simply permit such reimbursements from MSAs to be made.

Some of the proposals also permit payments from MSAs to be used for other medical expenses that are not covered by catastrophic insurance and that therefore would not count toward the deductible. Depending on the plan, expenses that do not count toward the deductible might include costs for eye care, dental care, or mental health services. Funds withdrawn from MSAs that are used to pay permitted types of medical bills are never taxed.

If funds are withdrawn from MSAs for *non*-permissible purposes, they are subject to income taxes as ordinary income in the year they are withdrawn. The various proposals generally also apply penalties to such withdrawals, but differ in the circumstances to which the penalties apply. Some bills also allow penalty-free withdrawal of funds after the holder reaches a specified age.

'Employer-Deposit' MSAs

"Employer-deposit" MSAs have been proposed in both houses of Congress. are Representative Andrew Jacob's amendment to the Ways and Means Committee bill (which is included in the House Democratic leadership bill), the substitute amendment proposed by Representatives Roy Rowland and Michael Bilirakis, and a sense-of-the-Senate amendment offered by Senator Harris Wofford in the Senate Labor and Human Resources Committee all include "employer deposit" MSAs. The bill recently advanced by Senator George Mitchell does not include an MSA provision.

"Employer-deposit" MSA proposals allow employers to offer their employees an option of a combination MSA and high-deductible insurance plan as an alternative to comprehensive insurance coverage. They contain some mechanism for requiring employers to spend the same amount per employee regardless of which option the employee chooses; the mechanism may either be a component of an employer mandate, as in the Jacobs amendment, or a non-discrimination requirement, as in the Rowland-Bilirakis proposal. In either case, parity is accomplished by requiring the employer to deposit into the MSA the difference between the employer's share of the premium cost for the high-deductible coverage and the employer's cost for comprehensive coverage.

---

[1](...continued)
offers and the premium cost of a comprehensive plan for the individual.

For example, under the Ways and Means bill, an employer would be required to contribute an amount equal to 80 percent of the cost of a comprehensive family plan for each worker. If a comprehensive plan cost $5,500, the employer's required contribution would be $4,400. If an employee chose the catastrophic/MSA option instead and the catastrophic plan cost $2,000, the employer would contribute 80 percent — or $1,600 — toward that plan and deposit the difference of $2,800 ($4,400 minus $1,600) in the employee's Medical Savings Account. Once an employer elected to make a contribution towards its workers' health insurance costs under the Rowland-Bilirakis proposal, the process would be similar.[2] Under this approach, employees may not make additional contributions to the MSA.

Under the Jacobs amendment, funds from the MSA must be used for health care costs; there are no provisions for withdrawal with penalty for other purposes. Unused funds must remain in the account. The only exception occurs after the employee reaches age 59½. After age 59½, the funds in the MSA become available for any purpose, without a penalty being imposed. The Wofford amendment was not accompanied by detailed provisions, but it was understood that provisions similar to those in the Jacobs amendment were intended. The Rowland-Bilirakis proposal would allow penalty-free withdrawals after the employee reaches age 65.

'Individual-deposit' MSAs: Healthy, Higher-Income Taxpayers have Incentives to Maximize Use

Many high-income taxpayers will garner substantial tax benefits from using an "individual-deposit" MSA and would be likely to view these MSAs as an advantageous way to pay medical expenses. For higher-income taxpayers who expect to remain healthy, individual-deposit MSAs would be particularly advantageous because the accumulated deposits would represent a new, tax-advantaged way to accumulate savings. As a result, higher-income taxpayers who anticipate remaining healthy would be likely to use MSAs and to contribute the maximum permissible amount to their MSAs.

Consider a taxpayer in the highest federal income tax bracket. Either to pay $1,000 in out-of-pocket medical expenses or to deposit $1,000 in a savings account under current law, a taxpayer in the 39.6 percent federal income tax bracket would

---

[2] Under the Rowland-Bilirakis proposal, deductibles for catastrophic plans would set so that these plans would have actuarial values equal to eighty percent of the actuarial value of comprehensive plans. Hence if comprehensive coverage cost $5,500 as in this example, a catastrophic plan would be expected to cost about $4,400. If an employer had chosen to make $4,400 contributions towards its workers' health care costs, a worker choosing the catastrophic/MSA option would receive a $1,100 contribution to his or her MSA and have $3,300 of the catastrophic plan's premium paid by the employer.

