

MSAs Can Be a Windfall for All

By Greg Scandlen

Outside of Washington policy circles, Medical Savings Accounts (MSAs) are no longer controversial.

They stirred up a fuss when the concept was first introduced some 10 years ago. But at the time, most of the attention in Washington and across the country was on the promise of managed care to deliver optimal health care and control costs at the same time.

Ten years later, managed care has proven to be of limited value. It has generated a widespread “backlash” by patients, physicians, employers, and politicians. After 10 years of experience, patients believe that managed care saves money by depriving them of services they want and need. Physicians believe managed care prevents them from providing the care that is best for their patients. Employers are realizing that managed care has not actually saved them any money; it just delayed cost increases for a few years. And politicians are sensitive to the discontent of their constituents.

All of these parties have come to realize that the reasons managed care has not worked as a national policy in addressing the concerns of cost, access, quality and patient satisfaction are the same reasons Medical Savings Accounts and other consumer-driven programs are attractive:

- MSAs work to restore the patient to a position of influence in the health care system, while managed care leaves the patient as a passive recipient of other people’s decision-making.
- MSAs reduce the influence of third-party payers in the health care system, while managed care makes the third-party payer the pre-dominant actor.
- MSAs help reduce costs by lessening the administrative burden on everybody, while managed care greatly increases the amount of health care dollars that are devoted to administration.

“Medical Savings Accounts enable patients to pay directly for medical expenses not paid by insurance.”

- MSAs help to restore the patient/physician relationship, while managed care weakens those relationships.
- MSAs encourage innovation and excellence in health care, while managed care encourages “cookbook” medicine.
- MSAs allow people to seek out alternative ways of maintaining and improving their health, while managed care either forbids or discourages alternative medicine.
- MSAs encourage competition, while managed care encourages monopoly.
- MSAs facilitate portability for workers between jobs, while managed care locks workers into their current jobs.
- MSAs help assure continuity of care when patients change health insurers, while managed care disrupts continuity.
- MSAs enable people to seek the preventive care services best tailored to their own needs, while managed care covers only those services the bureaucracy prefers.
- MSAs increase quality by allowing patients to pay more to see a better doctor, while managed care tends to pay all participating doctors the same, regardless of their skill.
- MSAs allow people to build-up a source of funds to pay for future health care needs, including long-term care and insurance premiums while unemployed, while managed care concentrates solely on the current year’s expenses.

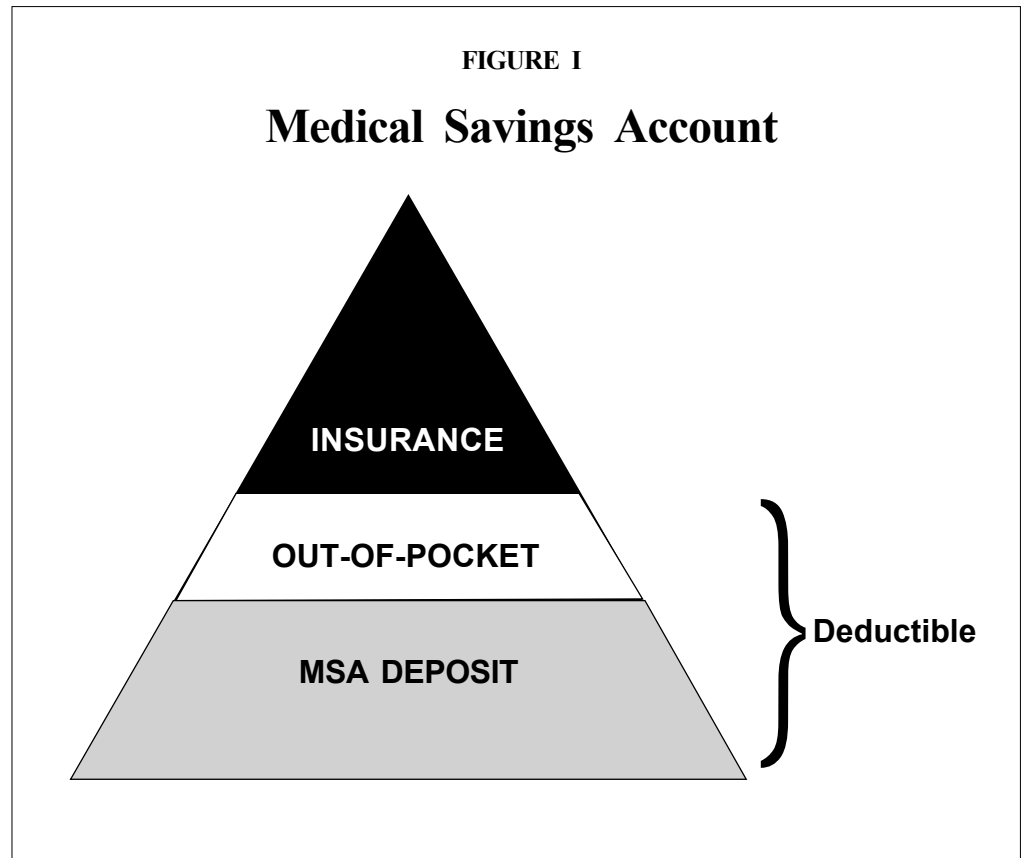
None of this is to say that managed care programs are not attractive for some people, or that MSAs are the best solution at all times. The question is rather what should be the thrust of national policy? Should it be reliance on empowered consumers making informed decisions through market mechanisms? Or should we rely instead on third-party bureaucrats allocating resources according to their preferences? The latter strategy has been tried and has failed. It is well past time to empower the patient.

