CENTER ON BUDGET AND POLICY PRIORITIES

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To:	Melanne Verveer
FAX NUMBER:	456-6244
FROM:	Bob Greenstein
REGARDING:	Medical Savings Accounts
DATE:	June 17, 1996
NUMBER OF PAGES: (including cover sheet)	12

Comments:

To: Melanne Verveer

From: Bob Greenstein

Subject: Medical Savings Accounts

Date: June 17, 1996

I'm concerned about the potential for a deal on MSAs that, over time, could cause damage to health care coverage by making conventional (i.e., non-MSA) insurance considerably more expensive — and thereby making it unaffordable for more Americans.

I'm enclosing a short piece we did last week explaining that the MSA compromise that Republicans worked out last week is not anything close to a limited demonstration project and poses serious dangers. (We don't have information about changes that have been made over the weekend.) I'm also enclosing an earlier piece about significant problems the Republican MSA proposal raises.

CENTER ON BUDGET AND POLICY PRIORITIES

June 12, 1996

MSA PROPOSAL IS A PHASE-IN, NOT A DEMONSTRATION

The MSA compromise agreed upon by House and Senate Republicans is not a carefully crafted test of the feasibility of MSAs. Rather it is a not-so-subtle phase-in of MSA usage. The proposal immediately allows all small businesses with fewer than 50 employees and all self-employed persons to use MSAs in conjunction with high-deductible health insurance policies. This reportedly would encompass 25 million to 40 million workers. An evaluation would be due on January 1, 1999. After January 1, 2000, MSAs would be available to all employers and individuals *unless* Congress has acted to repeal or delay the expansion.

This type of "demonstration" creates conditions that virtually guarantee continuation and expansion of MSAs. With such a large number of workers eligible to participate, a sizable, entrenched constituency of healthy individuals who benefit financially from MSAs and vendors who profit from MSAs will quickly develop and push hard for their continuation. In addition, the provisions for an independent evaluation are a sham. Since *all* small businesses and self-employed workers will be eligible to participate, no valid comparison of the behavior of these segments of the insurance market with and without the potential to offer MSAs can be made. Furthermore, the timing of the evaluation is designed to produce a finding favorable to MSA policy; submission of the study to Congress is due long before adverse selection in the insurance market or problems affecting healthy participants who subsequently become ill could possibly be expected to develop.

* * * * *

The Republican proposal would create a fact-on-the-ground that Congress would have great difficulty reversing before January 1, 2000, no matter what evidence was developing of adverse effects.

- Such widespread initial use of MSAs will create a constituency of currently healthy people who feel they are benefiting financially from MSAs.

- A nationwide "demonstration" will encourage vendors providing services to employers and MSA holders to develop into a significant, self-interested lobby in favor of perpetuating MSAs.

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- In addition, attempts to repeal MSA policy after three years would run afoul of awkward transition issues.

MSAs are known to benefit healthy people, who ultimately can keep funds not spent on medical care; approximately three-quarters of all Americans have little health care costs in any given year and could feel they benefit from retaining MSA funds. These "winners" would likely form a vocal constituency against repeal — just as do the beneficiaries of any tax break. This is likely to be the case despite the strong evidence that some current winners will become long-term losers as a result of subsequent health problems. Nevertheless, proponents of MSAs will be able to claim that it would be more practical to extend MSAs to everyone than to risk antagonizing small business employees and self-employed persons who already would be using MSAs.

Proponents of MSAs claim that a whole new industry will develop to track and verify eligible MSA expenditures through "smart cards" and other technological innovations, relieving employers of that burden. Moreover, various new banking and financial sector products to hold and invest MSA funds are certain to emerge. As such industries develop, a powerful lobby against repeal of MSAs will be born. This lobby will have a self-interest in the continuation of MSAs regardless of their effect on the health insurance market or their impact on families who face significant health care costs.

Furthermore, with MSA usage widespread rather than limited to a controlled demonstration, transition issues become more complex. There will be no possibility of obtaining prior agreement — as would be common in an experimental design — to assure that people participating in MSAs will be made whole if the experimental treatment is stopped. For example, there would be no way to guarantee that self-employed people who switched to a high-deductible plan with an MSA will be entitled to re-purchase a more comprehensive insurance policy, even if they develop health problems in the interim. Nor could small employers be guaranteed their former conventional coverage at reasonable cost.

In addition, there are issues of what would happen to funds on deposit in MSA accounts if the policy was not continued. Alternatives such as allowing rollovers into IRAs, allowing withdrawals free of penalty, or requiring immediate dissolution and payment of taxes would be viewed as equally unfair. The larger the number of people who would be affected by those decisions, the harder it would be to find an equitable and affordable solution.

The issues of entrenched constituencies and transition problems may never be faced, however, because Congress will not have valid, independent information on which it determine whether MSAs should be extended to all Americans. In the absence of such information, the extension is likely to be automatic.

- The nationwide eligibility for MSAs proposed by the Republicans will not provide the type of information necessary to evaluate the policy. Since *all* small businesses and self-employed workers will be eligible to participate, no valid comparison can be made of the behavior of these segments of the market with and without the option to offer MSAs.

- The time frames specified in the Republican compromise are far too short to allow full evaluation of the impact of MSAs. They virtually guarantee a finding favorable to continuation and expansion of MSA policy.

The health insurance market and the provision of health care is expected to change rapidly over the next few years in response to the expansion of managed care; it may change further in response to alterations in Medicaid and Medicare. Thus a comparison of the behavior of insurance markets and health care usage before and after the introduction of MSAs will be of little use. The best chance of obtaining accurate information on the effects of MSA policy would be to establish randomly assigned experimental and control populations with and without access to MSAs in a defined geographic area. Clearly, a nationwide "demonstration" is the antithesis of such a design and will not be able to disentangle the effects of MSAs from the effects of other changes taking place at the same time.

The timing of the evaluation also mitigates against valid results. The MSA provisions in the bill are effective beginning in calendar year 1997. By January 1, 1999 an independent organization would be required to submit a study to Congress evaluating the impact of MSAs on the insurance market, health costs, use of preventive care, and other issues. That time frame means that MSAs will be in effect a scant two years before the evaluation must be completed and submitted to Congress. This assures that few significant adverse effects will reported upon, because they will not have had time to develop.

MSA usage is unlikely to be widespread until at least the second year after enactment, because it will take time for employers' current insurance contracts to expire and for new insurance and financial products to emerge and become publicized. Thus the very soonest any first round adjustments to insurance markets might develop, in response to one full year of experience offering high-deductible policies in conjunction with MSAs, would be the end of the second year after implementation. Such first-year adjustments are likely to be minor compared to long-term changes, particularly if insurance companies are mindful of the evaluation that is taking place. Yet the only information that Congress will receive is the evaluation due as the second year of operation is completed. Thus the go/no-go decision Congress must make before January 1, 2000 will not be informed by valid information on how MSAs are likely to affect the insurance market over the long term.

CENTER ON BUDGET AND POLICY PRIORITIES

Revised April 26, 1996

MSA PROVISION IN HEALTH CARE REFORM BILL CREATES TAX SHELTER AND CASTS DOUBT ON EXPANSION OF INSURANCE COVERAGE

by Iris J. Lav

The main purpose of the health care reform bill is to extend health insurance coverage to some people who currently cannot obtain it. For a number of reasons, inclusion of a Medical Savings Account (MSA) provision in the bill could make it more difficult and less affordable for employers to offer adequate health insurance to employees most in need of it — potentially undermining the basic purpose of the legislation.

- The MSA provisions approved by the House of Representatives would create new tax shelter opportunities. Under these provisions, use of an MSA to accumulate funds for purposes other than medical costs would be highly advantageous to substantial numbers of higher-income taxpayers. As shown below, a taxpayer in the 36 percent bracket could increase the value of his savings by 20 percent to 30 percent by placing funds in an MSA and then withdrawing them for purposes other than medical care, rather than by depositing the funds in a regular savings account.

- Healthier employees would be most likely to choose MSAs over conventional insurance plans. These healthier employees would hope to keep and use their unspent, tax-advantaged MSA deposits for other purposes.

- Because a number of healthier employees would no longer be in conventional insurance plans, the people served by the conventional plans would tend to be less healthy on average. This would raise the cost to employers of providing such plans and could lead some employers to cease offering conventional insurance coverage.

- Low- and moderate-income employees would receive little or no tax advantage from using MSAs because they either do not pay income taxes or pay taxes at much lower rates. In addition, low- and moderate-income employees rarely have the resources to pay large unplanned out-of-pocket health care costs; thus, they are less likely to be able to take the risk of using a high-deductible plan with an MSA. Furthermore, low- and moderate-income employees would be those harmed the most if the self-selection of healthy people into MSAs resulted in employers dropping

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Robert Greenstein, Executive Director

comprehensive insurance coverage or imposing higher costs for employees' shares of insurance premiums.

- In short, proposals to use the tax code to grant substantial advantages to high-deductible insurance plans with MSAs as compared to conventional insurance are likely to result in fewer, rather than more, people remaining adequately insured.

MSA Provisions

Under the MSA proposal in the House health care reform bill, 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 high-deductible health plan. Taxpayer (or their employers) may contribute the amount of the deductible to the MSA, up to a maximum of $2,000 for an individual and $4,000 for a family.

Amounts that individuals contribute to MSAs may be deducted on their 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 made by employers on behalf of individuals (presumably even if salaries are reduced to allow the contributions to be made), the amounts contributed are not counted as wages or salary for purposes of computing income, FICA (Social Security and Medicare), or unemployment taxes. The interest earned on amounts accumulated in MSA accounts also is exempt from taxation.