MSAs Do Not Help, But May Adversely Affect, Low-Income Families

Medical Savings Accounts offer no advantage for low-income families. In fact, inclusion of MSAs in a health care reform bill would likely disadvantage such families, because MSA usage is likely to increase the cost of comprehensive insurance. The increased costs could make insurance unaffordable for some low-income families that do not qualify for full subsidies. In addition, the cost to the federal government of providing subsidies would be higher, increasing the likelihood that subsidies would be scaled back for budgetary reasons and thereby further reduce the affordability of insurance for low-income families.

Deductions No Value to Poor Households

MSAs subsidize the purchase of health care services through providing tax deductions for deposits into the accounts. This can be of considerable benefit to high-income taxpayers (as is explained starting on page 9). But such tax deductions are of no value to poor families that do not owe income tax, and thus MSAs cannot be used to subsidize the purchase of medical services by such families. Moderate-income families in the 15 percent federal income tax bracket would receive some subsidy from using an MSA, but are likely to have insufficient resources or discretionary income to take advantage of these benefits.

MSAs Will Increase the Cost of Insurance for Low-Income Families

All proposals for MSAs include some circumstances under which funds in the accounts may be used for non-medical purposes. In some cases, funds may be withdrawn without penalty if the balances remaining in the account meet a specified threshold; in other cases, a modest penalty is applied to funds withdrawn for non-medical purposes. In some bills, funds may be withdrawn without penalty when the holder reaches a specified age. These provisions invite younger, healthier people to choose catastrophic insurance with MSAs in the hope of keeping their unspent deposits as tax-advantaged investments, leaving an older and sicker pool of people to be covered by comprehensive health insurance. As a result, the price of a comprehensive health insurance plan will be higher than it would be if all people participated in a comprehensive plan.

For persons with incomes modestly above the poverty line, the increased cost of comprehensive insurance — resulting from the concentration of healthier people in catastrophic insurance — could represent a substantial burden. Since the various health care reform proposals begin to phase out subsidies for purchase of health insurance at or just above the poverty line, many low-income families are likely to bear directly a share of these higher premium costs. Some low-income families could find insurance unaffordable and, in the absence of a requirement to purchase insurance, fail to purchase it.

MSAs will Increase the Government Cost of Subsidies and Squeeze Funding Available for Subsidies

If the cost of comprehensive insurance rises, the cost to the federal government of providing subsidies to low-income households will increase along with it. As a result, over the long run, inclusion of Medical Savings Accounts in a health care reform bill could result in the scaling back of low-income subsidies for budgetary reasons. This, too, would cause insurance to be less affordable for low-income families and could lead some to fail to purchase insurance. In addition, the cost from MSAs in foregone tax revenues, much of which is likely to subsidize high-income taxpayer' tax-advantaged investments not related to medical care, may be substantial. A large revenue loss from MSAs would make a scale-back of subsidies particularly likely.

have to earn $1,696 before federal income tax and payroll taxes are subtracted. (The 39.6 percent income tax plus the 1.45 percent Medicare tax equals 41.05 percent. Taxing away 41.05 percent of $1,696 leaves $1,000.[3]) Using an MSA, however, would allow such a taxpayer to deposit $1,696 rather than $1,000. If the funds are used for medical payments, the taxpayer saves nearly $700 for every $1,000 he or she spends on medical care. If the funds are not needed for medical care but instead are viewed as an investment, the taxpayer will earn interest on a deposit of $1,700 rather than on $1,000.

The benefit of saving the maximum permissible amount through an "individual-deposit" MSA would increase with the length of time the funds remained on deposit. This may be illustrated by considering a deposit of $3,000 to an MSA in a single year that remains in the account in subsequent years. For purposes of illustration, the taxpayer is assumed to be in the 36 percent federal income tax bracket and in a seven percent state income tax bracket.[4] A three percent rate of interest is assumed to be earned on the deposits.

