



**MEDICAL SAVINGS ACCOUNTS –
A COMPARATIVE OVERVIEW**

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MEDICAL SAVINGS ACCOUNTS – A COMPARATIVE OVERVIEW

INTRODUCTION

Medical savings accounts (MSAs) are a form of health coverage that combines a catastrophic (high-deductible) health insurance policy with a savings account used to pay for certain medical expenses. In the past decade, MSAs have received a considerable amount of attention in the United States and Canada where they have been proposed as a health care reform and sustainability measure. In the United States, the debate over MSAs has been particularly vigorous.

- *Proponents* maintain that MSAs will: increase consumer choice; encourage consumers to make more prudent use of health care services; result in more timely access to health care services; and reduce health care spending.
- *MSA skeptics*, on the other hand, contend that MSAs will: realize only small health care savings at best; segment the risk in the insurance market and drive up insurance costs for those remaining in comprehensive health insurance plans; and have an adverse impact on health as people cut back on necessary health care.

MSA systems have been operating in a few countries – including Singapore, South Africa, China and the United States – and the government of Hong Kong recently proposed an MSA system as part of its discussions on health care reform. This paper reviews the medical savings accounts systems established in Singapore, South Africa and the United States as well as the proposals put forward in Hong Kong.⁽¹⁾ The paper then examines the debate over medical savings accounts and outlines the arguments made by the proponents and opponents of

(1) The Chinese system of MSAs is not discussed in this paper. David Gratzner gives a brief description of MSAs in China in his book *Code Blue*, ECW Press, 1999, pp. 201-202.

MSAs, focusing in particular on the impact of MSAs on health and health care costs. The paper concludes with an overview of the proposals for MSAs that have been put forward in Canada.

WHAT ARE MEDICAL SAVINGS ACCOUNTS (MSAs)?

Medical savings accounts are health accounts, similar to a bank account, set up to pay for health care expenses. They are typically established in conjunction with high-deductible (catastrophic) health insurance. The money put aside in the MSA is used to pay for qualifying (usually routine or minor) medical expenses while the insurance plan covers expenses after the deductible level has been reached. Under most MSA schemes, money contributed to the MSA belongs to the account holder, accumulates on a tax-free basis, and is not included in taxable income if used for health care expenses.

MSAs can involve three levels of payment:

- First, money in the account is used to pay for the account holder's medical expenses.
- Next, if the account is exhausted and the deductible has not been reached, the medical expenses are paid for out of the account holder's pocket.
- Third, the insurance policy covers expenses beyond the deductible level.⁽²⁾

Employers, individuals, governments or any combination of these can set up an MSA. In the United States, the employer-funded MSA is the most common type of plan. Under this plan, the employer buys a high-deductible health insurance policy for employees and deposits some or all of the savings gained from switching from a traditional comprehensive health insurance policy to the high-deductible policy into employee medical savings accounts. The employees use the MSA funds to purchase routine medical care services and then pay expenses out of their own pockets until the deductible amount is reached and the insurance takes effect.

Individuals can also establish their own MSAs and contribute funds to the plan on a tax-deductible basis. As well, it is possible for governments to create MSA accounts for the general population. These accounts could be funded in a variety of ways, such as using general

(2) Gratzer, *ibid.*, p. 192.

tax revenues, directing all or a portion of existing health care budgets to MSA accounts for individual health care consumers, or instituting payroll deductions or special levies.

MEDICAL SAVINGS ACCOUNTS – SINGAPORE

A. Overview

Singapore has a mixed public and private health care delivery system. The government manages the public system while the private system is provided by private hospitals and practitioners.⁽³⁾ Private practitioners provide 80% of primary health care services while government polyclinics provide the remaining 20%. The reverse applies to hospital care, where the public sector provides 80% of hospital services and the private sector provides the balance. Patients can choose public- or private-sector care.

The Singapore government's philosophy of health care delivery can be summed up in the following words – individual responsibility co-existing with government subsidies to keep health care affordable. An overview of the Singapore health care system describes the system this way:

Patients are expected to pay part of the cost of medical services which they use, and pay more when they demand a higher level of services. The principle of co-payment applies even to the most heavily subsidised wards to avoid the pitfalls of providing “free” medical services.⁽⁴⁾

B. Financing Health Care

In Singapore, health care is financed through a combination of general tax revenue, employee medical benefits, compulsory savings in the form of Medisave, insurance, and out-of-pocket payments.⁽⁵⁾

(3) Ministry of Health, Singapore, Overview of the Singapore Healthcare System, February 2001.
http://www.gov.sg/moh/mohinfo/mohinfo_a.html.

(4) *Ibid.*

(5) Information about the Medisave program comes from a document prepared by the Ministry of Health, Singapore, *Health Care Financing in Singapore*, June 2000.
http://www.gov.sg/moh/mohinfo/mohinfo_b.html.

To assist individuals with financing health care expenses, the government operates three programs:

- *Medisave* – a compulsory savings program for certain health care expenses;
- *MediShield* – a catastrophic insurance scheme to help cover the cost of large medical bills; and
- *Medifund* – an endowment fund that helps the poor and needy pay for medical expenses.

Each of these programs is described below.

1. Medisave

In 1984, the government of Singapore established Medisave, a compulsory savings scheme aimed at helping citizens build up savings to cover the costs of hospitalization and certain medical expenses. Employees must contribute 6-8% (depending on the age group) of their monthly salary, subject to certain upper limits, to a personal Medisave account. In 1992, the government made it compulsory for self-employed individuals to contribute to Medisave.

Medisave accounts are part of the government's Central Provident Fund (CPF) – a fund originally established in 1955 to require citizens to save for their retirement. People maintain three accounts with the CPF:

- *Ordinary* (for expenses such as housing, certain investments, insurance, loans for university education, etc.);
- *Medisave* (for hospitalization and certain medical expenses); and
- *Special* (for old age retirement).

Every employee is required to contribute 20% of their income to the CPF, with a matching contribution from his or her employer.⁽⁶⁾ The total contribution is distributed among the employee's personal accounts with 28-30% going to the person's Ordinary Account, 6-8% to his or her Medisave Account, and 4% to the Special Account.

(6) CPF contributions from employers were reduced to 12% for the year 2000, in response to the economic downturn. The 8% point cut (down from 20%) is comprised of a 6% point cut in contributions to the Ordinary Account and a 2% point cut in contributions to the Special Account. Contributions to the Medisave account remain the same.

Contributions to Medisave are shared equally between the employer and the employee, are tax-deductible, and earn interest. There is also an upper limit on total contributions (currently set at S\$22,000). According to the Ministry of Health, the limit is imposed “to prevent an excessive build-up of Medisave balance which could result in unnecessary use of medical services.”⁽⁷⁾ Amounts in excess of the limit are transferred to an individual’s CPF Ordinary Account.

Medisave accounts can be used to pay for hospital and certain other medical expenses for the individual account holder and his or her family. Withdrawals from Medisave are subject to limits that require some cash co-payment from patients, particularly those who choose private hospitals or more expensive ward accommodation in public hospitals.

Subject to a requirement to maintain a balance (the lower of the actual amount in the account or a minimum sum currently set at S\$17,000), account holders are permitted to withdraw their Medisave accounts at age 55. In addition, any remaining Medisave balance can be transferred to beneficiaries as part of the account holder’s estate.

As of December 1999, there are approximately 2.68 million Medisave accounts with a total balance of about S\$20.8 billion. About 87% of all hospital inpatients make use of Medisave to pay their hospital bills. In 1999, the total amount of contribution to Medisave was S\$1.98 billion.

2. MediShield

MediShield⁽⁸⁾ – a non-compulsory, low-cost high-deductible catastrophic illness insurance scheme designed to cover medical expenses from major and prolonged illnesses – was introduced in 1990 as a supplement to Medisave. Medisave account holders under 75 years of age are eligible to participate in the MediShield scheme.

MediShield premiums are paid from Medisave contributions and vary with age. Reimbursements from MediShield follow a system of deductibles and co-insurance. Annual and lifetime claim limits also apply.

In 1994, the government established an enhanced MediShield Scheme – called MediShield Plus – for individuals who prefer less-crowded accommodation in hospitals.

(7) *Health Care Financing in Singapore*, June 2000.