Taxpayers may use the funds in their MSAs to pay medical expenses. This includes expenses that count toward meeting the deductible of their health insurance plan as well as expenses for medical services such as eyeglasses or dental care that may not be covered under their plan. Premiums for long-term care insurance also may be paid from the account. Funds withdrawn from MSAs that are used to pay permitted types of medical expenses are never taxed.

If funds are withdrawn from the MSA for other purposes, they are subject to income taxes as ordinary income in the year they are withdrawn. If the taxpayer is below age 59 ½, amounts withdrawn for other purposes also are subject to a 10 percent penalty. After the taxpayer attains age 59 ½, funds may be withdrawn from MSAs for any purpose without incurring a penalty.

MSAs Create a Tax Shelter

For higher-income taxpayers who anticipate remaining healthy, MSAs represent a new, tax-advantaged way to accumulate savings. Because contributions made by or through an employer are permanently exempt from Social Security and Medicare payroll taxes and are exempt from income taxes until withdrawn, and because the interest earned on amounts remaining in the MSA is allowed to compound without yearly taxation, the 10 percent penalty on withdrawals for purposes other than medical expenses is not sufficient to prevent MSAs from becoming a tax shelter.[1] Even after the penalty is paid, the after-tax return to savings in an MSA would under many circumstances exceed the return to conventional savings.[2]

Figure 1
Value of $3,000 of Gross Income Saved in MSA Compared with Current-Law Savings
Taxpayer in 36 Percent Federal Income Tax Bracket

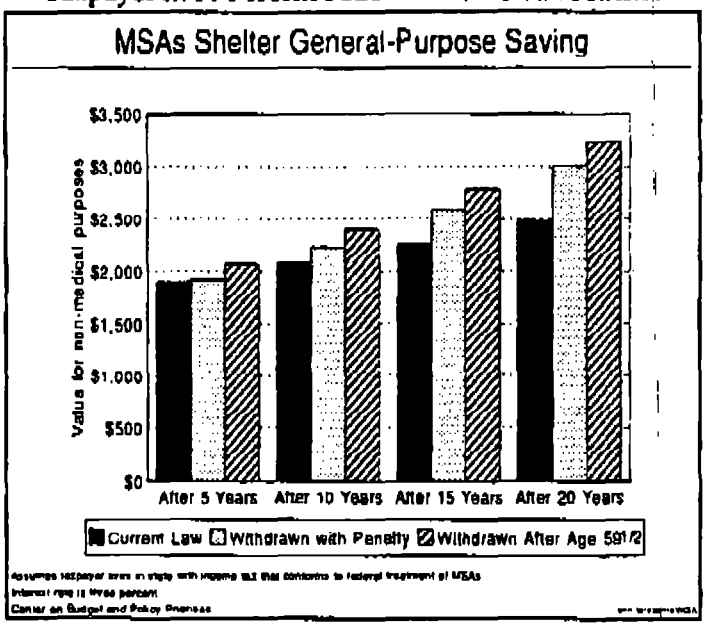

Figure 1 shows the difference to a taxpayer in the 36 percent federal income tax bracket between saving $3,000 of gross earnings under current law and saving the same amount in an MSA. Taxpayers in the 36 percent tax bracket generally have a gross income above $130,000 a year. In each case, the deposit is held at a three percent rate of interest. Under current law, the taxpayer would have $1,742 in after-tax funds to deposit in a conventional savings account. (The $3,000 gross earnings would be reduced by a 36 percent income tax, an effective state income tax of 4.5 percent after accounting for deductibility against federal taxes, and a 1.45 percent Medicare tax.

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[1] For Individual Retirement Account deposits, only income tax is deferred. FICA taxes must be paid on earnings deposited in IRAs.

[2] Some wealthier taxpayers could benefit from the higher return to savings in an MSA even if they incur health care costs. Under the House bill, taxpayers who can afford to do so would be free to leave funds on deposit in their MSAs — reaping the special tax advantages — and pay their medical expenses from other funds. Unlike some previously proposed versions of MSA legislation, the House-passed provision does not require withdrawals from an MSA when medical expenses are incurred.

Taking away 41.95% of $3,000 leaves $1,742.)[3] If those funds remain on deposit for 10 years with interest taxed yearly, they would grow to $2,079. By contrast, under the MSA provision, the taxpayer would deposit the entire $3,000 and interest would compound free of tax. After 10 years, the account would hold $4,032. The taxpayer could withdraw the funds for purposes other than medical care, pay income tax and the 10 percent penalty on the withdrawn amounts, and have $2,236 remaining.

In other words, after 10 years the value to the taxpayer of the funds saved in the MSA would exceed the value of conventionally-saved funds by 7.6%, even though a penalty was assessed for use of the funds for purposes other than medical care. If during those 10 years the taxpayer attained age 59 ½, no penalty would be assessed and the value to the taxpayer of the MSA savings would exceed the value of the conventional savings by more than 15 percent.

As shown in Figure 1, the differential value of the MSA savings grows with the length of the holding period. After 20 years, an MSA withdrawal with penalty exceeds the value of conventional savings by 21 percent, while an MSA withdrawal after age 59 ½ would exceed the value of conventional savings by 30 percent.[4]

It may be noted that the cost to the Treasury in foregone tax revenues also would increase over time, as growing amounts of savings are likely to be placed in MSAs and sheltered from taxation. According to the Joint Committee on Taxation, the cost of the MSA approved by the House grows steadily from $134 million in 1997 to $399 million in 2002. In years subsequent to 2002, the cost would continue to rise.

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[3] The 36 percent bracket applies to individuals with taxable incomes over $118,000 and married filers with taxable incomes over $144,000. Taxable income is gross income minus 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. A taxpayer in this income tax bracket has income that far exceeds the maximum earnings on which Social Security payroll taxes must be paid. As a result, the taxpayer would receive an exemption — through using an MSA — only from the Medicare tax, which is paid on all earnings. 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 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.

[4] Similar differentials would apply to many taxpayers in the 28 percent federal income tax bracket, many of whom would receive an exemption from Social Security as well as Medicare payroll taxes.

Moderate-Income Families Choosing MSAs Risk Unaffordable Medical Expenses

Some moderate-income families that use MSAs with a high-deductible insurance plan may not have sufficient resources to cover their exposure to health care costs. Consider, for example, the Jones family, which carries an 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 on January 1. Mr. Jones' employer makes deposits to his MSA of $110 a month during the year (reflecting the difference between the employer's premium for the high-deductible plan and the premium for conventional insurance).* By early November, the family had received an additional $1,100 into the account from the monthly deposits, and had paid $1,500 from the account for various medical bills that counted toward the insurance plan's deductible, leaving $600 remaining in the MSA.

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 insurance, but it was a permitted use of MSA funds. The Jones' decided to use the remaining $600 in the MSA to pay a portion of the dental bill, adding $400 from their money market account. Then in late-November, Mr. Jones became ill and required emergency surgery. The family withdrew an additional $1,500 from their money market fund to cover their remaining $1,500 deductible for that year. The family was left with $3,100 remaining in the money market fund.

In early January, as Mr. Jones prepared to resume work, complications developed and further surgery was required. Only $220 was available in the MSA (from the November and December deposits) 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 $2,780 deductible not covered by the MSA reduced the family's money-market savings to $320. As a result, the family did not have sufficient funds to meet living expenses during the unpaid leave.

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* The American Academy of Actuaries estimates the employer cost of the annual premium for a family plan with a $3,000 deductible would be between $3,900 and $4,050, while the employer cost for a $200 deductible plan would be $5,250. This examples uses a difference of $1,320, reflecting the higher end of the estimate.

Heavy Use of MSAs by Healthy Taxpayers Could Undermine Insurance

The example described above illustrates why using MSAs in conjunction with a high-deductible insurance plan could be highly popular with taxpayers who anticipate that they will remain in good health. This is particularly true for higher-income taxpayers who can afford the risk of paying some out-of-pocket health expenses if a family member becomes ill and the resulting insurance deductibles and co-payments exceed the amounts in the taxpayers' MSAs. (See box above for an example of the risk to moderate-income families). For these healthier, higher-income people, a high-deductible plan with an employer deposit to an MSA is the best of both worlds — it provides both a reservoir of funds for potential medical costs and tax-sheltered savings.

But if healthier people choose high-deductible insurance with MSAs in the hope of keeping their unspent deposits, 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 average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise.

Consider an example in which there are five people with health insurance provided by one company.[5] Together, the five people have $15,000 a year in medical expenses. The insurance company charges the group of five a premium of $14,000 a year for insurance, out of which it reimburses the group for approximately $11,000 in medical expenses. Note that in this example the result is the same whether the medical expenses of the five people are distributed as in column A or column B below. So long as the five people remain in a group, the employer would pay an average of $2,800 on behalf of each employee.

Hypothetical Distributions of Medical Expenses		
	Example A	Example B
Person 1	$3,000	$600
Person 2	3,000	600
Person 3	3,000	1,000
Person 4	3,000	6,400
Person 5	3,000	6,400
Total Medical Expenses	$15,000	$15,000

[5] The following example is not based on actuarial analysis. The numbers used are for illustration only.

Now assume that the medical expenses are distributed as in column B and that Persons 1 through 3 chose a high-deductible plan with an MSA. The employer pays a lower average premium for each of them and also deposits $2,000 in an MSA for each of them. Of the $6,000 deposited in the MSAs, only $2,200 (the sum of the expenses for Persons 1 through 3) would be used for medical expenses. The remaining $3,800 would become savings for Persons 1 through 3. (Some of that amount might or might not be used to pay medical costs in a subsequent year.)

Persons 4 and 5 did not choose a high-deductible plan because a high-deductible plan would result in higher out-of-pocket costs for them. But when the employer tries to purchase conventional insurance for a group consisting of just these two individuals who have average medical costs of $6,400 a year, the premiums exceed $6,000 per person. The employer cannot continue to offer comprehensive insurance at that price.