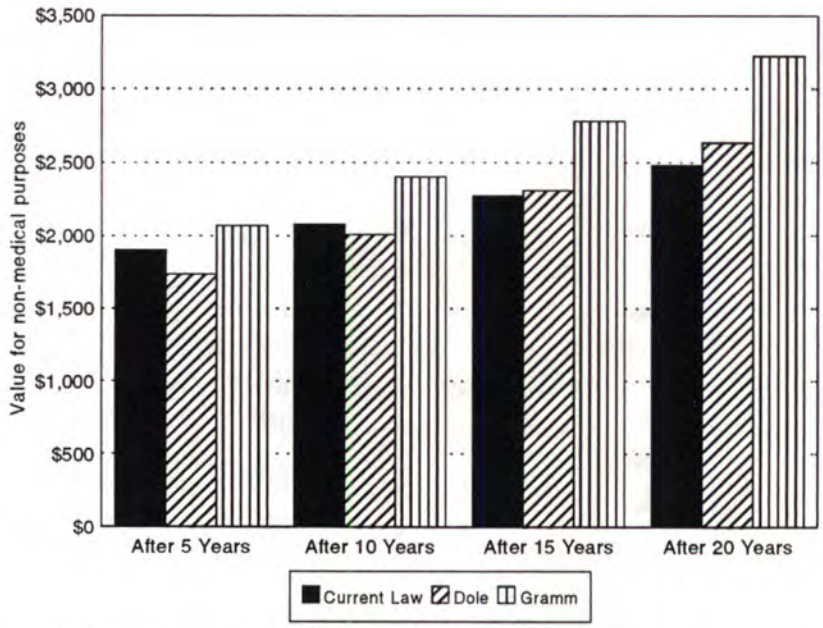
If the MSA deposit were made under the provisions of the Gramm proposal, interest on the $3,000 deposit would accumulate without being taxed on a yearly basis. After five years, the first year's deposit of $3,000 would have grown to $3,480. The Gramm proposal does not impose a penalty for withdrawals for non-medical purposes so long as the amount remaining in the account is equal to the yearly deductible amount of the catastrophic insurance plan. So assuming that the taxpayer made deposits in subsequent years and a sufficient balance remained, the individual could withdraw the entire $3,480 as ordinary income. Federal and state income taxes would reduce the proceeds to approximately $2,070. This can be compared to an investment the taxpayer could have made from ordinary after-tax earnings. The initial investment made from $3,000 in gross income on which income taxes and payroll taxes first had to be paid would have been much less — $1,742. In addition, the interest on the savings in the non-MSA investment would have been taxed on a yearly basis. So after five

---

[3] A taxpayer in this income tax bracket has income that far exceeds the maximum earnings on which Social Security payroll taxes must be paid and so would receive an exemption — through using an MSA — only from the Medicare tax, which is paid on all earnings. This simplified example does not include the impact of state income tax. As discussed below, this taxpayer is likely also to owe state income tax, and thus to have to earn more than $1,696 to retain $1,000 under current law.

[4] The 36 percent bracket applies to individuals with *taxable incomes* over $115,000 and married filers with taxable incomes over $140,000. Taxable income is gross income less all permissible exclusions and deductions from income. Thus, a taxable income of $140,000 generally would correspond to a much higher gross income — perhaps in the $170,000 to $200,000 range. In this and the following comparison, the taxpayer is assumed to live in a state with an income tax that conforms to federal treatment of MSAs. Thirty-seven of the 42 states that levy a personal income tax generally define adjusted gross income in the same way as it is defined for federal tax purposes. These states would be highly likely to conform to a change in federal tax laws relating to MSAs. The assumed marginal state tax rate is seven percent, which is the rate at this income level in the median state.

Figure 1
Value of $3,000 of Gross Income Saved Under Gramm and Dole MSAs
Compared with Current-Law Savings



Taxpayer is in the 36 percent federal income tax bracket and a 7 percent state income tax bracket. The state conforms to federal treatment of MSAs. Interest rate is three percent.