(8) Much of the information about MediShield comes from the Singapore Ministry of Health at [http://www.gov.sg/moh/mohinfo/mohinfo_b\(B\).html](http://www.gov.sg/moh/mohinfo/mohinfo_b(B).html).

3. Medifund

Established in 1993, Medifund is a government endowment fund that operates as a safety net to help the poor and needy pay for hospital medical care. At the time the fund was created, the government made an initial capital injection of \$200 million. This has been followed by other capital contributions. The interest income (but not capital) from the fund is distributed on a case-by-case basis to public-sector hospitals.

C. Evaluation of the Singapore System

The Singapore health care system is premised on the notion that individuals must take at least partial responsibility for covering the costs of medical care. The state is involved in managing virtually all aspects of health care, including requiring people to save money to cover their medical expenses.

A 1996 study prepared for the U.S.-based National Center for Policy Analysis on the Singapore experience with medical savings accounts concluded that the Singapore program provides incentives “to reduce consumption and offer protection against extraordinary events and free-rider abuses.”⁽⁹⁾ Because individuals must start saving at an early age, savings accumulate to cover costs later in life when medical care needs are greater. The study concludes that Medisave and MediShield have worked well as part of a system that balances personal savings for medical care and government management of the health care system that has kept overall costs relatively low.⁽¹⁰⁾

However, another study mentioned in a recent C.D. Howe Institute Commentary reports that: hospitals in Singapore did not start competing on price; and the per capita cost of health care rose faster after the introduction of the health care model that included MSAs than it had prior to that time.⁽¹¹⁾

(9) Thomas A. Massaro and Yu-Ning Wong, *Medical Savings Accounts: The Singapore Experience*, NCPA Policy Report No. 203, April 1996, p. 2. <http://www.ncpa.org/studies/s203/s203.html>.

(10) *Ibid.*, pp. 11-12.

(11) Cam Donaldson, Gillian Currie and Craig Mitton, *Integrating Canada's Dis-Integrated Health Care System: Lessons from Abroad*, C.D. Howe Institute Commentary No. 151, April 2001, p. 18, at www.cdhowe.org. The study cited is by W. Hsiao, “Medical Savings Accounts: Lessons from Singapore,” *Health Affairs*, 1995, 14(2), pp. 260-266.

MEDICAL SAVINGS ACCOUNTS – SOUTH AFRICA

South Africa has both a public health care system and a private health care system. For the most part, health care delivered through the public system is free of charge to users while patients pay for care delivered in the private sector. The private health care sector has been growing in the wake of public-sector cutbacks and issues relating to the quality of care.

After deregulation of the private insurance market in 1994, insurers began to offer a wide range of health insurance programs including medical savings account plans. Since their introduction, MSAs have grown to half of the private insurance market.⁽¹²⁾

MSAs allow individuals to pay for medical expenses that are less than the deductible amount specified in their medical insurance policy as well as for certain types of health care that are not covered by insurance.

Some of the features typically found in MSA plans include:

- first-dollar coverage (no deductible) for non-discretionary services, such as heart bypass operations and other inpatient hospital services;
- a deductible of about \$1,200 for discretionary expenses, such as visits to doctors and other outpatient services;
- first-dollar coverage for medications required to treat certain chronic conditions.⁽¹³⁾

Deductibles vary with the type of service. The degree to which an individual can exercise discretion in choosing a particular type of medical care or service is the rationale for varying deductible rates, the theory being that deductibles should not apply to procedures where the individual has little or no room for choice about having the procedure (for example, heart bypass surgery), but should apply where a person can make a rational decision about whether to have the service (for example, a visit to the doctor for a cold or sore throat).

A study prepared for the National Center for Policy Analysis (NCPA) – a long-time proponent of medical savings accounts – concludes that the South African experience with

(12) Much of the information on medical savings accounts in South Africa comes from a policy report entitled *Medical Savings Accounts in South Africa*, prepared by Shaun Matisonn for the National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000.
<http://www.ncpa.org/studies/s234/s234.html>.

(13) *Ibid.*, p. 9.

MSAs has been positive. MSAs have become a popular health care vehicle due in no small part to a flexible regulatory environment that allows insurers to tailor plans to the needs of the private market and offer incentives to encourage a healthy lifestyle and wellness.⁽¹⁴⁾

In evaluating the results of MSAs in South Africa, the NCPA study looked at a number of questions such as:

- Do MSA holders reduce discretionary spending?
- Do MSA holders substitute nondiscretionary spending for discretionary spending in order to avoid facing an expenditure that carries a deductible?
- Do MSA holders forego needed health care to save money?
- Do MSA plans attract only young and healthy individuals and therefore destabilize insurance risk pools?

Using two data sets – one comprised of individuals with MSAs and another of individuals with traditional plans, the study concludes that:

- MSAs save money – on average, MSA holders spend about half as much on outpatient services plus drugs as do people in traditional plans;
- there is no evidence that MSA holders substitute care with no deductible for care with a high deductible;
- similarly, there is no evidence that MSA holders forego appropriate care – a comparison of catastrophic claims under MSA and traditional plans does not reveal a higher level of such claims by MSA holders;
- although MSA plans appeal to people who are healthy, MSA plans can be attractive to those who are sick and have high health care costs.⁽¹⁵⁾

MEDICAL SAVINGS ACCOUNTS – UNITED STATES

Much of the discussion and literature and most of the controversy and debate relating to medical savings accounts originates in the United States where, in the wake of rising

(14) For example, the Policy Report notes that one plan offers a point system for having preventive tests such as pap smears and mammograms and participating in an exercise program. Accumulated points can be redeemed for benefits such as airline tickets.

(15) *Ibid.*, pp. 15-17.

health care costs and increasing criticism of the system of managed care by Health Maintenance Organizations (HMOs) and other providers, MSAs have been proposed as a way to reduce health care spending and empower health care consumers.

MSA-type programs have been operating in the United States for some time. In fact, a number of employer-sponsored MSA plans had been initiated prior to the introduction of state and federal legislation allowing a tax deduction for MSA contributions. For example, in 1993, Golden Rule Insurance Company instituted a plan under which it deposited \$2,000 a year into a medical savings account for employees who opted for a health insurance policy with a \$3,000 annual deductible. The National Center for Policy Analysis reported in 1996 that approximately 2,000 businesses had moved from traditional health insurance to some type of medical savings account option.⁽¹⁶⁾

By the mid-1990s, a number of state governments began to enact laws allowing for some degree of tax relief for medical savings accounts. The idea was to level the tax playing field between MSAs and employer-provided health insurance plans so that: employer contributions to an MSA would not be a taxable benefit for the employee; and employee contributions would be tax deductible.⁽¹⁷⁾ However, state approaches to MSAs are not uniform; they vary with respect to the tax relief offered, the amount eligible for preferential tax treatment, eligibility requirements to participate, and the treatment of unused account balances at the end of each year.⁽¹⁸⁾

A. Medical Savings Accounts under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

The first federal program in the United States to authorize favourable tax treatment for MSAs became effective on 1 January 1997. The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* established a four-year medical savings account demonstration project ending in 2000 and set out the requirements for the tax treatment of MSAs at the federal level. The demonstration project has since been extended for two additional years.

(16) National Center for Policy Analysis, November 1996. <http://www.ncpa.org/health/pdh25.html>.

(17) Some of these states are: Arizona, California, Colorado, Idaho, Illinois, Indiana, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, Washington, West Virginia, and Wisconsin.

(18) Marilyn Moon, Len M. Nichols and Susan Wall, *Medical Savings Accounts: A Policy Analysis*, The Urban Institute, March 1996. <http://www.urban.org/pubs/hinsure/msa.htm>.

The federal MSA demonstration is limited to 750,000 MSA account holders.⁽¹⁹⁾ Those eligible to participate in the federal program include self-employed individuals and businesses with 50 or fewer employees. (Unlike the federal MSA scheme, state MSA programs do not cap the number of employees.) Although employers with more than 50 employees are restricted from offering the federal MSA tax benefit to employees, they can still offer MSA-style programs, although with limited tax benefits.

To participate in the program, participants must have a qualified high-deductible (catastrophic) health insurance plan⁽²⁰⁾ to cover large health care expenses. For individuals, the deductible must be between US\$1,550 and US\$2,350 (with a total out-of-pocket maximum of US\$3,100); for families, the deductible must fall between US\$3,100 and US\$4,650 (with a total out-of-pocket maximum of US\$5,700).

