Medical Savings Accounts and Managed Care

Many people believe that Medical Savings Accounts (MSAs) and managed care are mutually exclusive. Some strong supporters of MSAs are bitter enemies of managed care, and the managed care industry generally has opposed MSAs.

But employers around the country are now combining Medical Savings Accounts and managed care. Medical Savings Accounts are inconsistent with the traditional philosophy of HMOs. But efforts to make medicine cost-effective are natural allies of Medical Savings Accounts. Let’s see why.

Combining MSAs and Managed Care. Medical Savings Accounts give people the opportunity to move from a conventional, low-deductible health insurance plan to one with a high deductible (say $2,000 to $3,000) and to put the premium savings in a personal account. Employees and their families pay all medical bills up to the deductible from their MSAs and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible. Currently, the IRS taxes MSA deposits, although employer payments for third-party insurance are tax free. MSA advocates in Congress want to end this discriminatory treatment.

Some employers are turning to MSAs for the same reason others are turning to managed care: to control rising health care costs. Since employees keep any MSA money they do not spend, they have a financial incentive to shop prudently in the medical marketplace. In general, they won’t spend a dollar on health care unless they get a dollar’s worth of value. Employer experiences with MSA plans show that the incentive works: employees curtail health care spending significantly.

Whether or not they have MSAs, today most employers and their insurance companies negotiate prices with doctors and hospitals and explore other ways to obtain quality care at a lower cost. Employees often regard the arrangements as burdensome, since their preferred doctor may not be in their employer’s network. With MSAs, however, employees have a financial self-interest in lower costs.

The NCPA’s Employee Health Plan. In 1994 the employees of the National Center for Policy Analysis had a conventional fee-for-service health plan with a $500 deductible and a 20 percent copayment. Under this policy, an employee was at risk for up to $1,500 out of pocket. If three members of the same family all became seriously ill, the family was at risk for $4,500 in medical bills. [See the table.]

In 1995 the NCPA adopted an MSA plan that limits the exposure of the employees and at the same time gives them more control over their health care dollars. At no extra cost to the employer, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit is $1,500. As long as all expenses are approved, the total out-of-pocket exposure is $375 per individual and $500 per family.
NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eye glasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, all spending counts toward the deductible only if employees see doctors within a network. If they go outside the network, only 75 percent of each “usual and customary” fee counts toward the deductible.

In the future, the buildup of MSA funds will give NCPA employees important options with respect to expensive medical procedures. For example, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to use their MSA funds outside the network to pay that portion of the bill not covered by the insurance.

This example of “patient power” plus managed care is only the beginning. In the future, the two concepts will likely be combined in even more interesting ways.

**Managed Care in the Information Age.** The traditional philosophy of HMOs was summed up by an HMO manager several years ago: “Patients do what their doctors tell them to do; therefore, if you can tell doctors how to practice medicine, you can cut costs.” This approach assumes that patients are compliant because they do not know what services they are not receiving.

A model based on patient ignorance is unlikely to survive in the new Information Age. Increasingly, patients will use the Internet and other computer services to tap into various medical libraries and databases, discuss ailments with other network users and follow diagnosis decision trees. Thus, the best model for the future assumes that patients will know as much as their doctors - not about how to practice medicine but about what medical practice offers.

One change that is almost certain to occur is full disclosure about how managed care organizations develop the protocols that doctors use to make such important procedural decisions as whether to order a mammogram or Pap smear, for example. Although they insist that their goal is cost-effective medicine, today no managed care organization will publicly discuss the cost-benefit standards it uses in developing protocols. In the future, patients will be able to use their computers to infer the standards.

**Being a Patient in the Information Age.** The successful managed care clinic of the future will practice cost-effective medicine, using publicly announced protocols. Patients who agree with a clinic’s general approach to the trade-off between money and health risk will use that clinic for most procedures. But because of, say, a history of family illness, a patient may want to obtain a medical test even if it falls outside the clinic’s protocols.

The services offered by these clinics need not be sold to employers the way managed care is usually sold today. Instead, they might be sold to individuals who pay for them with Medical Savings Accounts. Indeed, given the fact that individuals have different needs and preferences, MSA payments seem preferable.

The model described here is not all that futuristic. Many advocates of managed care today say the Mayo Clinic practices cost-effective medicine. But most of the clinic’s patients are fee-for-service customers.

**Practicing Medicine in the Information Age.** The doctor who makes decisions irrespective of cost will become obsolete. Patients using Medical Savings Accounts will seek doctors who are financial advisors as well as health advisors. Physicians will be aided by sophisticated computer programs.

No large bureaucracy will be required. When all patients have ready access to information, doctors acting as their agents will easily outperform any bureaucracy.

This Brief Analysis was prepared by NCPA President John C. Goodman and NCPA Health Policy Director Merrill Matthews, Jr.