This simple example illustrates how MSAs disrupt the principle of insurance. MSAs make it advantageous for healthy people to leave the insurance pool, which in turn removes from the pool funds currently available to help subsidize people whose medical costs exceed the premiums they pay. If MSA users remain healthier than average, they can use the excess funds in their MSAs for their retirement, or for education, vacations, or car purchases; these excess funds will *not stay in the health care system*. The result is that the price of a basic comprehensive health insurance plan will be higher than it would be if a normal cross-section of people of varying health statuses participated in a comprehensive insurance plan.

The American Academy of Actuaries has noted, "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."[6] One could add that the greatest burden is likely to be borne by low- and moderate-income families who would get little or no tax benefits from MSAs, cannot afford the risk of large uncovered medical expenses, and would face higher costs for comprehensive insurance if MSAs spread broadly.

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

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MEMORANDUM

From: Jim Mays

Subject: Relation of Catastrophic Plan Deductible Level to Change from Average Premium

Date: July 17, 1996

Based on the American Academy of Actuaries's Analysis of MSAs, it is reasonable to use .5 to approximate the relationship between catastrophic plan deductible levels and the difference in the premium compared to typical "traditional" coverage.

An increase in the deductible does not produce a commensurate decrease in the catastrophic premium because the insurer is not saving the equivalent of the deductible amount. This is because most individuals do not incur costs as large as the deductible. Therefore, a $100 increase in the deductible, if only saved on the 40% who have spent this much money, only has an expected value of $40. Allowing a tax subsidy on the entire extra $100 deductible would be expanding the tax subsidy substantially.

If it is accepted that something less than the full deductible should be tax-subsidized, one method of estimating an appropriate amount is to look at the Academy of Actuaries' analysis of the relationship between catastrophic deductibles and premium differentials (Table II-4A, "Medical Savings Accounts: Cost Implications and Design Issues", American Academy of Actuaries, Public Policy Monograph 1, May 1995, p.8). While this relationship exhibits the expected slope (a declining ratio of premium differential to deductible as the deductible increases), a value of .5 would be reasonable in the range of deductibles under discussion.

/a/m

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EMBARGOED

Not for release before 3 p.m., (CDT), Tuesday, June 4.

MEDICAL SAVINGS ACCOUNTS FOUND INEFFECTIVE IN RESTRAINING HEALTH SPENDING

SANTA MONICA, Calif., June 5 -- Tax-exempt Medical Savings Accounts would have little or no impact on overall health care spending, according to a new RAND study. But MSAs could prove attractive to some sick and lower income people as well as to the healthy and well-to-do.

The report, appearing in today's issue of the Journal of the American Medical Association, is by researchers Emmett B. Keeler, Jesse D. Malkin, Dana P. Goldman and Joan L. Buchanan. It implies that the arguments for and against MSAs have been overstated and oversimplified.

The disagreements over MSAs now threaten a bipartisan agreement on other, modest health insurance reforms. In March, the House of Representatives passed a bill containing a provision for tax-exempt MSAs. In April, the Senate approved the comparable Kassebaum-Kennedy bill, but only after defeating an MSA amendment. The bills are now awaiting action by a conference committee. The White House has threatened to veto any bill that includes MSAs.

The MSA concept is that individuals covered only by high-deductible, catastrophic health insurance ($1500 for individuals and $3000 for families in the House bill) will maintain special accounts

for use in paying routine medical expenses. Contributions to the account could be provided either by the individual or by an employer. The House bill provides tax exemption for these contributions.

Supporters contend that MSAs will curb the growth of national health care expenditures because consumers will be more cost conscious when spending their own money than they are when an insurance plan picks up the tab. But the proposed legislation would create a weak incentive to economize at best, the authors concluded, because the required deductible is not very high and the tax deduction for MSAs effectively subsidizes health care spending.

The researchers studied the proposed legislation in two steps. First, they used an updated model of spending on health care based on the earlier RAND Health Insurance Experiment, a randomized and controlled trial of a nationally representative set of families, to simulate the change in spending patterns that would occur if all non-elderly Americans switch to MSAs. The result was a spending decline ranging from zero for an account funded by the individual to six percent for employer-funded accounts.

Next, and more realistically, they analyzed the change in health spending that would occur if only those people who expect to benefit by doing so switch to MSAs (based on a computer model of how people select health insurance plans). Here the change in U.S. health care spending ranged from an increase of one percent to a decline of two percent, depending on assumptions about the reaction of people and employers to the legislation.

"The reason why the House bill's MSA does so little to discourage health care utilization is that account holders' out-of-pocket costs are relatively low after factoring in the tax exemption," explains lead researcher Keeler. "In fact, for the sickest and healthiest people, it actually provides less spending discipline than current fee-for-service plans."

While the proposed MSAs seem unlikely to produce significant spending reductions, the current system of exempting employer-paid premiums from income and social security taxes also favors employees in higher tax brackets and encourages more health care spending. MSAs give the same tax break to consumers who pay for services directly. Individual MSAs also extend the tax break to people who aren't covered by their employers.

The researchers found that MSAs of the House-endorsed variety would not necessarily skew the insurance market by attracting only the rich and the healthy. The analysis indicates that the median user would be only slightly wealthier than people in conventional insurance plans and HMOs because poor healthy people would be attracted to the low premiums. MSAs also would be attractive to seriously ill people in high tax brackets whose tax savings outweigh their increased out-of-pocket costs.

The study showed that if the deductible is pegged at a higher level, for example $2500 per individual, MSAs would be chosen mainly by the healthy.

The analysis was conducted by RAND's Center for the Study of Employee Health Benefits. It focused on MSAs designed for the non-elderly and did not assess proposals to link MSAs with Medicare reform.

RAND is a private, not-for-profit organization that helps improve public policy through research and analysis.

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Special Communication

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E*M*B*A*R*G*O*E*D

Not for release before
3 p.m., CDT, Tuesday, June 4.

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Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?

Emmett B. Keeler, PhD; Jesse D. Malkin; Dana P. Goldman, PhD; Joan L. Buchanan, PhD

Objective.—To understand how medical savings account (MSA) legislation for the nonelderly would affect health care costs.

Design.—Economic policy evaluation based on the RAND Health Expenditures Simulation Model.

Setting.—National probability sample of nonelderly noninstitutionalized households.

Participants.—Persons in 23 157 sampled households from the 1993 Current Population Survey.

Interventions.—Medical savings account legislation would allow all Americans who are covered only by a catastrophic health care plan to set up a tax-exempt account that they can use to pay medical bills not covered by their health insurance. The interventions we evaluate differ in the deductibles of the catastrophic plan and in whether the employee or employer funds the MSA.

Main Outcome Measures.—Changes in national health expenditures and net societal benefits of health care.

Results.—If all insured nonelderly Americans switched to MSAs, their health care expenditures would decline by between 0% and 13%, depending on how the MSAs are designed. However, not all nonelderly Americans would choose MSAs; taking into account selection patterns, health spending would change by +1% to −2%.

Conclusions.—Medical savings account legislation would have little impact on health care costs of Americans with employer-provided insurance. However, depending on the size of the catastrophic limit, waste from the excessive use of generously insured care could be reduced, and MSAs would be attractive to both sick and healthy people.

(*JAMA.* 1996;276:1666-1671)

AS POLICYMAKERS struggle to contain health care costs, attention has shifted to a novel form of insurance known as medical savings accounts (MSAs). The US Congress has debated 2 initiatives. One would make MSAs part of Medicare reform. The other is the focus of this article: it would let younger people establish tax-subsidized MSAs to pay out-of-pocket expenses if they are covered only by catastrophic insurance.

Under current tax law, employer-provided health insurance is excluded from personal income and thus is exempt from taxation. This system gives workers an incentive to buy insurance through their employer and to prepay health care costs through premiums, as opposed to out-of-pocket payments.[1,2] They do so by buying generous fee-for-service (FFS) policies or by purchasing care from health maintenance organizations (HMOs) that is prepaid except for minor visit fees.

The premise underlying MSA legislation is that current financing arrangements insulate Americans from the true cost of medical bills. For example, many FFS plans require patients to pay only 20% of the actual price of care. At this discounted price, patients buy some health care services they would not buy without insurance. Society, as a whole, wastes resources on this excessive care to the extent that the costs of producing it exceed what patients would be willing to pay. With fully prepaid care, the entity bearing the risk (eg, the provider or insurance company) does have an incentive to manage care to reduce costs, but this requires a management structure that interferes with traditionally private patient-physician relations and adds to administrative costs.

With an MSA, by contrast, patients pay for medical services with money they otherwise could keep. Advocates argue this would restore incentives to economize on care, so care would not have to be heavily managed.[3,4] Critics counter that MSAs would do little to reduce service use and would benefit healthy and wealthy people at the expense of the seriously ill and poor.[5,6] This article estimates the impact of MSA legislation on health care costs. Because these estimates depend on the tax treatment of contributions to the MSA, we begin by describing the proposed legislation.

STRUCTURE OF MSA LEGISLATION

Medical savings account legislation is designed to promote health care plans with tougher cost-sharing requirements. This is done by offering a deal: to qualify for a tax-subsidized MSA, consumers must be covered only by "catastrophic coverage," ie, a health insurance policy

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that pays nothing until a high deductible is met.