The MSA is set up through a trustee such as a bank, insurance company or any other entity approved by the Internal Revenue Service. Contributions can be made by the employer or the employee, but not by both during the same year. Individuals can make contributions up to 65%; for families, the contribution limit is 75% of the annual health plan deductible. There are also upper limits on contributions based upon the individual's wages or compensation. The MSA is portable; it is owned by the account holder and follows the account holder when the individual changes jobs.

MSAs offer a number of tax advantages. For example, employer deposits into an MSA plan are not classified as taxable benefits for employees, employee contributions qualify for a tax deduction, and funds accumulate in the MSA on a tax-free basis. Contributions in excess of annual limits, however, are subject to a 6% excise tax.

MSA funds are typically used for routine health care expenses. Withdrawals from MSA plans are tax-free if used for medical expenses that would qualify as a medical deduction for income tax purposes. Non-medical spending from an MSA is subject to taxation and additional tax penalties. Money remaining in the MSA account at the end of the year can be rolled over to the next year without penalty.

(19) United States, Internal Revenue Service, Publication 969, *Archer MSAs*, gives a detailed description of the requirements for federal medical savings accounts. This publication is the main source of the information about the federal MSA program.
http://www.irs.ustreas.gov/prod/forms_pubs/pubs/p96901.htm.

(20) A high-deductible health plan is a comprehensive health insurance plan with a higher annual deductible than typical health plans and a maximum limit on annual out-of-pocket medical expenses.

A beneficiary can be designated for an MSA account. If a spouse is designated, on death the account is treated as the spouse's plan. If someone other than the spouse is designated, on death the account loses its MSA status and its fair market value is taxable to the designated beneficiary. Where there is no designated beneficiary, the fair market value of the plan is included in the deceased's final income tax return.

B. Experience with the MSA Market under the HIPAA

When tax-advantaged MSAs became available at the federal level in 1997 under the HIPAA pilot project, proponents of the legislation thought that insurers would be quick to enter the MSA market and many individuals would opt for MSAs. However, the market has developed slowly with some 100,000 MSAs having been set up.⁽²¹⁾

A report to Congress by the Medicare Payment Advisory Commission (MedPac) on Medical Savings Accounts in the context of Medicare (November 2000) cited four main reasons for the slow development of MSAs.⁽²²⁾ These reasons – limited supply, lack of broker interest, limited demand, and program design problems – are discussed below.

- *Limited Supply*: The federal law establishing MSAs limited eligibility to self-employed people and those employed in firms with 50 or fewer employees. According to the MedPac report, these eligibility requirements had the effect of limiting suppliers of MSAs to insurance companies that participate in or want to enter the individual and small group insurance markets. Companies entered the MSA market to have a market presence in case the plans became popular, but many did not enthusiastically pursue MSAs when they found that the level of interest was low. Furthermore, insurers were reluctant to enter the market because MSAs were established as a four-year demonstration project (rather than as a permanent program).⁽²³⁾

(21) Linda Klinger, "Few Takers for Medical Savings Accounts," *Washington Business Journal*, 2 April 2001. <http://washington.bcentral.com/washington/stories/2001/04.02/focus4.html>.

(22) Medicare Payment Advisory Commission (MedPac), Report to Congress, *Medical Savings Accounts and the Medicare Program*, November 2000, pp. 6-7. <http://www.medpac.gov/>.

(23) *Ibid.*, p. 6.

A United States General Accounting Office (GAO) Report to Congressional Committees on MSAs (December 1998) found that although a wide range of insurers were offering MSA plans, only a minority of them were marketing them aggressively.

While some insurers believed strongly in the MSA concept and entered the market aggressively, many offerors entered the demonstration primarily to protect market share or for similar defensive reasons. For many insurers, having made the investment in a qualifying plan, staying in the market meant little additional effort. About 20% of offerors report continuing to pursue the market actively as of summer 1998, using multiple marketing techniques, while the remainder report a more passive approach, simply making their qualifying products available.⁽²⁴⁾

- *Lack of broker interest:* The MedPac report notes that agents have not displayed a great deal of interest in selling MSAs. Because MSA policies tend to have lower premiums than other policies, agents receive lower commissions for sales. Furthermore, the public's lack of familiarity with MSAs and the somewhat complicated nature of the accounts required agents to devote a considerable amount of time to selling the product. As a result, agents have been reluctant to commit the time necessary to learn about and sell the product.⁽²⁵⁾
- *Limited demand:* The MedPac report points out that self-employed individuals could constitute a potentially large market for MSAs. However, many of the self-employed continue to prefer the certainty of traditional comprehensive medical insurance plans with relatively low deductibles.⁽²⁶⁾

The GAO report confirmed that sales were lower than expected. Some insurers participating in the GAO survey felt that the low sales numbers were not surprising in light of the complexity of the MSA product and the limitations of the demonstration project.⁽²⁷⁾

- *Program design problems:* The MedPac report also found that the restrictions applying to federal MSAs have impeded their growth. These restrictions – which were put in place partly to allay concerns about possible negative effects on tax revenues and the health

(24) United States General Accounting Office (GAO), Report to Congressional Committees, *Medical Savings Accounts Results from Surveys of Insurers*, December 1998, GAO/HEHS-99-34, p. 11. <http://www.gao.gov/archive/1999/he99034.pdf>.

(25) MedPac, *Medical Savings Accounts and the Medicare Program*, p. 6.

(26) *Ibid.*, p. 7.

(27) GAO, *Medical Savings Accounts Results from Surveys of Insurers*, p. 12.

insurance market if MSAs were taken up in large numbers by healthy and relatively wealthy individuals – have had a dampening effect on the MSA market.⁽²⁸⁾

A 1998 Policy Report by the National Center for Policy Analysis looked at obstacles to the growth of the MSA market.⁽²⁹⁾ Among other things, the NCPA suggested that the range of permitted deductibles was too narrow and the limit on the amount that could be deposited to an MSA account could expose MSA holders to substantial out-of-pocket health care expenses before their insurance took over. Concluding that the MSA legislation was “the result of a number of political compromises that had little to do with health policy, economic research or market demand,”⁽³⁰⁾ the NCPA made a number of recommendations for MSA reform, including the following:

- allow a wider range of deductibles thereby giving insurers more flexibility in designing MSAs to meet consumer needs;
- allow the market to determine the out-of-pocket exposure under MSA plans;
- permit employer and employee contributions to MSA plans; and
- remove the enrolment cap of 750,000.⁽³¹⁾

C. Medicare Medical Savings Accounts

The *Balanced Budget Act of 1997* introduced a number of new health insurance options for Medicare beneficiaries. One of these options is a Medicare+Choice MSA, a demonstration project that began in January 1999 and runs to the end of 2002.⁽³²⁾ The Medicare+Choice MSA plan combines a high-deductible health insurance plan (approximately \$6,000) and a medical savings account. Under this program, Medicare pays the insurance premium which because of the high deductible is lower than a typical health insurance premium, and deposits the difference between the cost of the premium and the normal Medicare capitation

(28) MedPac, *Medical Savings Accounts and the Medicare Program*, p. 7.

(29) National Center for Policy Analysis, *Medical Savings Accounts: Obstacles to Their Growth and Ways to Improve Them*, NCPA Policy Report No. 216, July 1998. <http://www.ncpa.org/studies/s216.html>.

(30) *Ibid.*

(31) *Ibid.*, pp. 2-4.

(32) United States, Internal Revenue Service, Publication 969, *Medicare+Choice Medical Savings Accounts*, sets out the Medicare MSA requirements. This publication is the main source of information for this section. http://www.irs.ustreas.gov/prod/forms_pubs/pubs/p96902.htm.

amount in an MSA. Plan contributions are the same for all beneficiaries but payments are adjusted for demographic and health status.

The Medicare+Choice MSA is intended to give Medicare beneficiaries more control over their health care by allowing them to choose their health care providers under the financial arrangements they negotiate. Policy-makers hoped this approach would reduce spending on discretionary health care as beneficiaries became more conscious of the costs involved.