Center on Budget and Policy Priorities

years, the initial investment outside of the MSA would have grown to approximately $1,903. Consequently, the $3,000 of gross income put into the MSA would be worth 9 percent more than $3,000 of gross income saved in the normal way. If those initial deposits were held for 20 years, the MSA deposit under the Gramm proposal would be worth 30 percent more than a normal deposit that did not enjoy such tax advantages. (See Figure 1).

Other "individual-deposit" MSA proposals have more restrictive provisions. But where these restrictions lessen the value of MSAs for ordinary investment purposes, they would not completely eliminate this tax advantage. For example, Senator Dole's proposal taxes the interest earned on MSA deposits on a yearly basis.

The Dole proposal also applies a 10 percent penalty to a withdrawal for non-permitted purposes, no matter what balance remains in the account. Under the Dole proposal, the after-tax-and-penalty value of an MSA withdrawal made by a taxpayer in the 36 percent federal income tax bracket would be slightly greater than the value of a comparable investment made with after-tax dollars if the investments were held at least 14 years.

These examples, however, assume a *modest three percent rate of interest* earned on the savings. If interest rates rise in the future, the value of retaining tax-advantaged savings in an MSA would increase substantially. If a five percent rate of interest were earned on the savings, for example, after 20 years the $3,000 of gross income deposited and held in an MSA would be worth 51 percent more under the Gramm proposal — and 16 percent more under the Dole proposal — than a deposit made from after-tax income.

If the taxpayer in the example used above were in the 28 percent federal tax bracket rather than the 36 percent bracket, saving through a Gramm-style MSA would still confer substantial advantage — albeit somewhat less advantage than that secured by the higher-income taxpayer.[5] Under the Gramm proposal, an MSA deposit withdrawn after five years for non-medical uses would be worth 7 percent more to a taxpayer in the 28 percent federal tax bracket than a deposit based on the same amount of gross income made into a normal account, based on a three percent rate of interest in each case. After the 20th year, the MSA deposit would be worth 24 percent more.

In sum, the value of the tax break that MSAs confer increases with the income — and the income tax bracket — of the user and is greatest for the healthiest, highest income taxpayers. "Individual-deposit" MSAs would afford a substantial new tax break to healthy, high-income people that would be unavailable to the vast majority of moderate-income families that fall in the 15 percent tax bracket. In this respect, MSA usage is likely to be similar to usage of Individual Retirement Accounts before IRA use was limited to low- and moderate-income taxpayers in the Tax Reform Act of 1986. Prior to the 1986 Tax Act, 82 percent of IRA deductions were taken by the one-third of individuals with the highest incomes. (See box on next page.)

In addition, since virtually all of the taxpayers who would benefit from MSAs can afford excellent health care insurance under the current system, the establishment of MSAs would not contribute to the goal of making affordable health care coverage available to every American. As discussed below, MSAs are likely to detract from the ability to reach that goal by driving up the cost of comprehensive health insurance.

---

[5] The 28 percent federal income tax bracket applies to single individuals with *taxable income* between approximately $23,000 and $55,000 and married couples with taxable income between approximately $38,000 and $92,000. Taxable income is gross income less all permissible exclusions and deductions from income. Thus, a taxable income of $60,000, for example, would correspond to a much higher adjusted gross income — on average, between $75,000 and $100,000 in adjusted gross income.

'Individual-Deposit' MSAs Similar to Pre-1986 IRA

The pattern of usage of Individual Retirement Accounts before 1986 gives an indication of what might be expected under the MSA proposals. Prior to the Tax Reform Act of 1986, taxpayers at all income levels could deposit up to $2,000 per year in Individual Retirement Accounts and deduct the contribution from their taxable income. Interest on funds deposited in IRAs accumulated free from taxation. Funds could be withdrawn after age 59½ and were subject to taxation as ordinary income at that time. As a result, the benefits from IRAs came from the deferral of taxation on the annual deposits and the interest build-up and from the expectation that taxpayers would be in a lower tax bracket after retirement than during their working years. IRAs were advantageous savings vehicles for some higher-income taxpayers, however, even if they intended to pay the penalty for early withdrawal.