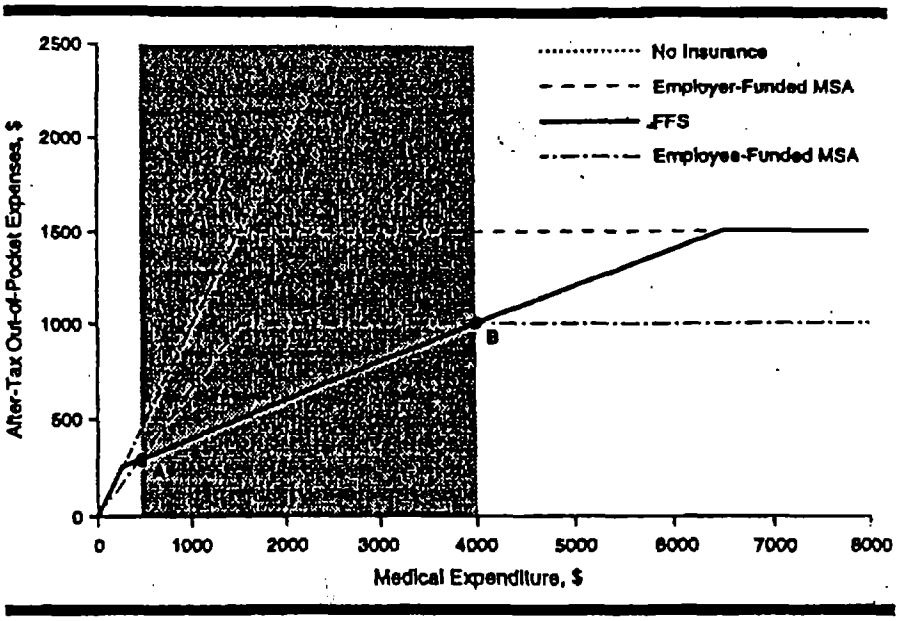
Major provisions of MSA legislation approved by the House of Representatives (HR 3103) include the following[7]: (1) the deductible on the catastrophic plan must be at least $1500 for an individual, or $3000 if the plan covers family members; (2) funds withdrawn from MSAs to pay for medical expenses would be excludable from gross income. "Medical expenses" include not just those services covered by the catastrophic insurance plan, but any service recognized by the Internal Revenue Service as a medical expense, including psychoanalysis and orthodontia, as well as medical expenses for other family members (under current law, medical expenses in excess of 7.5% of adjusted gross income are deductible; the Internal Revenue Service could use its current enforcement procedures to verify that funds withdrawn from MSAs were used for legitimate medical services, but more people would need to be checked); (3) the amount put in an MSA each year that can be deducted or excluded from income is limited; and (4) MSA funds used for nonmedical expenses would be taxed as ordinary income plus a 10% penalty on the amount withdrawn. The penalty is waived for individuals who are at least 59½ years old.

The tax implications of the MSA–catastrophic insurance package depend on who funds it. Employer contributions to the MSA are treated just like premium contributions under the current system: the money is not counted as income and is therefore exempt from federal income and Social Security payroll tax. If the employer does not fund it, the employee can elect to do so. As with an individual retirement account, an employee's contribution to an MSA is exempt from income taxes but not Social Security payroll taxes.

INCENTIVE EFFECTS OF MSAs ON USE OF CARE

The method of funding (employer or employee) has important effects on the incentive to use care. If the MSA is funded by the employer with a modest annual amount so that employees expect to use the balance only for current or future medical bills, the incentives of the employee are simply those of the catastrophic plan: 100% coinsurance up to the deductible, at which point the insurer covers all costs.

If the MSA is funded by the employee, then the after-tax coinsurance rate can be approximated by 100% minus the marginal income tax rate. For example, suppose an individual wants to keep $1500 in his MSA at the start of each year and is in a 33⅓% marginal income tax bracket. If he spends $300 on an episode of medical care and uses the MSA to pay for it, then he must pay back that $300 to the MSA at the start of the next year. At that point, he saves $100 on his taxes, so the after-tax cost of a treatment is $200, or only two thirds of the amount spent on care. In this way, employee-funded MSAs provide a tax subsidy of out-of-pocket spending.[8] Incentives are similar for employer-funded MSAs where the annual contribution is so large that in most years employees withdraw some money for other uses after paying income tax and the penalty, because, as with employee-funded MSAs, money spent on medical care goes farther than money spent on something else. In this article, we let employee-funded MSAs represent the employer MSAs with large contribution and only consider employer MSAs with modest contributions.



The relationship between medical expenditure and after-tax, out-of-pocket expenses for different insurance plans; MSA indicates medical savings account, and FFS indicates fee for service. For annual medical expenses outside the shaded region between A=$429 and B=$4000, out-of-pocket spending is greater with conventional FFS than with a $1500 deductible plan with an employee-funded MSA.

Insurance has 4 features that affect use: the deductible, the coinsurance rate, the cap on annual out-of-pocket spending (beyond which the insurer pays for everything), and tax considerations. Advocates of MSAs assume the required high deductible would impose more cost discipline on consumers than typical FFS plans. In a catastrophic plan, the deductible is the cap. While current FFS plans typically have low deductibles, they also have high caps and do not get any tax advantages for out-of-pocket spending.

The relationship between after-tax out-of-pocket spending and total medical spending for different plan types is shown in the Figure. We continue to assume the individual faces a marginal income tax rate of 33⅓%. The employee-funded MSA depicted in the Figure has a pretax deductible of $1500, but an after-tax coinsurance rate of 66⅔% (100% minus the marginal tax rate) and an after-tax cap of $1000 ($1500 × 66⅔%). In addition to the employee-funded MSA, we show 3 plans: an MSA modestly funded by the employer with an effective coinsurance rate of 100% up to a cap of $1500; a typical 1996 FFS policy with a $250 deductible, a 20% coinsurance rate above the deductible, and a cap of $1500; and no insurance. Because HMOs control utilization by means other than cost sharing, they are not included in the Figure; however, we do include an HMO plan in the simulations that follow.

The Figure shows that employer-funded MSAs require at least as high an out-of-pocket payment for every level of medical expenditure as FFS plans. Taxpayers with moderate expenses (in the shaded region defined by the points A and B where the FFS plan has the lowest out-of-pocket cost) have higher after-tax out-of-pocket expenses under employee-funded MSAs than under FFS plans, but taxpayers with low or high medical expenses do not. For people who are very healthy or very sick, a typical FFS plan is more stringent than the employee-funded MSA.

Since employee-funded MSAs would cause some people to face a higher price for health care services and others to face a lower price, there is no way to

know a priori whether people switching from FFS plans to employee-funded MSAs would increase or reduce health care spending.

PRIOR EXPERIENCE WITH MSA-LIKE PLANS

Some firms already offer plans resembling MSAs without the tax benefits, and have reported success in curtailing health care expenses. *Forbes* magazine's medical claims had been rising between 10% and 30% annually throughout the late 1980s, for example, but dropped 23% the first year after it started giving employees a bonus for not filing claims.[9] (Such bonuses have the same effect as an increase in the deductible.) Since Golden Rule Insurance Company began offering an MSA plan in 1993, its insurance premiums have not increased. These companies' experiences have been touted in the press as evidence that MSAs will reduce health care costs.[10,11] However, it is important to understand the limitations of these results:

- Savings in employers' health care expenses on premiums have been offset in part by the higher wages or bonuses needed to compensate workers for increased out-of-pocket payments. At *Forbes*, for example, employees received about $125 000 in bonuses in 1992 by not filing claims.
- The company experiments had no control groups. As a result, any other variable that changed over time is confounded with the availability of MSAs. Over the last several years, many firms that did not create MSAs have also succeeded in curtailing premium increases. In 1994, for example, Golden Rule's insurance premiums were unchanged from 1993, but nationwide, firms with 10 or more workers reduced premiums by 1.1%.[12]
- Because MSA legislation offers tax breaks, it would lead more firms to offer—and more employees to select—MSAs than under the present system. Firms and employees now using MSAs are a select group; it is unclear to what extent their experiences would carry over to the rest of the population.

METHODS

We use a behavioral simulation model based on results from the RAND Health Insurance Experiment (HIE) to estimate the change in expenditures that we can expect if all nonelderly Americans switch to MSAs. Additionally, we use a plan selection model to estimate the change in health spending if only those people who expect to benefit by doing so switch to MSAs.

The HIE studied the effects of alternative insurance plans on utilization and health. From 1975 to 1982, 3 to 5 years of expenditure and utilization data were collected from 7708 individuals who were randomly assigned to 1 of a set of simple health insurance plans in 6 sites across the country. At 1 site, families were randomized into an HMO or the simplified FFS plans.[13] As a randomized controlled trial of a nationally representative set of families, the RAND HIE enables us to overcome the limitations of the *Forbes* and Golden Rule experiments.

One possible criticism of the HIE data is its age. The management, delivery, and mix of health care services have changed dramatically since the late 1970s and early 1980s. Nonetheless, we believe human nature regarding trade-offs between money and health has not changed much. A recent health insurance experiment in China, for example, found responses to varying coinsurance for medical care similar to those seen in the RAND HIE.[14]

We have updated the model to reflect changes in health spending from the time of the HIE to 1996. Specifically, we reduced the number of hospital episodes and multiplied the costs of each episode of treatment by factors based on increases in spending from Health Care Financing Administration and National Medical Expenditure Survey data, adjusted for changes in age and insurance status.

Behavioral Simulation Model of Spending

The behavioral simulation model used in this study is based on economic theory and a statistical analysis of HIE claims grouped into episodes of treatment. Cost sharing had larger effects on the number of illness episodes that patients decided to have treated than it did on the cost of each episode.[15] The model derives an expected rate of episodes of treatment if spending were fully covered for each family based on their personal characteristics. Random draws generate the actual number of episodes for any given year conditional on the expected rate, and the cost of those episodes. Families proceed through the year, and their remaining cost-sharing requirements are computed after each episode based on spending up to that time. These requirements (coinsurance and amount of deductible or out-of-pocket dollars before the limit) act to prevent treatment of some episodes that would have been treated with free care, and slightly reduce the cost of treated episodes. The model of response to cost sharing has been tested extensively in its original version[15,16] and on more recent data.[17]

All model estimates are based on the 1993 Current Population Survey. The marginal tax rate is assumed to be 15% for single-person households with income less than $24 750, for single-parent families with income below $34 880, and for 2-parent families with income less than $42 940, and 33⅓% for those with higher incomes. For employer contributions to MSAs or health premiums that are exempt from Social Security and federal and state income taxes, the marginal tax rate is assumed to be 32% for families in the lower tax bracket and 45% for the others.