Under the program, only the Medicare authority is permitted to make deposits to MSAs; Medicare beneficiaries cannot contribute to the account. Deposits and interest earned are free of federal income tax, and qualified spending from the account is tax-free. No more than 390,000 Medicare beneficiaries can be enrolled in the Medicare+Choice MSA plan.

Beneficiaries who do not have major health expenses can take the MSA payment as additional income over time. The savings account can be used for medical expenses that qualify for income tax deductions and for payment of certain insurance premiums such as long-term care. If money in the account accumulates to more than 60% of the annual deductible level, the amount above 60% can be withdrawn penalty-free for any purpose (although these amounts will be treated as taxable income).

On death, the MSA can be transferred to a spouse who is designated as a beneficiary and will be treated as the spouse's MSA. Otherwise, the MSA loses its MSA status and the fair market value becomes taxable.

As of November 2000, no organization had applied to offer an MSA plan to beneficiaries under Medicare+Choice. Consequently, Congress asked the Medicare Payment Advisory Commission to report on how the program could be changed to make it a viable option for organizations and Medicare beneficiaries.

MedPac concluded that the private sector would not offer Medicare MSAs for two reasons:

- (1) little demand from the risk-averse Medicare beneficiary population, and
- (2) the expense and difficulty of marketing a complex product such as Medicare MSAs to a fragmented and scarce set of customers.⁽³³⁾

MedPac noted that the relatively low premiums and broad coverage of the traditional Medicare plan provide few incentives for Medicare beneficiaries to move to MSAs.

Furthermore, even if the conditions that discouraged participation were changed, underlying market conditions would continue to impede more Medicare recipients from enrolling.⁽³⁴⁾

Nevertheless, MedPac went on to suggest that one possible way to test the viability of an MSA program within Medicare would be for Medicare itself to run an MSA demonstration that would “test if beneficiaries would be willing to enroll in a high-deductible option, show whether use of discretionary health care would decrease, and show whether providers would be willing to take on the risk of treating beneficiaries with high deductibles.”⁽³⁵⁾

After the demonstration, the private sector could reevaluate the market and the government would have more information about the characteristics and health care use of those who chose MSAs.⁽³⁶⁾ Payment rates could then be set more equitably, and various administrative changes could be adopted to reduce administrative requirements.

MEDICAL SAVINGS ACCOUNTS – PROPOSALS IN HONG KONG

In December 2000, the Hong Kong government released a consultation document on health care reform – *Lifelong Investment in Health*.⁽³⁷⁾ Acknowledging that the sustainability of Hong Kong’s health care system is “highly questionable,” the document puts forward a three-pronged strategy for ensuring the system’s long-term financial sustainability. The third prong, after reducing costs/enhancing productivity and revamping the fee structure, is the introduction of personal savings for medical expenses through the creation of individual Health Protection Accounts.⁽³⁸⁾ Such savings would be directed to supplementing government financing of the health care system.

(33) MedPac, *Medical Savings Accounts and the Medicare Program*, p. 19.

(34) *Ibid.*

(35) *Ibid.*

(36) *Ibid.*

(37) Hong Kong, *Lifelong Investment in Health*, Consultation Document on Health Care Reform, December 2000. <http://www.info.gov.hk/hwb/english/CONSULT/HCR/HCR2.HTM#Contents>.

(38) *Ibid.*, p. 51.

The Health Protection Account proposal would have the following key features:

- (i) the creation of a personal account comprised of mandatory contributions by the individual of one to two percent of earnings from age 40 to 64 to cover the future medical needs of the individual and his or her spouse;
- (ii) the savings could not normally be withdrawn from the account until the age of 65;
- (iii) on withdrawal, the savings could only be used for the individual's or spouse's medical and dental care, based on public sector rates, or to purchase medical and dental insurance from private insurers;
- (iv) services provided by the private sector would be reimbursed at public sector rates from the accumulated savings, any price difference would be met from the individual's resources outside the personal account or from private insurance;
- (v) on death, money remaining in the account would be transferred to the surviving family.⁽³⁹⁾

The purpose of the Health Protection Account is to assist “individuals to pay for heavily subsidized medical services after retirement, and not to shift the burden to the next generations.”⁽⁴⁰⁾ To keep the savings rate at an affordable level, the proposal would: limit withdrawals from the account until age 65 and after; and provide for reimbursement of costs at public-sector rates. The government estimates that for a family at a median income level, based on the average utilization rate, a couple will be able to pay for medical expenditures at public-sector rates up to the average life expectancy age.⁽⁴¹⁾

The Hong Kong government intends to conduct a further study of the merits and feasibility of Health Protection Accounts in 2001-2002.

For individuals who have saved very little or who have exhausted their savings because of frequent illness, the consultation document makes brief reference to (but does not detail) a second “safety net” to be provided by the government. For those requiring long-term nursing care, however, the document mentions a proposal for a separate personal savings account, “Medisage,” to purchase long-term care insurance on retirement. Medisage would be financed by individual contributions at the rate of 1% of a person's salary. Because long-term

(39) *Ibid.*, p. 57.

(40) *Ibid.*, p. 58.

(41) *Ibid.*

care insurance is not well developed in Hong Kong, the government proposes to conduct more in-depth studies of options for long-term care and the features of the scheme.⁽⁴²⁾

MEDICAL SAVINGS ACCOUNTS: THE DEBATE

Medical savings accounts have been one of the most controversial health care reform proposals debated in recent years. Proponents argue that MSAs will help to address a number of problems plaguing the health care system, particularly in relation to costs, quality and access. Opponents, on the other hand, maintain that MSAs are not likely to contain costs, may result in people foregoing necessary care, and can have an adverse effect on the insurance market by segmenting risk. These and other arguments are examined in more detail below.

A. Arguments for MSAs

MSA proponents argue that MSAs will have a number of beneficial impacts.

MSAs will promote health care consumerism by giving individuals more choice among health care providers and services and greater access to services. Consequently, MSAs are seen as a viable alternative to the managed care plans that have been adopted by many employers in the United States. In an attempt to curb escalating health care costs, these managed plans have: disputed health care claims; limited access to certain types of health care; and placed controls on doctors' services.

MSA supporters believe that MSAs will give patients greater freedom to choose their health care providers and the type of medical care they want. Because the individual controls the money in an MSA and can spend it as he or she chooses (subject to the expenditures being made for medical purposes), consumers will have increased access to services, doctors will not face pressure from managed care organizations to withhold care, the doctor-patient relationship will be freed from third-party restrictions, and patients will be able to choose the appropriate services based on their value rather than on the basis of insurance coverage.⁽⁴³⁾

MSAs will reduce the number of uninsured individuals. Low deductible amounts are typical features of traditional comprehensive health insurance plans. Because

(42) *Ibid.*, pp. 58-59.

(43) American Medical Association, "Why the American Medical Association Supports Medical Savings Accounts." 1998.

MSAs are coupled with a high-deductible insurance policy, the premiums will be lower than those of traditional plans and more people will be able to afford insurance.

MSAs may reduce administrative costs. This claim is based on the contention that administrative costs will be reduced because individuals will use their MSAs to pay for most of their medical expenses and therefore will not make an insurance claim. A study prepared for the U.S. National Coalition on Health Care (NCHC)⁽⁴⁴⁾ refers to data from the American Academy of Actuaries that indicate the annual medical expenses of a large portion of the U.S. population fall below the deductible levels applicable to high-deductible policies and would, under an MSA plan, therefore not trigger insurance claims.

The American Academy of Actuaries estimates that in 1995 about 17% of the adult population had essentially zero medical expenses and 78% had expenses below \$2,000. Their costs will be fully covered by withdrawals from their medical savings accounts or out of pocket, and the insurance carrier need not be involved at all. The insurer thus avoids the costs that would be incurred in processing and paying claims for expenses that are above the normal deductible of comprehensive coverage plans but below the level at which MSA catastrophic coverage begins.

... the administrative costs related to the savings account portion of protection should be only a bit higher than 2%, compared to about 15% for premiums for typical comprehensive coverage insurance.⁽⁴⁵⁾

MSAs will encourage people to save for their health care expenses. The funds in an MSA belong to the account holder. Any funds remaining in the account at year-end are allowed to accumulate on a tax-free basis to be used as needed for health care or, in some cases, for other expenses. When the account is the property of the account holder and account balances do not lapse, there is an incentive to save for health care.