Medical Savings Accounts are a broad term for the notion that much of health care can be paid directly by the consumer, and that government policy should be neutral as to whether such expenses are paid through an insurance mechanism or directly by the patient. [See Figure I.] To the extent contributions to health insurance premiums are tax-advantaged, so should be contributions to an account that is dedicated to paying for health care expenses.

Once this concept is understood and adopted, consumers will be free to determine for themselves how best to allocate their resources between insurance coverage and direct payment. Some consumers may continue to prefer first-dollar insurance coverage, and they will put all their resources into premiums. Others may rather have a high-deductible health plan that covers only very

“MSAs help restore the doctor-patient relationship.”

“By choosing higher health insurance deductibles, people can reduce their premium payments and put the money saved into an MSA.”



expensive conditions, and pay for lower-cost services from an MSA. Still others may prefer a mix, with insurance coverage that pays for “non-discretionary” spending combined with an account for “discretionary” services. Plans might develop that cover physician and hospital services with insurance, but use a cash account for dental, vision, pharmaceutical and alternative services.

The specific benefit design can vary substantially, and policy makers cannot know ahead of time what the optimal mix will be in terms of efficiency and popularity. This is precisely what markets are superb at determining. Some designs will be tried and rejected in the market. Others will succeed and become the standard for future enhancements.

The failure of managed care and the movement towards privatization in those countries with nationalized health care systems have combined to create a new imperative — one that relies on the consumer of health care services as the ultimate judge of the value of those services. MSAs and other consumer-centered models of financing are essential for allowing these consumers to make those judgments.

Types of Health Spending Accounts

There are currently several models of MSA design available. Not all of them are tax advantaged, and none of them are widely available in the market as of this writing. Curiously, they all face vehement political opposition from certain factions who disagree with the core concept of empowering patients.

But the idea of consumerism in health care has become widely accepted in the past few years, especially among health care providers and employers.

High Deductible MSAs. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA),¹ which authorized a four-year demonstration project of Medical Savings Accounts. Unfortunately, the legislation was severely limited and has had minimal impact on the health insurance market. The limitations came from two sources, proponents of MSAs and opponents of MSAs.

Proponents limited the program by using an illustration of how MSAs work that was ultimately turned into law. The illustration was not supposed to be the final word on benefit design, but was only intended to explain the concept. In 1992, the National Center for Policy Analysis first explained the concept by proposing a high, across-the-board deductible plan with an MSA to pay expenses below the deductible.² To numerically illustrate the concept, the chairman of Golden Rule Insurance Company said an employer currently paying \$4,500 in premium could switch to a \$3,000 deductible policy and lower his premium to \$1,500.³ The Congressional Budget Office took this illustration literally, however. Sure enough, what finally became law was a requirement for across-the-board deductibles ranging from \$1,500 to \$2,250 for singles and \$3,000 to \$4,500 for families.

Opponents also weighed in with concerns that ended up written into law. As enacted, the MSAs allowed under HIPAA included the following restrictions:

- MSAs are available only to the self-employed and employers with 50 or fewer employees.
- No more than 750,000 MSAs are allowed.
- Deductibles must range from \$1,500 to \$2,250 for individuals and \$3,000 to \$4,500 for families (with adjustments for inflation).
- No coverage is allowed below the deductible, even for preventive service, unless mandated by state law.
- MSA contributions are limited to 65 percent of the deductible for individuals and 75 percent of the deductible for families.
- MSA contributions are allowed only by the employer or the employee, but not both in a single year.
- Total out-of-pocket costs cannot exceed \$3,000 for singles and \$5,000 for families.
- Non-medical withdrawals are subject to a 15 percent penalty as well as income taxes.
- The pilot program originally was scheduled to last for only four years and recently was extended for only two more years.

“The most common plan has a high across-the-board deductible.”