Model of Health Plan Selection

To understand the changes we might see in response to MSA legislation, we modeled a health insurance market in which 3 types of plans are offered. All plans cover the same broad set of services; they differ only in terms of the cost-sharing provisions and the degree to which care is managed:

- The first plan is a typical 1996 FFS policy, with a $250 deductible, a 20% coinsurance rate above the deductible, and a cap of $1500.[18] It includes the typical cost-control measures of today's FFS plans.
- The second plan is the MSA–catastrophic insurance option. We consider 2 different deductibles; for each, we evaluate both the employer-funded and employee-funded MSA plan. The low deductible has a $1500 individual deductible and $3000 family deductible, as in HR 3103. The high deductible has a $2500 individual deductible and $5000 family deductible as in legislation (S 1249) proposed by Sen Bill Frist (R, Tenn). The companies offering these plans would presumably manage hospitalizations, but not less expensive care purchased out-of-pocket.
- The third plan is a typical staff-model HMO. Based on results from the HIE, we assume that if their members were equally healthy, such HMOs have costs similar to the baseline FFS plan described above. Our selection model focuses on expected use of services and costs, but individuals also consider such factors as control over choice of physician and over amount of care when choosing a health care plan.[19] Insofar as FFS and MSA–catastrophic insurance plans rank better than HMOs on these nonfinancial criteria, patients may choose such plans over HMOs despite higher expected total costs. As a result, we assume in our selection simulations that $1 of HMO care is worth $0.90 of FFS care to its recipients.

Premiums for individual workers and workers with families for each plan are calculated separately. They are community-rated, that is, calculated from the average amount the insurance company

Table 1.—Results of Each Plan When All Nonelderly Noninstitutionalized Americans Choose It (Family Averages)*

Plan	Average Spending, $	Change in Spending, %†	Change in Tax Cost, $†‡	Change in Value to Consumer, $†	Change in Value to Society, $†	Premium, $§	Waste, $‖	After-Tax Out-of-Pocket, $	Risk, $¶	% Over the Cap
FFS	6414	...	...	...	...	4904	579	1149	170	10
HMO#	5414	...	492	6	−486	6226	1062	0	0	0
MSA										
Employee, $3000	5437	0	130	114	−16	4102	710	1441	169	37
Employer, $3000	5085	−6	0	53	53	3790	570	1770	271	33
Employee, $5000	5061	−7	−139	−17	122	3030	427	1867	444	23
Employer, $5000	4729	−13	0	−60	−60	2618	342	2279	739	20

*FFS indicates fee for service; HMO, health maintenance organization; and MSA, medical savings account.
†Relative to FFS.
‡The estimated tax cost of FFS is $1825 per family.
§1.15×(expected insurance payments), ie, assumes administrative expense is 15%.
‖Difference between costs of care and what people would pay out-of-pocket for it.
¶What people would pay to avoid the uncertainty of out-of-pocket payments.
#Assumes $1 of HMO care is worth $0.90 of FFS care.

would pay to each insurance unit if everyone were on that plan, plus an additional 15% for costs of administration.[9] We assume the employer gives an amount of money to each employee with individual coverage and a different amount of money to each employee with a family that is independent of an insurance choice. The amount is divided between health insurance premiums, wages, and MSA contributions. If employer-funded MSAs have catastrophic plans whose premiums are lower than the FFS premium, the employer puts the difference into the MSA. With employee-funded MSAs, the difference is given in wages. Because the premium is higher for the HMO, wages of those choosing it are reduced by the amount of difference from the FFS plan.

In choosing health insurance, employees are concerned with more than just their premium and out-of-pocket expenditures. In addition to expected out-of-pocket spending, the model computes the value to the family of the health care received, waste, and risk. The value of care is the most that a family would pay out-of-pocket for it; insured people may buy care whose value to them is less than the total spending (insurance payments plus out-of-pocket spending). If they do, the waste is the difference between total spending and what they would have paid out-of-pocket (value). Risk is the amount a family would pay to avoid the uncertainty of out-of-pocket payments. People are assumed to choose the plan with the highest expected net after-tax value, which equals the value of health care they expect to buy minus out-of-pocket expenditures and risk plus any change in wages. In addition, we collect measures of tax cost and net societal benefit for each plan. Tax costs to the government include the foregone taxes on employer-paid premiums and on contributions to the MSA. Net societal benefit is the value of the plan to the consumer minus the tax cost. (Model details are available on request from the authors.)

RESULTS

Table 1 shows per family expenditures and other results when the entire sample is assigned to each of the different plans. We find that the change in spending is sensitive to the design of the MSA. If everyone switched from FFS and HMO plans to the low-deductible, employee-funded MSA, health care expenditures would not change appreciably. By contrast, if everyone switched to MSAs with high deductibles and/or those funded by employers, health care expenditures would decline by between 6% and 13%. Relative results for single workers (not shown) are almost identical.

The employee-funded MSA with a low deductible generates spending similar to the FFS plan. This reflects the competing effects of the high deductible and the low cap. After families exceed the cap, they face no cost sharing for the rest of the year, and so consume more services (some of which are wasteful). Even though 37% of families exceed the cap for this MSA vs only 10% with the FFS plan, the effects are balanced by the disincentives to use care for MSA families in the shaded area of the Figure. The higher-deductible plans and especially the employer-funded, high-deductible plan are more stringent than FFS, and so reduce waste from overuse of services, but at the same time they increase the financial risk of large out-of-pocket payments.

The tax costs of the HMO are much higher than of the FFS plan because the out-of-pocket costs have been transferred to the premium, which is free of both income and Social Security taxes. The tax costs of employer-funded MSAs are the same as FFS plans because we assume that the savings from lower premiums on catastrophic insurance are put into MSAs with the same tax treatment as premiums. The tax costs of employee-funded MSAs depend on average out-of-pocket spending, which is tax-subsidized, but at a lower rate than premiums. These tax costs are savings to the consumer, but must be paid for by society.

Of course, not everyone will switch to an MSA simply because MSA legislation is enacted. The legislation's effect on national health expenditures will be diluted by the millions of Americans who retain their current coverage. We simulated consumer plan choice to get an overall savings estimate. Table 2 summarizes the impact of MSA legislation on family plan choice for low-deductible and high-deductible plans. We find that if plan choice is considered, total health spending changes by between −2% ([$5286–$5414]/$5414=−2%) and +1% compared with the FFS-HMO estimate of $5414, depending on the size of the deductible.

The reduction in aggregate health spending is small because upper-income sick people would switch into employee-funded MSAs. These plans are attractive because they have low after-tax caps and are therefore more generous than FFS plans for such people. These sick people affect overall spending out of proportion to their numbers, because their expected spending is almost double the average.

The results in Table 2 are based on several assumptions: $1 of HMO care is valued equally to $0.90 of unmanaged care; both employer- and employee-funded MSAs are offered to employees; and funds in MSAs are valued equally to fully fungible money. We tested the sensitivity of the results to these assumptions. If HMO care is valued the same as FFS care, compared with FFS, aggregate health care spending declines by 2%. If the only MSAs offered to employees are employer-funded, spending declines by 2%, and if people value MSA funds at only 75% of money that is fully liquid, spending increases by 2%. The assumptions have a large impact on

Table 2.—Plan Choice and Resultant Change in Health Care Spending*

Plan	% Choosing	Their Total Spending, $	Their Family Income, $
	$3000 Family Deductible for MSA		
FFS	13	3888	26 000
HMO	31	6321	43 000
Employee-funded MSA	22	9679	66 000
Employer-funded MSA	35	2645	29 000
Total	100	5442†	41 000
	$5000 Family Deductible for MSA		
FFS	10	8732	25 000
HMO	42	7265	47 000
Employee-funded MSA	8	8073	71 000
Employer-funded MSA	40	1770	33 000
Total	100	5266†	41 000

*FFS indicates fee for service; HMO, health maintenance organization; and MSA, medical savings account.
†Overall average spending in current FFS was $5414.

which plans get selected, but little impact on aggregate spending.

Most analyses of MSAs to date have implied that healthy people will select MSAs while sick people retain their current coverage.[20] This argument follows previous research showing that high-risk individuals are more likely to purchase generous coverage than low-risk individuals when offered a choice among plans.[21,22] If premiums are based on the payment experience of the plan unadjusted for age and disability, such a selection pattern could lead to a so-called death spiral of rising premiums for HMO and FFS policies, eventually driving them from the market altogether.

Consumers choosing the stringent employer-funded MSAs are healthier than average (shown by their low health expenditures in Table 2), but those choosing employee-funded MSAs are sicker than average and both are in the same catastrophic insurance plan. So, how do people choosing MSAs, on average, compare with people retaining traditional HMO and FFS coverage?

The answer depends on the size of the deductible. In the low-deductible plan, people choosing MSAs have average health expenditures of $5314 (=[(22% × $9679) + (35% × $2645)]/57%), as compared with $5609 for people choosing HMO and FFS policies—a difference of only 5%. In the high-deductible plan, by contrast, per capita health expenditures of MSA users are only $2840 vs $7549 for people in conventional HMO and FFS plans. Such a large discrepancy makes adverse selection a legitimate concern.