MSAs will encourage more prudent use of the health care system. This argument is based on the belief that people will be more circumspect in using the health care system if they are aware of the costs of the services and have to pay for the services themselves.

(44) The National Coalition on Health Care – a non-profit, non-partisan organization founded in 1990 – is comprised of large and small businesses, labor unions, consumer groups, religious groups and primary care providers.

(45) Elliot K. Wicks and Jack A. Meyer, *The Role of Medical Savings Accounts in Health Care Reform*, Study prepared for the National Coalition on Health Care, May 1998, p. 8.

When services are free or are covered under comprehensive health insurance policies with low deductibles and co-payments, there is no real financial incentive to make economical use of health care services.

MSA supporters argue that free health care services result in over-consumption which, in turn, makes the health care system less accessible. They believe that MSAs will discourage needless consumption and, over time, improve access to health care.

MSAs will help contain health care costs/spending. MSA advocates believe that the combination of catastrophic insurance coverage (to protect against large medical expenses) and MSAs (to cover routine and low-cost medical services) will encourage people to be more responsible and economical in purchasing health care. As a result, health care spending will decrease. The impact of MSAs on health care spending will be examined in a separate section below.

B. Arguments against MSAs

Opponents of MSAs argue that the benefits claimed by MSA proponents are overstated at best and that MSAs could have serious negative consequences by fostering risk segmentation in the insurance market and encouraging people to forego necessary medical care.

MSAs could result in people foregoing necessary and preventive medical care. MSA opponents question whether those who reduce their medical spending will eliminate only unnecessary medical services. When expenses have to be paid from MSAs, people may forego necessary and preventive care and ultimately cost the health care system more when they have to be treated for serious medical problems.

MSAs will not result in people becoming better health care consumers. Opponents argue that using MSAs to pay for routine health care will not necessarily result in consumers taking a more active role in their health care (by becoming more informed about procedures, alternative treatments, medications, etc.) and thus make consumers better able to judge the advice given by their physician. Because of the complexity and technical nature of modern medicine, most people simply do not have the experience, information or the ability to decide whether a medical service is suitable or needed.⁽⁴⁶⁾

<http://www.nchc.org/1998PolicyStudies/RoleofMSA.html>.

(46) *Ibid.*, p. 9.

By attracting young and healthy individuals, MSAs will segment the risk pool in the insurance market. MSA opponents believe that segmentation of the risk pool will result in higher premiums for those who remain in traditional insurance plans. In August 2000, the U.S. Consumers Union (CU) published a report⁽⁴⁷⁾ written by Gail Shearer (the CU's Director of Health Policy Analysis). In the report, Shearer argues that MSAs will appeal to the young and the healthy whose medical costs are relatively low and who can accumulate balances in their MSAs rather than to the elderly and the sick whose medical expenses are much higher. Shearer maintains that if a substantial number of the young and the healthy opt for MSAs, the insurance risk pool will be depleted and those with higher risks will be saddled with higher premiums. She notes that the ability to spread the risk as broadly as possible is essential to maintaining reasonable health insurance premiums. If a substantial number of low-risk individuals leave the pool, the remaining higher-risk individuals will have to pay more.

Although the limited number of MSAs sold during the HIPAA pilot project makes it impossible to analyze the actual impact on premiums for those who choose traditional comprehensive insurance coverage,⁽⁴⁸⁾ Shearer attempts to predict what the average total health care costs would be for various risk pools if a certain percentage of the average healthy and sick opt for MSAs. According to Shearer, "relatively modest enrolment in MSAs can have a very real impact on the risk pool: if 20% of the healthiest 80% of risks enroll in MSAs, the average per capita health care costs of those who stay in traditional policies would increase from \$3,338 to \$3,835, a 15% increase."⁽⁴⁹⁾

The Urban Institute also examined the effects of risk segmentation on premiums. Using a number of assumptions about the proportion of healthy people switching to MSA plans, Urban Institute researchers found that if one-fourth of the people who would be financially better off (in any year) by switching to an MSA made the switch, the premium for the comprehensive plan would rise by 60%; if half of the better-off people made the switch, premiums would double. Finally, if all who would gain by moving to MSAs did so, the premium for the comprehensive plan would rise by over four times.⁽⁵⁰⁾

(47) Gail Shearer, *The Health Care Divide: Unfair Financial Burdens*, 10 August 2000, Consumers Union. <http://www.consumersunion.org>.

(48) *Ibid.*, p. 22.

(49) *Ibid.*, p. 24.

(50) Len M. Nichols, Marilyn Moon and Susan Wall, *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996, p. 9. <http://www.urban.org/pubs/hinsure/winlose.htm>.

MSAs will appeal to those who are already insured rather than to the uninsured. Opponents of MSAs contend that MSAs will be attractive to those who already have insurance and who want to attempt to reduce their health insurance costs. Those who are uninsured are not likely to have the financial ability to purchase an MSA in the first place.

MSAs will provide a tax benefit for the wealthy. Because contributions to an MSA account are tax deductible, those who have higher incomes and thus fall into a higher tax bracket will reap a greater benefit from contributing to an MSA than those with lower incomes.

MSAs will not have a significant impact on health care spending. MSA opponents contend that the cost savings estimated by MSA proponents have been exaggerated. Some wasteful spending will likely be discouraged, but such expenses do not represent a high portion of total medical expenses.

C. Medical Savings Accounts and Health Care Costs/Spending

A considerable amount has been written about the impact of MSAs on health care costs and spending. It is important to note, however, that there is not a great deal of practical experience from which to draw; most of the studies are based on data simulations and there would appear to be no real consensus in the economic literature on the overall impact of MSAs on health care costs.

An in-depth report on medical savings accounts published by The Fraser Institute⁽⁵¹⁾ notes that studies of employer-sponsored MSAs in the United States indicate that savings can be generated. The report discusses three examples.

- The MSAs examined in one study of 27 Ohio companies offering MSAs found that employees' out-of-pocket health expenditures had decreased and employers' total average cost for the MSA plans was 12% less than that of traditional comprehensive plans.⁽⁵²⁾
- A survey of 17 firms offering MSAs found that the account balance at the end of the coverage year was approximately US\$600, on average, for individual accounts and US\$900 for family accounts.⁽⁵³⁾

(51) Cynthia Ramsay, *Medical Savings Accounts: Universal, Accessible, Portable, Comprehensive Health Care for Canadians*, The Fraser Institute, Critical Issues Bulletin, May 1998.
http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/.

(52) *Ibid.*, p. 9. http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/evidence.html

(53) *Ibid.*, p. 10. http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/evidence.html

- Another study of companies providing MSA plans found that the companies had achieved significant cost decreases and had highly satisfied employees.⁽⁵⁴⁾

Other research has attempted to examine the impact of medical savings accounts on health care expenditures. The results of this research were reported in studies prepared for the National Coalition on Health Care⁽⁵⁵⁾ and The Fraser Institute⁽⁵⁶⁾ as well as in a C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System: Lessons from Abroad*.⁽⁵⁷⁾ This research mentioned the following findings:

- A 1996 simulation study estimated the savings that would be realized if everyone in the United States switched from plans offered through health maintenance organizations (HMOs) and fee-for-service plans to MSAs. The savings would differ depending upon the features of the MSA plan and would range from zero to 13%. If people could choose from several types of plans, the simulation indicates that adding options to MSAs would produce fewer savings (because those most likely to use medical services would tend to pick more comprehensive plans with higher levels of financial protection). Under these conditions, national health spending could fall by up to 2% or rise by as much as 1%.⁽⁵⁸⁾
- A simulation study by the Urban Institute (1996) found that if all people in employer-sponsored health plans switched to an MSA plan with catastrophic coverage, the reduction in national spending on health care would be in the 4% to 6% range.⁽⁵⁹⁾
- Another study of non-elderly adults compared comprehensive insurance and a combination of medical savings with catastrophic insurance. The findings indicated that a savings/catastrophic plan would result in a 2% to 8% reduction in medical spending.

(54) *Ibid.*, p. 10. http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/evidence.html.

(55) Wicks and Meyer, *The Role of Medical Savings Accounts in Health Care Reform*, May 1998.