Even though taxpayers at any income level could use IRAs, actual usage was concentrated among upper-income taxpayers. IRS tax return data show that in 1986, the last year in which IRA tax deductions were available to all taxpayers, 66 percent of the tax units in the top four percent of the income scale made IRA contributions. By contrast, only 13 percent of taxpayers in the middle third of the income scale made such contribution. And only four percent of those with adjusted gross incomes below $15,000 participated.

Furthermore, upper-income taxpayers tended to have the funds to make the maximum-permitted contribution, while other taxpayers made more modest contributions. As a result, the distribution of the amount of IRA deductions was even more tilted to the upper end of the income scale. According to Congressional Research Service expert Jane Gravelle, "...IRAs cannot be characterized as a subsidy to the middle class. In 1986, 82 percent of IRA deductions were taken by the upper third of individuals filing tax returns (based on adjusted gross income). Since these higher-income individuals had higher marginal tax rates, their share of the tax benefits was even larger."[1]

MSAs may have distributional effects that are similarly skewed in favor of upper-income taxpayers as those of pre-1986 IRAs. As discussed in the text, few low- or middle-income taxpayers are likely to have sufficient savings to bear the risk of high uninsured health care costs. And the benefits to savings through an MSA increase with increases in income and marginal tax rates.

[1] Statement of Jane G. Gravelle, Congressional Research Service, Senate Committee on Finance, May 16, 1991.

'Individual-Deposit' MSAs May Leave Moderate-Income Taxpayers Exposed to Unaffordable Medical Bills

In addition to being unable to take advantage of the lucrative tax breaks MSAs can offer, there is another reason that MSAs are not a benefit for ordinary, moderate-income taxpayers. For moderate-income taxpayers who have families and for those who anticipate normal-to-high medical expenses, using an MSA with a catastrophic insurance plan may pose a significant financial risk.

Persons covered by catastrophic health insurance must have the yearly deductible amount — which may be several thousand dollars — available at the

beginning of each new year to which the deductible applies in case large expenses are incurred early in the year. In addition, catastrophic insurance plans may cover fewer types of medical services than comprehensive plans, and only payments for covered services would count toward fulfilling the yearly deductible. As a result, a person with limited financial resources who chooses catastrophic rather than comprehensive coverage might risk incurring large medical bills that are not covered by insurance and that the individual cannot afford. (See box on next page.)

'Individual-Deposit' MSAs Increase Cost of Comprehensive Insurance and May Result in Fewer Insured

As noted, maximizing MSA deposits would be particularly advantageous to high-income taxpayers, and to some moderate-income taxpayers, at times in their lives when they anticipated relatively low medical expenses. At times when high medical expenses might be anticipated, however, persons with modest financial reserves would be better off using comprehensive insurance.

Under the current health insurance system, a significant bar to keeping minimal coverage until substantial costs are anticipated is a worry that a "preexisting condition" will develop and forever preclude the ability to obtain insurance. Such barriers would be eliminated by many of the reform plans, so people would be allowed to choose to be covered by catastrophic insurance when they are healthy, and then opt to buy comprehensive insurance when they know, for example, that they will be starting a family or requiring surgery.[6] If this occurs, the pool of people using comprehensive insurance will tend to have higher health care utilization and a higher per-person cost of health care than would be the case if everyone working for a company or living in an area were covered by comprehensive insurance.

To the extent that the cost of basic, comprehensive insurance plans increase because they are covering less healthy people, the costs to employers and individuals for premiums and the costs to the government for low-income subsidies also will increase. In the absence of an employer mandate, this cost pressure could cause some employers to drop insurance coverage. It also could result in the scaling back of subsidies for budgetary reasons, causing some low-income families to fail to purchase

---

[6] If a reformed system uses a similar preexisting condition barrier to shifting from catastrophic to comprehensive coverage, many people would be stuck forever with deductible amounts that are unaffordable in their changed circumstances. Some of the bills that include "individual-deposit" MSAs continue to allow insurance companies to deny insurance coverage based on pre-existing conditions under some circumstances.