Some have worried that people with high incomes would choose MSAs while people with low incomes would retain their current coverage.[5] Our model does not support this hypothesis. People using employee-funded MSAs have higher incomes than average, but the larger group of MSA users—those choosing employer-funded MSAs—have below-average incomes. Lower-income people are more attracted to employer-funded MSAs because the relief from Social Security taxes is more important to them. (The Old-Age, Survivors and Disability Insurance portion of the Social Security payroll tax is 12.4% of an employee's annual gross wages up to $62 700.) The median MSA user would be only slightly richer than people in conventional FFS and HMO plans, which already contain substantial tax breaks.

COMMENT

In this article, we used a simulation model to calculate the impact of MSA legislation on health care spending and plan choice. If MSA legislation causes all Americans to switch from FFS and HMO plans to MSAs, then health spending would decline by between 0% and 13%. But because people would switch plans selectively, passing MSA legislation would reduce health spending by 2% or less. How robust are these results on spending?

All models simplify reality, and ours is no exception. Six important assumptions are noteworthy. The first 5 suggest that our model overstates cost savings, while the sixth implies that it understates them:

- First, the model assumes people realize that spending money from their MSA prevents them from future health spending or cashing it out with a penalty. People who consider spending money from the MSA on health care as essentially costless would have higher spending than our model indicates.
- Second, our model assumes that out-of-pocket spending would include only those expenses covered by insurance. But MSA legislation would allow MSA funds to be used to pay for such services as acupuncture, psychoanalysis, eyeglasses, contact lenses, hearing aids, and nursing home expenses. These are not typically covered by insurance. Employee-funded MSAs put after-tax coinsurance rates at 60% to 85% on such uncovered services, which we estimate would generate 10% to 15% more such spending not accounted for in our model. However, the waste from overconsumption of these services would be small, because people would be paying close to full price.
- Third, the HMO in our simulation model is assumed to reduce spending to the level of the typical FFS plan, as was the case in the RAND HIE. However, many current HMOs are more assertive about rationing care than was the HMO studied in the HIE. Shifts from less costly HMOs to MSAs would result in less cost savings than those predicted by our model.
- Fourth, our estimates are limited to people who already have health insurance. However, almost 40 million Americans are uninsured.[23] If MSA legislation prompts these individuals to establish MSAs and purchase catastrophic coverage, that would be good, but such a shift would increase spending.
- Fifth, our National Medical Expenditure Survey–based estimates of spending are lower than some other reasonable estimates. They are about 11% less than American Academy of Actuaries estimates for individuals younger than 65 years and privately insured.[9] If we had used higher estimates of spending, more families would have exceeded the MSA caps and been released from financial constraints on spending.
- Finally, total health care costs should include administrative costs, and MSAs would lead to savings from reduced administrative expenses. Most people will pay their bills directly, save the claims, and submit them only if they exceed the deductible. For high-deductible MSAs, less than one fourth will need to do so annually. Our model estimates administrative costs as 15% of premiums,[9] and the expected savings after selection are up to (for high-deductible MSAs) 1.9% of spending. To some extent administrative costs would be shifted from insurance companies to individuals who have to keep receipts and fill out more complex tax forms. Moreover, MSA requirements would lead to increased administrative costs for the Internal Revenue Service, which would have to verify that MSA holders have qualifying catastrophic health insurance and use MSA funds for valid medical expenses.

Selection is based on the value to the consumer, which includes tax subsidies that vary across plans. For society as a whole, value to the consumer is important, but the plans with higher tax subsidies (HMOs and employee-funded, low-

deductible MSAs) are less attractive (Table 1). If everyone had to pick 1 plan, the most attractive plan to society on net is the high-deductible, employee-funded plan, although differences between plans are small. In the simulation, we assumed funds deposited in MSAs just covered differences in spending and premiums. The tax costs of people who fund MSAs up to the current proposed limits each year as a way of saving for retirement would be much higher. Because medical spending has no impact on their taxes, the incentives and medical cost savings would be like those of employer-funded MSAs.

Contrary to some predictions, those choosing lower-deductible MSAs were not much healthier, on average. Such MSA plans are not as stringent as they seem and are more appealing to the unhealthy than the catastrophic plans now available. In fact, low-deductible catastrophic plans with employee-funded MSAs are more generous than standard FFS plans for sick people.

Employers today are making workers more aware of the costs of their insurance by reducing cross-subsidization of policies. This change makes cheaper FFS and HMO plans a better deal for young healthy workers, many of whom are relatively poor. Such workers suffer from paying high premiums for health care they probably will not need. Medical savings accounts would level the playing field between HMOs and FFS plans by reducing the relative tax subsidy of premiums as opposed to out-of-pocket care, but HMOs would remain popular because of their ability to provide care that suits their average enrollee without imposing financial risks. Whether or not MSAs become law, if the market offers plans that are more attractive to healthy people, there will be a need for risk adjustment to ensure that premium differences reflect differences in plan generosity and efficiency and not just the average health of members.

A key policy issue is how high the deductible should be for a plan to qualify as catastrophic. The larger the deductible, the less waste from buying care of low value after the deductible is exceeded, but the higher financial risk of out-of-pocket payments. Also, higher deductibles make the MSA option more attractive to healthy people, and to the extent that allowing such choices by healthy people would cause problems in the market, higher deductibles are undesirable. Based on our results here, an MSA mandating intermediate deductibles, for example, a $2000 deductible for individuals and a $4000 deductible for families, might be best. Such a plan would retain much of the cost discipline of the high-deductible option without imposing excessive risks on families using the employer-funded option, or making MSAs attractive mainly to healthy people.

Pauly and Goodman[24] recently offered an MSA proposal that would give a refundable fixed-dollar tax credit for those buying their health insurance without a tax subsidy and setting up an MSA with after-tax dollars. Because their taxes would be unaffected by health care spending, people who combine a Pauly-Goodman MSA with a catastrophic insurance plan have the same incentive to use care as those with an employer-funded MSA, ie, a coinsurance rate of 100% up to the insurance policy's deductible. The 2 types of MSAs thus have the same impact on spending, waste, and risk, but giving the same credit to rich and poor is not as regressive as the tax subsidies of the current system or the MSA schemes analyzed in the article.

Our simulations show that the MSA approach is not likely to produce the reduction in health care use that its advocates foresee. The MSA approach of increasing tax subsidies for spending cannot solve the problem of overinsurance caused by unlimited tax subsidies of employer-provided insurance. To solve that problem, we need either to limit the amount of employer-paid premiums that can be excluded from income or to replace the tax exclusion with a tax credit that is offered to each person with an adequate insurance policy.[24,25] However, MSA legislation could be designed to avoid losing tax revenues or disrupting the insurance market.

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THE WHITE HOUSE

WASHINGTON

June 3, 1996

MEMORANDUM TO THE PRESIDENT

FROM: Carol Rasco and Chris Jennings

SUBJECT: James Glassman's Medical Savings Account Op Ed Piece

You asked how we would respond to the James Glassman Medical Savings Account (MSA) Op Ed in the Washington Post. This memo responds to the flawed, if not completely inaccurate, claims Mr. Glassman makes in his article.

Glassman Claim: MSAs Promote Cost-Containment. Glassman states that MSAs and their high deductibles will make families smarter health care consumers. He cites the respected RAND Corporation's 1974-82 study on the removal of first-dollar coverage and its effectiveness on cost containment to conclude that "wise shopping -- and judicious use -- should have the effect of limiting increases in health care costs overall."

Response: There is NO evidence that MSAs would produce any more cost constraint than what today's market is achieving through managed care and now prevalent non-first-dollar benefit packages. In fact, in a study that will be released in JAMA in a few days, RAND concludes that MSAs would have absolutely no demonstrable impact on cost containment. This finding, which is based on an elaborate model of the impact of MSAs on the insurance market, is devastating to the advocates of MSAs, particularly since it will come from RAND. (It is important to note that the study, which cannot be cited publicly until it is published, also concludes that the damaging effects of MSAs on the insurance market have been overstated.)

Glassman Claim: Employers Will Foot the Cost of the Deductible.
Glassman says that with MSAs, "your employer puts $2,000 into an account in your name... In effect, you're spending your own money on health care -- with the kinds of beneficial results that the Rand study predicts."

Response: There is absolutely no requirement that employers will give back to employees all or any of whatever they are saving through the reduced cost of a catastrophic benefit package. Even if one makes the economically valid assumption that employers will maintain their current health care contributions and give back the premium savings to their employees, both the American Academy of Actuaries and the Urban Institute have reported that it is impossible for savings from a high deductible premium to come close to being sufficient to fill the hole left by the deductible. (This is based on a well known insurance principle that reflects the fact that most health care costs are produced by a few, very high-cost consumers.)

Glassman Claim: MSAs Aren't Just for the Healthy and Wealthy. Glassman cites a woman who wrote you a letter, "Penny Blubaugh, who makes $16,000 a year," as an example that MSAs are not just for the healthy and wealthy. He then goes on to provide an accounting of the "average employer's premium on an MSA" to illustrate how these policies could save money for both workers and employers.

Response: It may well be the case that MSAs are not be a bad option for healthy individuals -- regardless of their income. Unfortunately, that is also precisely the point. The more we segment the market between the healthy and sick, the harder it will be to insure the sick. Having said this, it is worth pointing out that the Congress' own Joint Committee on Taxation (JCT) estimates that less than 2 percent of those who will use MSAs will have incomes of less than $30,000.

Regardless, Glassman's example of Mrs. Blubaugh may still be full of holes. First, the amount of dollars she had to spend for her daughter's one emergency room visit was well below her deductible and we have no idea whether her employer is providing dollars to pay for anywhere near the entire deductible. Second, almost every emergency room visit is 90 or 100 percent paid for by traditional plans, so it is unclear what additional benefit the MSA is providing. Third, we (and she may) have no idea what her catastrophic health coverage is. It is important to point out that there is no requirement that prohibits today's MSAs (or those under the House-passed version) to impose life-time limits or high copayments on their catastrophic plans. In other words, even their limited insurance may not provide adequate protection for catastrophic health care encounters.