(56) Ramsay, *Medical Savings Accounts*, 1998.

(57) Donaldson, Currie and Mitton, *Integrating Canada's Dis-Integrated Health Care System*, April 2001. <http://www.cdhowe.org>.

(58) Wicks and Meyer, *The Role of Medical Savings Accounts in Health Care Reform*, May 1998, pp. 6-7. The reference is to a study by E.B. Keeler, J.D. Malkin, D.P. Goldman and J. Buchanan, "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *Journal of the American Medical Association*, 5 June 1996, Vol. 275, No. 21, pp. 1666-1671.

(59) Wicks and Meyer, *The Role of Medical Savings Accounts in Health Care Reform*, May 1998, p. 7. The reference is to a study by Len M. Nichols, Marilyn Moon and Susan Wall, *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996.

However, another study indicates that for the elderly Medicare population in the United States, this approach would be less appealing, thereby reducing potential overall savings.⁽⁶⁰⁾

The C.D. Howe Institute Commentary suggests that evidence from other countries does not clarify unresolved issues from the U.S. literature nor does it examine changes in health outcomes. One study points out that hospitals in Singapore did not start competing on price, and that the per capita cost of health care rose faster after the introduction of medical savings accounts than it had before.⁽⁶¹⁾ Another study indicates, however, that costs were controlled following the introduction of MSAs.⁽⁶²⁾ A paper on the Chinese system of MSAs pointed out that although medical savings accounts appeared to be promising as a viable model of health care finance, they create the potential for risk selection, cost shifting, and a reduction in equity.⁽⁶³⁾

There is evidence that patients will use fewer health services when they have to pay more out of their own pockets for the services. But there would appear to be no consensus about the effect of higher cost-sharing on all health care spending. A 1996 study prepared for the Urban Institute noted that

Some advocates of MSAs have assumed rather large effects, whereas the professional economic literature suggests modest responsiveness to cost-sharing when compared with the price sensitivity of other goods. The effect of increased cost-sharing is not likely to be uniform across different services and may differ for different population groups as well. For example, low income groups are particularly sensitive to cost-sharing, likely because of the relative burdens of such costs as compared with their resources. Indeed, one of the reasons why MSAs are thought to be so popular with higher income families is that the deductibles usually associated with such plans are not likely to be very constraining on behavior.⁽⁶⁴⁾

(60) Donaldson, Currie and Mitton, *Integrating Canada's Dis-Integrated Health Care System*, April 2001, p. 18. The reference is to a study by L. Ozanne, "How Will Medical Savings Accounts Affect Medical Spending?" *Inquiry*, 1996, 33(3), pp. 225-236 and to a study by P.L. Grimaldi, "Is a Medical Savings Account in your Future?" *Nursing Management*, 1996, 27(5), pp. 14-16.

(61) Donaldson, Currie and Mitton, *ibid.* The reference is to a study by W. Hsiao, "Medical Savings Accounts: Lessons from Singapore," *Health Affairs*, 1995, 14(2), pp. 260-266.

(62) Donaldson, Currie and Mitton, *ibid.* The reference is to a study by T.A. Massaro and Y. Wong, "Positive Experience with Medical Savings Accounts in Singapore," *Health Affairs*, 1995, 14(2), pp. 267-272.

(63) Donaldson, Currie and Mitton, *ibid.* The reference is to a study by W. Yip and W. Hsiao, "Medical Savings Accounts: Lessons from China," *Health Affairs*, 1997, 16(6), pp. 244-251.

(64) Moon, Nichols and Wall, *Medical Savings Accounts*, March 1996, p. 5.

Commentators also point out that MSAs may have little impact on containing health care costs because very ill people whose expenses would exceed the deductible level account for such a large portion of health care spending.

The 78% of adults in 1995 that are estimated to have incurred medical claims below \$2,000 (comparable to the MSA's catastrophic trigger point of between \$1,500 and \$2,250) account for only 13% of charges. A very large portion of the nation's medical expenses go to pay for services of the seriously ill: the 10% of the adult population that incurred charges in excess of \$6,000 in 1995 are estimated to have accounted for 84% of total medical expenses. This means ... that most expenses incurred by people with medical savings accounts will not be paid out of the pockets or the savings accounts of the insured person but by the insurer providing the catastrophic coverage. Once that coverage begins to pay, the person insured with an MSA has no more (nor less) incentive to economize than does the person covered by a plan that has front-end coverage.⁽⁶⁵⁾

The Urban Institute study suggests that a shift to MSAs might produce a one-time reduction in health care spending that would lower the spending base but would not necessarily reduce the expenditure growth rate.

A one-time reduction in health spending as a result of widespread shifts to MSA/catastrophic arrangements, however large or small, does not necessarily translate into reductions in the rate of cost growth. And it is the growth in spending that most concerns analysts regarding health care costs. That is, the shift in type of policy could result in a one time reduction in the base, but after that, the causes of growth in costs could largely be unaffected. Many analysts believe technological improvement is the major reason health care costs continue to grow year in and year out, and much of this technology is heavily used in inpatient settings – where patients' costs are likely to exceed the high deductible of a catastrophic policy. Thus, high priced procedures and techniques may actually face less market discipline if we move to an open-ended fee-for-service policy that fully protects families above the deductible as compared with pressures on technology in a managed care context. It is possible, therefore, that widespread MSA/catastrophic indemnity arrangements could actually increase long run health care cost growth rates. While MSAs may have other desirable effects depending on one's point of view, significant aggregate reductions in health care costs are not likely to be among them.⁽⁶⁶⁾

(65) Wicks and Meyer, *The Role of Medical Savings Accounts in Health Care Reform*, May 1998, pp. 8-9.

(66) Moon, Nichols and Wall, *Medical Savings Accounts*, March 1996, pp. 5-6.

D. Medical Savings Accounts and Health Outcomes

The effect of MSAs on health is another contentious issue. Proponents argue that MSAs will not have a negative effect on health; indeed, MSAs will encourage people to take greater responsibility for their personal health and reduce consumption of unnecessary health care services. MSA opponents, on the other hand, maintain that when expenses have to be paid from MSAs or out-of-pocket, people may forego necessary and preventive care and ultimately cost the health care system more when they require treatment for a serious medical problem.

Unfortunately, there is little direct evidence on this question. However, because cost-sharing for health care expenditures is inherent in the MSA concept, studies have looked at the impact of cost-sharing on health outcomes and preventive care and have sought to apply those results in the context of MSAs.

The results of a number of these studies are discussed in The Fraser Institute report which noted that although cost-sharing does not necessarily translate into a decline in overall health, it does have an adverse impact on the poor.⁽⁶⁷⁾ The report referred to the following study conclusions:

- On the whole, reduced use of medical services as a result of cost-sharing has little or no net adverse effect on health; however, the health of the poor and the sick is adversely affected by cost-sharing.
- Cost-sharing reduces both necessary and unnecessary care; however, the type of cost-sharing plan was found to have no effect on most measures of health.
- Co-payments reduce the use of physicians' services.
- There is a slight decrease in the consumption of preventive care when cost-sharing increases.⁽⁶⁸⁾

PROPOSALS FOR MEDICAL SAVINGS ACCOUNTS IN CANADA

Various proposals for medical savings accounts have been put forward in Canada. The most comprehensive proposals come from two policy think tanks – The Fraser Institute and the Frontier Centre for Public Policy – and from author David Gratzer. Another think tank – the

(67) Ramsay, *Medical Savings Accounts*, 1998, p. 11.
http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/evidence.html.

(68) *Ibid.*, pp. 11-15.

C.D. Howe Institute – has also examined the concept of medical savings accounts in a Commentary about the Canadian health care system.

Each of these proposals is described below.

A. The Fraser Institute

In 1996, The Fraser Institute proposed a system of medical savings accounts in the context of the Canadian health care system.⁽⁶⁹⁾ The proposal would see the creation of a Medical Premium Account (MPA) financed through general tax revenues with the government standing in a position equivalent to that of the employer in the typical employer-funded MSA.