Moderate-Income Families Choosing MSAs Risk Unaffordable Medical Expenses

Some moderate-income families who use a combination "individual-deposit" MSA with a catastrophic insurance plan may not have sufficient resources to cover their exposure to health care costs. Consider, for example, the Jones family, which carries a catastrophic insurance plan with a $3,000 deductible through the husband's employer. Like many moderate-income families, mortgage and living expenses consume all of the Jones' income and they are mildly over-extended on credit-card consumer debt. The Jones' keep $5,000 for emergencies in a money-market fund, but have no other liquid assets.

Assume the Jones' had $1,000 in MSA savings going into the year and made additional deposits through the employer of $250 a month during the year. By early November, the family had paid $2,500 into the account from the monthly deposits, and had paid $2,000 from the account for various medical bills that counted toward the deductible, leaving $1,500 in the account. In mid-November, the Jones' teen-age son broke two teeth in a sports game. The $1,000 cost of necessary dental work did not count toward the deductible amount of their catastrophic insurance, but it was a permitted use of MSA funds. The Jones' decided to pay the bill through their MSA, bringing the balance down to $500. Then in late-November, Mr. Jones became ill and required emergency surgery. The family added $500 from their money-market fund to their MSA balance to cover their remaining $1,000 deductible for that year.

In early January, as Mr. Jones prepared to resume work, complications developed and further surgery was required. No funds were available in the MSA to pay the $3,000 deductible for the new calendar year. In addition, Mr. Jones faced several additional weeks before he could return to work and did not have sufficient sick leave to receive his salary for the period of anticipated absence. Paying the $3,000 deductible would reduce the family's money-market savings to $1,500, causing the family serious concern about meeting living expenses during the unpaid leave.

health insurance. A scale-back of subsidies would be particularly likely if the cost in foregone tax revenue of MSAs turns out to be high.[7] Such pressures are likely to increase the proportion of the population that is uninsured.

---

[7] In addition to increasing the cost of comprehensive insurance and federal subsidies, "individual-deposit" MSAs could result in substantial federal and state revenue losses. If MSA-users with high incomes deposit the maximum-permitted amounts in order to secure tax-advantaged savings (above and beyond amounts in MSA accounts that are used for medical costs), it is possible that greater tax deductions would be taken for MSA/catastrophic insurance combinations than for comprehensive insurance.

Assume, for example, that a comprehensive family plan has a premium of $5,500 which can be paid with pre-tax income either by an employer or an individual. For comparison, assume that a catastrophic family plan has a premium of $2,500 and that the maximum permitted contribution to the MSA is $4,000, bringing the total that can be paid or deposited with pre-tax income to $6,500. In this scenario, the Treasury and state governments could lose tax revenue from an additional $1,000 of potentially taxable income if a taxpayer chose the MSA/catastrophic combination and maximized MSA contributions. A substantial revenue loss would be particularly likely if the enacted MSA deposit limits were high — they are $5,000 in Rep. Michel's original health care reform bill, for example — and some catastrophic insurance plans had high premiums (which could occur if a plan offered full coverage for medical expenses exceeding the deductible amount).

The additional revenue loss could be avoided by limiting the MSA deposit to the difference between an individual's catastrophic insurance premium and a comprehensive insurance premium, as the "employer deposit" MSAs do. The Dole bill attempts to address this issue by requiring that any individual whose employer subsidizes insurance costs may deposit funds into an MSA only through the employer, and by limiting the amount of tax-free MSA deposits in such cases to the difference between the cost of a comprehensive plan for that individual and the cost of his or her catastrophic plan.

'Employer-Deposit' MSAs Also Increase Costs for Employers and Government

"Employer-deposit" MSAs do not allow individuals to make deposits to their accounts.[8] Instead, the employer would deposit into the MSA the difference between what the employer would otherwise contribute towards the premium for a comprehensive plan and the employer's share of the premium for a catastrophic plan. By equalizing the employer payment and tax deduction for each option, the potential for large federal and state revenue losses is avoided. But "employer-deposit" MSAs create incentives for gaming the system similar to those induced by "individual-deposit" MSAs. These incentives ultimately would lead to increased costs for health insurance.

Consider, for example, a young, single person earning $35,000 a year whose employer deposits $2,500 each year for 10 years into the employee's MSA. If the person withdraws no funds for medical expenses, the account would total just under $28,000 at the end of the 10-year period. By contrast, if the same person took $2,500 of earnings, paid federal and state income taxes and payroll taxes and then saved the after-tax earnings each year for 10 years, he or she would have just under $16,600 saved at the end of the period.[9] (See Figure 2.)