Finally, the idea that Glassman cites premium numbers provided by MSAs biggest advocate (Golden Rule's Pat Rooney) to back up his claims borders on the irresponsible. In short, as Brookings Institution's Joe White points out in his attached Washington Post response to Glassman, "about every health policy analyst doubts those premiums..." Analysts are particularly suspicious of the premiums since Golden Rule has refused to provide relevant data to the American Academy of Actuaries for confirmation and analysis.

Glassman Claim: MSAs Are Already Being Used -- Even by the UMW. Glassman suggests that MSAs must be a good idea since so many companies and their employees are using them, including "the United Mine Workers union."

Response: The UMW recently wrote a letter to Senator Dole explicitly denying that they have MSAs and severely rebuking claims to the contrary. Having said this, there are probably scores of high deductible MSA plans in the country. Citing their existence as a reason why they should receive a Federal subsidy, however, certainly does seem like weak rationale. Moreover, if a new Federal subsidy enhances utilization of MSAs to 20 percent of the nation's employees, the Urban Institute has just completed a study which projects that the cost of traditional premiums (for the remaining sicker employees who opt to stay in their current plans) would increase by almost 60 percent. As Robert Samuelson says in the attached Post MSA Op Ed, "Businesses might [in response] abandon comprehensive insurance or lower workers' salaries to pay for it."

Conclusion/MSA Update From the Hill: To date, there has been relatively little progress in breaking the Kassebaum-Kennedy MSA log-jam. The Republicans are pushing very strongly for an MSA that is nationally-based. Although they (particularly the Senate) seem willing to address obvious flaws in their current bill and to, perhaps, limit the MSA to particular populations (perhaps small businesses), they have shown no interest in constructing an MSA demonstration. (This is the option that we have indicated your willingness to consider.)

It is unclear what impact, if any, the RAND study will have on the discussions on the MSA issue by interested parties dealing with the Kassebaum-Kennedy legislation. Although RAND concludes that MSAs would no impact on cost containment, they will suggest that MSAs can be designed to address risk selection problems and, in general, conclude that these policies have a relatively benign impact on the health insurance market. In other words, the study -- which may well command a great deal of attention -- will have something for everyone.

Today, senior staff of the House and Senate Republicans tax writing Committees are meeting to discuss all the tax provisions in the Kassebaum-Kennedy legislation. MSAs will be a major focal point. We may have a report this evening or tomorrow on whether there has been any significant movement.

Tomorrow evening (Tuesday), the Republican conferees will be meeting to see where they stand on their internal, bicameral discussions on the Kassebaum-Kennedy bill. At that time, Senator Kassebaum hopes that, either directly or indirectly, Senator Dole will advise his Republican colleagues that he wishes to have a bill on the Senate floor before his departure. Even if he does this, it is unclear how sympathetic and responsive the House will be. If we don't get a breakthrough in the next few days on MSAs (and on the mental health parity provision, medical malpractice, and the deregulation of Multiple Employer Welfare Arrangements), it seems impractical to imagine the Kassebaum-Kennedy bill getting a final vote before Senator Dole leaves the Senate. (See attached today's Post Editorial.)

For this to happen, a great deal of hard compromising must be done on MSAs, as well as the mental health parity, MEWA, and medical malpractice provisions in the next few days. Working closely with John Hilley and Susan Brophy, we will keep you apprised of developments.

James K. Glassman

$2,000 Health Care Trick

Between 1974 and 1982, the Rand Corp. conducted a giant experiment for the U.S. Office of Economic Opportunity to find out how the country would respond to different kinds of health insurance.

The results were startling and, until now, largely ignored. But they could have a major bearing on today's most important health care debate: the fight over medical savings accounts (MSAs).

While the issue sounds arcane, it's vital to the country's economic future. MSAs may be the answer to stopping runaway health costs by freeing people to make their own decisions.

A total of 3,958 Americans in 2,005 families took part in the Rand study. Each family was randomly assigned to an insurance plan for three to five years. One plan provided completely free care. Others required families to pay a share (25 percent, 50 percent or 95 percent) of the bills up to a limit, where a catastrophic policy kicked in. Here's what Rand found:

First, families that received free care used far more medical services than families that paid for part of their care.

For example, families with free care had one-third more hospital admissions than families that paid 95 percent of their own health bills. The free-care families incurred medical expenses of $777 per person (in 1984 dollars) while families that paid 50 percent of their own bills spent $583 per person.

These findings are common sense. When you spend your own money for something, you're more apt to spend it wisely than if the government, your employer or an insurance company is footing the bill.

But, with your own dollars at stake, will you stint on care you really need and thus damage your health? Rand, in its second key discovery, says no.

"Free care," the study concluded, "had at most a small effect on any of five general health measures for the average enrollee." Thus, Rand said, free care "is not justified by the health benefits realized."

Which brings us to the hot health care issue of the moment: medical savings accounts, or MSAs. The House and Senate will decide soon whether to include MSAs in the final version of the Kennedy-Kassebaum bill, which tries to make health insurance more accessible and portable.

I'm no fan of Kennedy-Kassebaum, since it will lead, inevitably, to an expensive Washington-controlled national health system that will restrict personal choices. MSAs, on the other hand, could be our passage out of the horrendous swamp of our current system.

An MSA is a health insurance policy that's divided into two parts: For the first part, a family pays its own health costs up to, say, $2,000 a year. For the second, the family's expenses beyond $2,000 are covered by a catastrophic policy.

Based on what Rand discovered, we can expect families to shop wisely for health care when their own dollars are at stake. That wise shopping—and judicious use—should have the effect of limiting increases in health care costs overall.

In other words, by bringing the consumer directly into the health care market, supply and demand pressures take hold—just as they do with any other market. Health care providers will respond to price-sensitive consumers, as dry-cleaning providers or fast-food providers do now. The current system of government constraints and managed care has proven that it cannot hold down costs—though it can generate tons of paperwork and infuriate lots of people.

But where will a family get the $2,000 to pay its initial medical bills?

Enter MSAs. If you have an MSA at work, your employer puts $2,000 into an account in your name. You then use that account to pay your bills for the year. It becomes, in effect, first-dollar insurance—a boon to the poorest working Americans, who, under policies today, have large deductibles or co-payments.

When an MSA's initial $2,000 is used up, the catastrophic policy kicks in. At the end of the year, you keep any of the $2,000 you haven't used. (Under the proposed law, the money goes into a tax-free savings account, like an IRA. So pay attention, Citicorp and Fidelity.)

In effect, you're spending your own money on health care—with the kinds of beneficial results that the Rand study predicts.

MSAs already exist. Pat Rooney, chairman of Golden Rule Insurance Co., which writes MSA policies, says that more than 1,000 companies (including his own) are using them now, to the general pleasure of their employees. Among the participants in MSAs: the United Mine Workers union.

A typically enthusiastic user of MSAs is Penny Blubaugh, who makes $16,000 a year as a secretary in the Danville, Ohio, school system. She recently testified before the Senate Finance Committee and later wrote to President Clinton about how "my daughter stepped on a nail in our garage and . . . I was advised to take her to the emergency room. This trip cost $375 for the emergency room and $70 for reading X-rays."

She didn't have $445, but her MSA did. It gave her first-dollar coverage. "As for the things I heard last week in Washington about the medical savings being only for healthy and wealthy people, that is 'bunk,'" Blubaugh wrote.

The average employer's premium on an MSA policy (with a $2,000 deductible) is $2,300 per family, compared with $5,000 for a conventional health insurance policy, according to Golden Rule. So an employer that provides the $2,000 for out-of-pocket expenses comes out ahead. (Meanwhile, workers under some MSA plans get to keep an average of $1,000 a year for their own use.)

If my wife and I were still running a business, we'd sign our company up for an MSA tomorrow—even though the tax consequences are utterly unfair.

Taxes are what the new MSA bill addresses. Under current law, premiums on employer-paid health insurance are not taxable to employees who benefit from them—but deposits by employers into employee MSAs are. Under the new bill, MSA accounts wouldn't be taxed.

The loss to the Treasury would be tiny, but the benefits could be huge. MSAs would put Americans themselves in charge of spending their medical dollars, increasing choice and personal responsibility—and lowering costs. Now, that's a good deal.

Joe White

Tax Breaks For Healthy People

James K. Glassman's endorsement of medical savings accounts (MSAs) unfortunately ignores a lot of the available evidence and fails to recognize glaring errors in the advocates' case ["$2,000 Health Care Trick," op-ed, May 14].

His readers may mistake the implications of the Rand health insurance experiment in many ways, among them:

(1) Glassman argues that people who have to pay more of their own money for health care would "shop wisely" and be "price sensitive." In fact, none of the savings in the Rand experiment stemmed from shopping for better prices. All came simply from some people choosing not to go to the doctor in the first place. Once people consulted a physician, they spent just as much as anyone else.

Taking Exception

(2) Glassman leaves the impression that the savings from MSAs would be comparable to those the Rand study showed from the difference between high consumer payments and "free" care. In fact, cost-sharing in the average insurance plan is now so high that the Rand scholars themselves reported that more than half the savings from charging consumers are already part of the system.

(3) He assumes that people will be as unwilling to spend money in their MSAs as to spend other assets. But the MSA money could only be saved or spent on medical care—and is labeled as money for medical care. In the Rand experiment, people were choosing among spending for medical care or clothes or food or other goods. Most people are far more interested in consuming than in saving. So clearly the incentives not to spend on health care in the Rand experiment were much greater, and its estimates cannot be extended to situations where people have money in a medical savings account.