The Medical Premium Account was said to have the following benefits:

The MPA concept would create a more efficient and a more effective method of providing publicly funded universal insurance. An MPA would be truly portable, as the funds belong to the individual. It would be truly comprehensive, as the funds could be used to purchase any health services the individual desired, thus offering greater consumer choice. It would inform the consumer and the supplier of the true costs of health care and it would provide them both with incentives to use the system appropriately. As well, an MPA would ensure that the health provider was the agent of the patient, not the agent of the state or a specific institution. The doctor-patient relationship, which has been eroded over the years by government regulations and cost cutting measures, would be restored.⁽⁷⁰⁾

Like the typical MSA, the MPA would be comprised of two parts: the individual's account and a high-deductible catastrophic insurance policy. The government would provide every citizen with an MPA. The account would be used to purchase private insurance to cover catastrophic illness and to pay for health care services and routine medical bills. Any medical service could be funded from the MPA, but only covered services would count towards the deductible. The individual would be required to use the money in the MPA, or his or her own funds, to pay for medical expenses until the deductible was reached and the insurance coverage applied. The account would belong to the individual and any funds left over at the end of the year would continue to belong to the account holder.

(69) William McArthur, Cynthia Ramsay and Michael Walker, eds., *Healthy Incentives: Canadian Health Reform in an International Context*, The Fraser Institute, 1996.
http://www.fraserinstitute.ca/publications/books/health_reform/section2.html.

(70) *Ibid.*

In a study for The Fraser Institute, Cynthia Ramsay also argues for the adoption of MSAs in Canada.

Evidence from American firms that have adopted MSA plans show that MSAs are conducive to more prudent health spending without compromising individuals' health. Where they have been adopted, MSAs have resulted in lower employer and employee costs, accumulated savings, and high degrees of employer and employee satisfaction. The empirical literature in the United States indicates that MSAs or similar arrangements have the potential to reduce health expenditures up to 20%. One would predict an even larger decrease in health expenditures had these simulations been performed using Canadian data because Americans already face financial incentives with respect to their use of health care while Canadians do not for the most part.⁽⁷¹⁾

Ramsay notes that, except in relation to the poor, studies have demonstrated, for the most part, that cost-sharing reduces the use of health care services with "little or no net adverse effect on people's health."⁽⁷²⁾ Furthermore,

Medical savings accounts can encourage more prudent use of the health care system and introduce competition into the medical marketplace without creating financial barriers to care. MSAs provide incentives for consumers to take a more active role in their consumption of medical care services and in their overall health status. The most promising characteristic of MSAs in a Canadian context is that individuals will be able to purchase medical services with money they can otherwise keep because any funds remaining in the account at the end of the year are the property of the individual. In effect, MSAs can indirectly establish a cost-sharing device without infringing on the important philosophical cornerstones on which the Canadian health care system is built: universality, accessibility, portability and comprehensiveness.⁽⁷³⁾

Recognizing that MSAs are controversial and that their impact in the Canadian context is uncertain, Ramsay called for the creation of an MSA pilot experiment in one region of Canada to provide data on issues of concern with respect to MSAs, including the following:

(71) Ramsay, *Medical Savings Accounts*, 1998, p. 1.
http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/summary.html.

(72) *Ibid.*

(73) *Ibid.*, p. 2.

- How will MSAs influence the consumption of health care services?
- Will the use of necessary services decrease by more (or less) than unnecessary services?
- Will the change, if there is a change, in health care consumption differ across income groups?
- Will MSAs affect individuals' use of preventive medicine?
- Will MSAs affect individuals' health status?
- Will physicians induce demand if MSAs decrease consumption?⁽⁷⁴⁾

B. The Frontier Centre for Public Policy⁽⁷⁵⁾

In a policy report, Dennis Owens and Peter Holle of the Frontier Centre for Public Policy make a case for establishing a system of “Universal Medical Savings Accounts” (UMSAs) as a model with the potential for solving many of Medicare’s problems and guaranteeing access to medical care.⁽⁷⁶⁾

Owens and Holle maintain that the structure of Medicare is at the root of the problems now being experienced in Canada’s health care system, and five elements of that structure in particular have led to the system’s deteriorating performance. These elements are:

Zero Price – Because health care services are funded through tax revenues, the services are treated as free goods. As a result, demand increases and there is over-consumption and waste.

Monopoly – Medicare’s single-provider system may be administratively more efficient, but it creates a monopoly, fails to satisfy consumers as customers, and functions to serve the interests of those running the system rather than the interests of its clients.

Lack of Separation – Because the government both provides and administers the funds for health care services in Canada, there is an inherent conflict of interest and a low level of accountability for results.

(74) *Ibid.*, pp. 1-2.

http://www.fraserinstitute.ca/publications/critical_issues/1998/msa/recommendation.html.

(75) The Frontier Centre for Public Policy is a Winnipeg-based independent non-profit organization undertaking research and education in areas such as health, government, education, local government and social policy.

(76) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts: Consumerizing Medicare to End Waiting Lists and Improve Service*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000. <http://www.fcpp.org>.

Lack of Transparency – The lack of real information about costs prevents an assessment of the system’s performance. Without the information provided by prices, the various stakeholders – governments, health care workers, and patients – are not aware of the costs of their behaviour.

Politicization – Because Medicare is a government program, it is subject to distortion through the political system.⁽⁷⁷⁾

Under the Owens and Holle proposal for Universal Medical Savings Accounts, each citizen would have a UMSA into which would be deposited an amount equal to the average amount governments now spend per capita on health care. The UMSA would be a combination of catastrophic insurance and an account, and would operate this way:

At the beginning of each fiscal year, health authorities would deposit each citizen’s share of the Medicare budget into a dedicated bank account in that person’s name. Each account-holder would gain access to those funds through an electronic debit card. In the case of dependent children or people who are incapacitated and unable to manage their resources, parents or public or private trustees would be responsible for administering the UMSA.⁽⁷⁸⁾

Withdrawals from the account would be allowed only to pay for health-care services. Minor, non-catastrophic events requiring a visit to a clinic or doctor would be paid by direct electronic debit from an individual’s or family’s UMSA. Individuals would cover themselves against catastrophic events by purchasing insurance from competing commercial carriers, co-operatives or mutual benefit associations. Money not spent would be rolled over and left to accumulate tax-free over the account-holder’s lifetime until the fund reached some pre-determined amount sufficient to create an income stream that would cover future medical emergencies.⁽⁷⁹⁾ Special cases, the small minority who run out of money or have special needs, are accommodated separately with extra government assistance.⁽⁸⁰⁾

The cost of catastrophic insurance would depend on the age of the person and the size of the deductible.

(77) *Ibid.*, pp. 2-3.

(78) *Ibid.*, p. 19.

(79) *Ibid.*

(80) *Ibid.*, p. 20.

Owens and Holle see UMSAs as a cure for Medicare's structural problems. They maintain that under their USMA model:

- Prices would be restored to the health care system. Providers and consumers would have information about the costs and benefits of their behaviour; individuals would benefit personally because they could keep unspent funds; and society would benefit from the more efficient use of resources.
- Competition would be introduced. The income of hospitals, clinics and medical personnel would no longer be disconnected from performance. In order to retain clients, they would have to provide service as effectively as other providers.
- The funding and administration of health care would be separated. The government would continue to fund health care but would no longer deliver it.
- The health care system would become more transparent. If pricing were restored to the system, it would be possible to measure costs and results.
- Politicization of the health care system would be reduced. As governments moved away from involvement in the design, delivery, operation and management of health care delivery, political influence would lessen.⁽⁸¹⁾

C. David Gratzer – *Code Blue*

In his 1999 book, *Code Blue*,⁽⁸²⁾ David Gratzer proposes a system of medical savings accounts as a way to preserve the sustainability of the Canadian health care system.

Gratzer argues that the “fundamental flaw of the medicare system is that patients bear no direct costs for medical services they receive.”⁽⁸³⁾ He maintains that in a free system, there is no incentive for people to have second thoughts about visiting a doctor for minor ailments or for visiting hospital emergency rooms when there is no real emergency.

Gratzer believes that “perverse incentives” in the current system distort the doctor-patient relationship and result in inefficient and wasteful health care at high costs. Thus:

- patients have a perverse incentive to over-use the system because they are not directly responsible for the costs;

(81) *Ibid.*, pp. 21-22.

(82) David Gratzer, *Code Blue: Reviving Canada's Health Care System*, ECW Press, 1999.

(83) *Ibid.*, p. 118.