There would be strong incentives to accumulate tax-advantaged savings at times when few health care expenses are anticipated. When the individual came to a point in life when high medical expenses became more probable, such as when he or she married and started a family, he or she would presumably change to comprehensive coverage and simply retain the MSA accumulation as "retirement savings." In this example, the taxpayer withdrawing the accumulated funds after age 59½ (under the Jacobs amendment) or age 65 (under the Rowland-Bilirakis proposal) would receive an advantage over having saved the funds in the normal way if his or her combined federal and state marginal income tax rate at the time of withdrawal was less than 41 percent, a very likely scenario for all but the highest-income taxpayers.

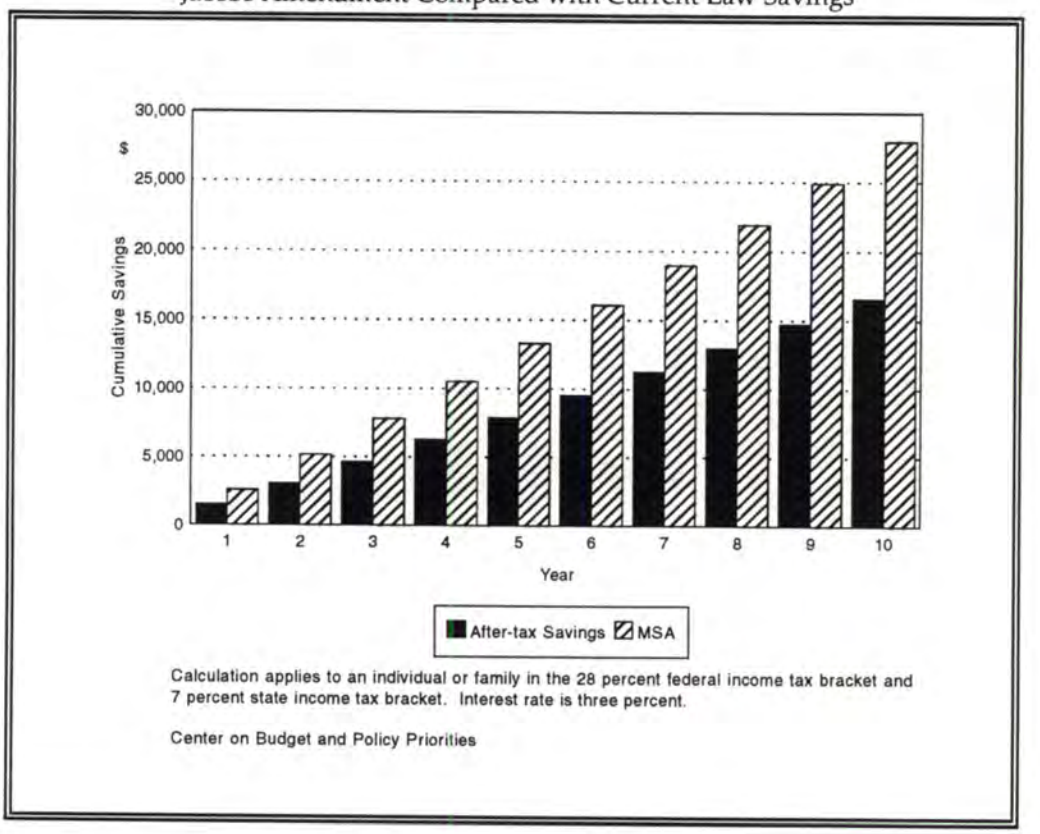
As is the case with "individual-deposit" MSAs, younger, healthier employees would be likely to choose the catastrophic/MSA combination, while employees at greater risk of high health care costs would choose comprehensive coverage. As a result, the cost of health insurance to employers, individuals, and the federal government would go up. Premiums for comprehensive coverage would have to

---

[8] If "employer-deposit" MSAs did allow individuals to make deposits to their accounts, they would be similar to "individual-deposit" MSAs in their effects.