When he moves away from the Rand data, Glassman relies on the premiums reported by the Golden Rule Insurance Co. for its catastrophic insurance plans, and compares them to premiums for other, more comprehensive, plans. He shows a $2,700 difference. Glassman ignores the likelihood that these premiums are applied to different populations. Golden Rule is well known for "risk selection": selling only to healthier people, who therefore have lower costs. And the economic incentives also are for healthier people to choose MSAs. So just about every health policy analyst doubts those premiums would be true for the general population. We don't know for sure, because Golden Rule and other prototype MSAs refused to provide data about their risk profiles, or other relevant data, to the American Academy of Actuaries. But that itself should make fair-minded people wonder.

These are just some of the reasons why neutral analysts such as the Academy of Actuaries and the Congressional Budget Office do not believe the MSA advocates' savings estimates. So the tradeoff between the advantages and disadvantages of MSAs is likely to be much different from what Glassman suggests.

The basic disadvantage is that healthier people might choose MSAs, leaving sicker people in comprehensive insurance. The former get a tax break for being healthy: If their costs are less than the MSA contribution, the excess contribution is tax-free income.

But a diabetic, for example, will know that his or her costs would be so much higher than the MSA contribution that he or she would do better with the cost-sharing in traditional insurance. MSA advocates try to get around this by arguing that MSA benefits would actually be higher (compared, for instance, with policies that do not pay for pharmaceuticals). But if benefits are higher, then by the advocates' own logic there shouldn't be savings.

So sicker people should choose conventional insurance, and it should become much more expensive. Insurance for people who need it will be made less accessible, so as to give tax breaks for healthy people. That does not seem worth the small savings in total health care costs that responsible analysts would project from the catastrophic insurance/MSA combination.

MSAs are not an entirely bad idea. Under limited conditions, one could make them make sense. For example, MSAs with community-rated catastrophic insurance policies, sold at the same price to both sicker and healthier people, would be different from the version Golden Rule markets. The benefit to sicker people from community rating might be worth the reduction in total insurance coverage.

But the debate at least should begin from proper data about the possible savings. MSA advocates misuse the Rand data and refuse to submit their anecdotal evidence to neutral review. That's not a good basis for policymaking.

The writer is a senior fellow at the Brookings Institution.

Robert J. Samuelson

Dubious Crusade for Medical Savings Accounts

Just why some Republicans have chosen Medical Savings Accounts (MSAs) for their latest crusade is a mystery known only to them. Some issues assume symbolic meaning well beyond their practical significance—the minimum wage, for example. Its mainly liberal advocates wrongly portray it as an important way of reducing poverty. Medical savings accounts are a similar phenomenon. Their mainly conservative supporters see them as a bold way to control health costs and expand patient choice. All this is dubious.

They are simply another health care subsidy in a system already swamped with them.

Judgments must be hedged because, unlike the minimum wage—where there's ample experience—MSAs are mostly an untested concept. They would allow people to combine a catastrophic health insurance policy with an annual tax-exempt contribution (made either by employers or by individuals) into an MSA. People would use their MSAs for normal health expenses (checkups, colds, minor injuries) and rely on insurance for crises. This, the theory holds, would inspire cost consciousness. Americans would shop for doctors and hospitals with the lowest prices and best care.

On their face, MSAs are not a nutty idea. If we were starting a health insurance system, they might make sense. One basic problem of the present system is that comprehensive insurance made almost everyone indifferent to costs. Patients wanted the best care. Doctors and hospitals benefited financially by maximizing care. Arguably, the health cost spiral might have slowed if insurance had covered only expensive disasters.

But we aren't starting from scratch. Government policies have created a different system. Tax subsidies encouraged companies to provide workers comprehensive insurance. The subsidy is the exclusion of the employer's insurance contribution from taxes. Suppose a company buys $4,500 of insurance for each worker; the workers don't pay taxes on that $4,500. In 1995 these subsidies cost the Treasury $59 billion. And of course, there's Medicare and Medicaid for more than 65 million elderly and poor. As a result, most Americans have broad insurance and like it.

This is why tax-free MSAs, if offered, might not attract many takers. Congressional Republicans have twice tried to create MSAs: first for Medicare recipients in legislation vetoed by President Clinton; and now for the under-65 population in the House version of the Kassebaum-Kennedy bill, which would protect workers against insurance loss. The Congressional Budget Office projected that 2 percent of Medicare recipients would switch; for the under-65 population, the congressional Joint Committee on Taxation put usage at about one percent.

If accurate, these estimates mean that MSAs wouldn't do much to cut costs or expand choice. Moreover, the basic theory may be flawed. Buying health care is not like buying groceries. With their money at stake, people may not rush to the doctor at the first sniffle; and competitive pressures might trim 10 percent of seriously sick Americans. These people have heart attacks, AIDS or complicated pregnancies. Catastrophic insurance would cover these costs; MSAs wouldn't matter.

The explosion of "managed care" has also undermined MSAs' potential. Competition has already come to the health care market in the form of massive groups of buyers and sellers—companies, local governments, health maintenance organizations—haggling over prices, coverage and quality. At least temporarily, this has dramatically slowed health spending. MSAs embody a different philosophy of cost control. Individuals wouldn't have much clout in today's medical market.

What's the fuss then? If MSAs wouldn't matter much, why not authorize them and be done with it? The main reason for caution is that all the predictions of modest usage could prove wrong—and if MSAs became hugely popular, they could radically change the health care system. Under today's insurance system, the premiums of younger and healthier workers subsidize the higher health spending of less healthy middle-aged and older workers. MSAs would, in theory, enable millions of younger workers to opt out of this invisible subsidy.

They could take the cheaper catastrophic coverage and keep the unused portion of their MSAs as tax-free saving to be withdrawn at age 59½. A mass defection of younger workers could have a devastating effect on the premiums of older workers. A study by the Urban Institute estimates that if 20 percent of workers switched to MSAs, premium costs for those sticking with comprehensive insurance would rise almost 60 percent. Just what would happen then is anyone's guess. Businesses might abandon comprehensive insurance or lower workers' salaries to pay for it.

Cross subsidies and managed care (which many MSA advocates dislike) are legitimate subjects of debate. But we should not unleash a health care upheaval simply as an afterthought. If MSAs are as good as claimed, let them prevail as a stand-alone measure after a full debate. Right now, they're simply hitchhiking on other health care legislation. (The same objection also applies to a rider on the Senate-passed Kassebaum-Kennedy bill: the requirement that mental health benefits be included with insurance. No one knows the consequences of this; it could be immensely expensive.)

The political puzzle is why so many Republicans are obsessed with MSAs. There's no public clamor for them. Portraying them as a triumph of individualism over government control is a rhetorical delusion. MSAs are simply another government health care subsidy in a system already swamped with them. Like other subsidies, MSAs would channel and constrict people's freedom. The funds in these accounts, for example, could not easily be used to buy "managed care" policies.

Yet again Republicans seem to be falling into a self-made trap. The White House cited MSAs as one reason for rejecting the congressional plan to curb Medicare spending. And now the president has threatened to veto the Kassebaum-Kennedy bill if it authorizes MSAs, even though the bill's main features—protecting workers with "preexisting" health conditions against losing insurance—have wide support. If Republicans let their ideological fantasies obstruct useful legislation, they risk being attacked ruthlessly. And they will deserve it.

THE WASHINGTON POST
MONDAY, JUNE 3, 1996

The Washington Post

AN INDEPENDENT NEWSPAPER

Sen. Dole's Final Business

BOB DOLE HAS only a few days left in the Senate. How will he spend them? He said last month that he hoped before stepping down to stage one more vote on a balanced budget amendment to the Constitution, even though it's pretty clear that the proposition would fail—as well it should. He has also said that he would like to see to enactment of the so-called Kassebaum-Kennedy health insurance bill, meant to help people keep their coverage when they fall ill or are between jobs.

The latter surely is the better use of his remaining time. The balanced budget amendment is show horse legislation—a deceptive, destructive proposal whose likely effect would be less to balance the budget than to weaken the structure of government by entrenching minority over majority rule. The health insurance bill would allow Mr. Dole to leave the Senate having, fittingly, as his last act, accomplished something substantive instead. The bill is a modest step only. It mainly would help the already insured, and not so much with the crushing cost of insurance as by preserving their eligibility for it. But that's a useful thing to do. It's exactly the kind of constructive compromise with which Mr. Dole should want to seal his congressional career.

To make it into law, however, the bill needs to be kept clean. That means stripping out three provisions, two of which would be downright harmful and one of which would confer a benefit without sufficient examination of its costs.

The first is a House-passed proposal to subsidize so-called medical savings accounts. Instead of buying conventional health insurance, people would be allowed to accumulate cash tax-free to pay their routine medical bills. The notion is that the country would be better off if people were buying health care more carefully with what they regarded as their own money; the shift from insurance to savings accounts would, according to this view, help to hold down costs. But in fact the effect would be to fracture the insurance market; the healthy, for whom the savings accounts would have greatest appeal, would no longer be in the pool to help pay the bills of the sick, whose costs would rise. Mr. Dole supports the idea, a favorite of conservatives, but the president has rightly said he would veto a bill that contained it; it should be struck.

The second provision, also in the House bill, would allow insurance pools created to help small businesses and others cut their costs escape state regulation. The pools are a good idea, but not the escape from scrutiny. Among much else, they too should be kept from serving only the healthy and further fragmenting the insurance market. Finally, the Senate bill includes a requirement that insurance plans treat mental and physical illnesses essentially the same; they could no longer "discriminate" against the mentally ill by imposing tighter limits on the one than on the other, as most do now. Even health care economists who would like to confer the benefit warn that the effect would be to add to both the cost of insurance and the number of uninsured. The proposal is better intentioned than it is thought through.

Maybe Mr. Dole can't broker a clean bill like this in the time he has left, and perhaps he doesn't want to. But if he doesn't, it isn't clear who later will. The reputation he has always cherished is that, in the end, he gets things done. Here's a last one well worth doing.