- physicians have a perverse incentive to over-service patients because they operate on a fee-for-service basis; and
- health care administrators have the perverse incentive to enhance global budgets because hospitals are funded through block allocations.⁽⁸⁴⁾

Gratzer contends that the five principles of the *Canada Health Act* miss the point. Canadians, he argues, should define their health care system not by the constructs of the *Canada Health Act*, but rather by the foundational elements upon which good health care rests. Those elements include:

- *quality* – a system that includes the latest technology, modern facilities, and highly trained doctors and nurses;
- *timeliness* – where illnesses are diagnosed and treated quickly;
- *cost effectiveness* – acceptable results for the money spent;
- *patient orientation* – a system that serves patients rather than providers and where patients, not bureaucrats, are the ultimate decision-makers about their individual care; and
- *accessibility* – a system where no Canadian is deprived of needed medical care.⁽⁸⁵⁾

Gratzer maintains that by covering catastrophic health expenses as well as routine discretionary spending, Medicare has strayed far beyond the boundaries of typical insurance coverage. He argues that Medicare should return to an insurance-based system where coverage is provided for catastrophic illness, but where the individual pays for routine health care procedures. This, he notes, is in keeping with the traditional function of insurance – to protect against large, unpredictable losses.

Gratzer asserts that revitalizing health care in Canada means restoring the doctor-patient relationship. His solution is to create MSAs to finance health care. Under an MSA system,

Patients would be held financially accountable for their decisions. Every dollar spent on a test would be one dollar less in the patient's account. The doctor, in turn, would receive compensation from patients, not from a provincial government. The doctor patient relationship would be reinvigorated with financial ties.⁽⁸⁶⁾

(84) *Ibid.*, p. 147.

(85) *Ibid.*, p. 167.

(86) *Ibid.*, p. 196.

Although readily admitting that MSAs are not a panacea for Medicare's woes, Gratzer believes they have the potential to preserve the characteristics of an effective health care system and to address many of the problems in the current Canadian system. In Gratzer's view, long-term sustainability of the system is possible with MSAs, but only if people have an incentive to spend the money prudently and are able to invest the remaining funds.⁽⁸⁷⁾

D. C.D. Howe Institute

In a C.D. Howe Institute Commentary, *Integrating Canada's Dis-Integrated Health Care System: Lessons from Abroad*,⁽⁸⁸⁾ health economists Cam Donaldson, Gillian Currie and Craig Mitton contend that the lack of integration between the private health care system (the portion of health care funded by insurance and individuals out of their own pockets) and the public health care system in Canada has led to perverse incentives within the publicly funded system that influence the three parties – health authorities (hospitals), doctors, and consumers (patients) – and lead to over-use and abuse.

The authors argue that health authorities have responsibilities without power. They are responsible for the health of their local populations but do not have enough control over resources within the system either to direct those resources according to established priorities or to control the total dollars spent.

Doctors, on the other hand, have power without responsibility. They exercise a great deal of influence in the health care system but are remunerated separately from health authorities.⁽⁸⁹⁾ The fee-for-service method for remunerating doctors gives doctors an incentive to generate demand and to spend little time with patients.⁽⁹⁰⁾

Consumers, the authors maintain, are the most vulnerable because they have neither power nor responsibility. They have little or no role to play in health care planning and, because many services are free, they have an incentive to over-use the system.⁽⁹¹⁾

Donaldson, Currie and Mitton consider reforms in other countries in order to provide guidance as to how Canada's health care system might be better integrated. Medical

(87) *Ibid.*, p. 205.

(88) Donaldson, Currie and Mitton, *Integrating Canada's Dis-Integrated Health Care System*, April 2001.

(89) *Ibid.*, p. 3.

(90) *Ibid.*, pp. 4-5.

(91) *Ibid.*, p. 5.

savings accounts are examined as a method of placing more control over health care spending in the hands of consumers and addressing the problem of over-use. The authors note that MSAs have a certain conceptual appeal, but there are many uncertainties about how an MSA system would actually work and what impact MSAs would have on the health care system. They point out that in the absence of hard data on health outcomes, it is not clear what effect MSAs would have on individual health. Furthermore, because of the differences between the U.S. and Canadian health care systems, they question whether citing cases from the United States as evidence of the potential impact of MSAs in Canada produces valid results in the Canadian context.⁽⁹²⁾

As for implementing MSAs in Canada, Donaldson, Currie and Mitton point out that the task would not be particularly easy. Before any benefits associated with MSAs could be realized, the following practical problems associated with implementation and other structural issues would have to be addressed.

- The advantages of consumer choice associated with MSAs might be limited in the Canadian context because Canadians already have considerable leeway in choosing their doctors and specialists.
- MSAs might have a limited impact on encouraging Canadians to invest in their own health beyond medical care because Canadians can already make many of these investments.⁽⁹³⁾
- The problem of “asymmetrical information” limits the possibility for gain from MSAs; many consumers might have difficulty making informed decisions about their health care because they lack the appropriate information.
- The ability of consumers to become active health care consumers might vary across age and socioeconomic groups.⁽⁹⁴⁾
- If governments were to allocate their health care dollars to MSAs, health care spending would remain the same. With money in MSAs, however, consumers might demand more and better access to services but the system might not be able to accommodate those increased demands and expectations.

The Commentary concludes by suggesting that “valid and reliable piloting of the medical savings account model in a Canadian setting would certainly be required before fully informed judgments about its impact can be made.”⁽⁹⁵⁾

(92) *Ibid.*, p. 19.

(93) *Ibid.*

(94) *Ibid.*, p. 20.

CONCLUSION

Although the merits and impacts of MSAs have been hotly debated, at least in the United States, there is insufficient evidence to make any definitive conclusions about the role of MSAs as a health care reform measure in the Canadian context. Most would agree that MSAs are not a panacea for the problems of the health care system. That being said, it would be premature to dismiss the concept. MSAs are operating in other countries, and the approaches adopted in such countries may offer guidance as to the impact of MSAs on health care systems and how medical savings accounts might operate in Canada.

The evidence indicates that MSAs should discourage some forms of consumption of medical services. Consumers are likely to think twice before using certain medical services if they have to pay for them from an MSA or out of their own pockets. If this is the case, health care spending may decline. However, it is difficult to determine the magnitude of any reduction because this would depend on a number of factors such as: how many people use MSAs (whether they are universal or apply to only certain segments of the population); the characteristics of the MSA system (what is covered by the plan, the level of the deductible and to what services the deductible applies, who contributes to the plan and the contribution level, the out-of-pocket amount that people are required to pay for medical services and whether account holders can retain and accumulate unused funds in the account); and the attributes of the particular health care system. Also, it is not clear how MSAs would address some of the important drivers of health care costs such as new technology and prescription drug use.

Whether MSAs will result in lower administrative costs is uncertain in the Canadian context. Administrative costs for health care in Canada are already relatively low, and the data from the United States on administrative cost impacts may not be readily applicable to the Canadian health care system.

Evidence of the impact of MSAs on health is also not definitive. Studies of the impact on health of co-payments for medical services would appear to indicate that overall health levels are not adversely affected. However, this is not the case for the poor and the sick, whose health status may worsen if they are required to pay a portion of health care costs. MSA systems

may have to introduce special programs to deal with the poor and the sick as well as those with other special needs.

The extent to which MSAs will encourage health care consumerism is also unknown. As Donaldson, Currie and Mitton point out, consumers may not have access to the appropriate information to make informed health care choices, and demographic and socioeconomic factors may affect the degree to which individuals can be active health care consumers.

To determine whether MSAs would generate the benefits claimed by proponents or realize the expectations of its critics, the U.S. Congress initiated an MSA demonstration project applicable to self-employed individuals and small employers. This was followed by another MSA demonstration project for Medicare recipients in which the government agreed to use Medicare entitlements to fund a limited number of MSAs. Unfortunately, because the take-up rate under these projects was low, it is not possible to draw conclusions about the impact of MSAs from the demonstrations.

Donaldson, Currie and Mitton have suggested that piloting MSAs in Canada would be required before informed judgements about their impacts can be made. Ramsay has also recommended that undertaking an MSA demonstration project would be beneficial. Piloting MSAs in Canada may therefore be necessary before serious consideration can be given to MSAs as a health care reform measure.