[9] This calculation assumes a three percent rate of interest on the deposits and current taxation of yearly interest earnings in both cases. The individual is assumed to be in the 28 percent federal income tax bracket and a seven percent state income tax bracket.

Figure 2
Cumulative Value of $2,500 Gross Income Saved Each Year for 10 Years
Jacobs Amendment Compared with Current Law Savings



increase to compensate for the higher average health care expenditures of the older, less healthy pool of employees covered under the comprehensive plan.

- In bills with employer mandates, employers would have to pay their 80 percent share of the increased cost of the premiums for comprehensive plans. And since the cost to the employer for covering employees under a catastrophic plan is tied to the cost of a comprehensive plan, the employer also would have to make larger payments into the MSA to comply with the requirement that the same amount be spent on each option. In bills with no mandates, the employer would either have to increase its contribution — possibly reducing wages to recover its costs — or leave its workers to pay an increased share of premium costs.

- Individuals who want or need comprehensive coverage also would face increased costs for their share of the premium. If the absence of healthier subscribers in the comprehensive insurance pool increased the premium costs beyond a level that employers would tolerate, benefits under the comprehensive option eventually might be cut back or higher co-

payments imposed — either of which could increase burdens on some middle-income families needing care.

- The cost to the federal government of subsidizing low-income households that buy insurance and small businesses that must provide insurance for their employees would rise in tandem with the increase in the cost of a comprehensive benefit plan. These added costs would swell the deficit unless offsetting cost containment measures were implemented. If measures used to offset the increase in cost included reductions in subsidies, insurance could become unaffordable for some low-income households and small businesses. Mandates to purchase insurance could be difficult to maintain in the face of such pressures.

Conclusion

There does not appear to be a way to design an MSA that is not detrimental to the goal of achieving universal or near-universal health care coverage at a reasonable cost. To the extent that individuals who can benefit from choosing a catastrophic/MSA combination rather than comprehensive insurance do so — because they judge they are less likely to become sick and hope to use the tax-advantaged savings for other purposes — the cost of the comprehensive insurance needed by the majority of Americans will increase. Comprehensive insurance will become less affordable for both employers and individuals, and the cost to the government for subsidies for low-income households will rise.

Thus, the ultimate cost of allowing Medical Savings Accounts, with or without employer mandates, is likely to be fewer benefits with higher co-payments in comprehensive insurance plans used by middle- and lower-income families. In addition, in the absence of an employer mandate, a lower proportion of the population is likely to be covered by adequate health insurance — since the increased cost of comprehensive insurance would likely lead some employers to drop insurance coverage, and a scale-back of subsidies would probably cause some low-income families to fail to purchase health insurance.

August 17, 1994

Order Form

(Please print)

Name _____

Organization _____

Address _____

City _____ State _____ Zip Code _____

Phone Number ( ) _____

Qty	Title	Price Each	Total
	Warning: Inadequate Low-Income Subsidy Design Can Cause Problems for Health Care Reform	$12.00	
	Warning: Inadequate Low-Income Subsidy Design Can Cause Problems for Health Care Reform --- Summary	$3.00	
	Comprehensive Subscription (see below)	$40	
	Basic Subscription (see below)	$25	
	In the District of Columbia, add 6% for sales tax (If tax exempt, include copy of certificate)		
		TOTAL	

ALL ORDERS MUST BE PREPAID

SUBSCRIPTIONS:

Comprehensive Package- $40 for a one-year subscription. Includes all poverty and income reports, all budget analysis, and all reports and analyses on all three additional topics listed below.

Basic Package - $25 for a one-year subscription. Includes all poverty and income reports and analyses and all budget analyses. Plus all reports and analyses on one of the following:

(check one)

_____ labor issues, including employment, unemployment insurance, minimum wage

_____ hunger and welfare issues, including food, nutrition, and health programs

_____ state fiscal policy issues, including state budget and tax issues

Send this form and payment to:

Publications Service
Center on Budget and Policy Priorities
777 North Capitol Street, NE, Suite 705
Washington, DC 20002
***Tele*: (202) 408-1080 *Fax*: (202) 408-1056**
HandsNet #HN0026