These rigid design restrictions have prevented the MSA concept from being reliably tested under the HIPAA provisions. But the underlying concept remains valid. By choosing higher health insurance deductibles, people can reduce their premium payments and put the money saved into an MSA to help cover expenses below the deductible. A pioneering national survey by John Goodman and Gerald Musgrave found that raising deductibles leads to substantial savings in health insurance premiums.⁴ In fact, the premium savings may be greater than the increase in the deductible.⁵

This concept works for other kinds of insurance as well. The Bollinger Insurance Agency estimates that raising an auto insurance deductible from \$200 to \$500 could reduce the cost of comprehensive coverage by 15 percent to 30 percent. Similarly, homeowners can save 12 percent of premiums by raising the deductible on homeowners' coverage from \$250 to \$500, 24 percent by raising it to \$1,000, 30 percent by raising it to \$2,500, and 37 percent by raising it to \$5,000.⁶

Flexible MSAs. There is another model of MSA design that has become popular in South Africa and has recently become available in the United States. Rather than using an across-the-board deductible, these plans distinguish between “discretionary” and “non-discretionary” spending. They offer first dollar coverage for non-discretionary health care services, such as acute care hospitalizations, but apply a deductible to discretionary services such as physician office visits and outpatient care. The plans may also provide first dollar coverage for medications required to treat chronic conditions such as asthma, diabetes and hypertension. South Africa has been able to develop this plan because it provides the same regulatory and tax treatment to this benefit design as to all others. It has been extremely popular in that country, currently serving about one-half of the privately insured population.⁷ The largest company offering these products in South Africa, Discovery Health, has recently opened an American subsidiary, the Illinois-based Destiny Health, which is marketing a similar product design, but without the tax advantage that is available to HIPAA-qualified MSAs alone.⁸

“Under a flexible MSA, the deductible varies, depending on the type of expenditure.”

Flexible Spending Accounts. Another approach to achieving MSA-like benefits is Flexible Spending Accounts (FSAs). FSAs are allowed under Section 125 of the Internal Revenue Code and were first enacted by Congress in 1978.⁹ They enable workers to set aside tax-free money to spend on health care expenses not otherwise covered by their insurance, or to pay for health insurance premiums. FSAs are exactly like MSAs with one essential difference — money not spent by the end of the calendar year is forfeited with an FSA, but may be rolled over into the next year with an MSA.

The FSA provides exactly the wrong incentive: it forces workers to spend needlessly at the end of the year to avoid forfeiting their own money. The MSA encourages workers to be thrifty in their health care spending be-

“MSAs are increasingly popular among employers.”

cause they may keep unspent funds. This drawback could be changed under a proposal by President Bush to allow \$500 in unspent FSA funds to roll over into an MSA or other form of trust account at year’s end. Such a provision would enable all workers to have an MSA-type program, regardless of the underlying insurance plan they had.

Other Types of MSAs. Now that MSAs have been around for a few years, the idea is no longer seen as exotic. Many employers, benefits consultants and entrepreneurs who were focused on the growth of managed care in 1996 are now exploring ways of making MSA-type programs available to parts of the market that do not qualify for HIPAA-enabled MSAs. These efforts usually start with an insurance plan that is supplemented by a cash account of some kind. Some examples:

- Definity Health, based in Minneapolis, perhaps the most prominent. It features a “Personal Care Account” that is described as “an account where consumers choose how to spend their health care dollars. Consumers select providers and care options, including alternative medicine. Funds remaining in the account at the end of the year rollover and stay with the consumer.” Some of Definity’s accounts include Medtronics, Textron, Raytheon, Dade Behring and the University of Minnesota, none of which qualify for a traditional MSA program.¹⁰
- MyHealthBank, based in Portland, Ore. It uses the slogan, “your money, your health, your choice,” and features a “Health Freedom Account” which can roll over from year to year. In partnership with Regence Blue Cross and Blue Shield, MyHealthBank had enrolled 1,500 members in Oregon by April 2001, and has since expanded into Washington, Utah and Idaho.¹¹
- Lumenos, based in Alexandria, Va. It also has a rollover account that it calls a “Health Savings Account.” Lumenos describes the account exactly like an MSA: “You can use your HSA as you choose, you don’t need a referral to receive care and you can use any licensed doctor.” Also like an MSA, Lumenos has a “bridge” of out-of-pocket responsibility between the HSA and the insurance coverage. Lumenos, too, is marketing mostly to large employers who are not eligible for HIPAA-MSAs.¹²

These programs may or may not be tax-advantaged. An employer is always free to provide high-deductible coverage and make an after-tax cash account available to cover expenses below the deductible, and some employers have done just that.¹³ But more recently firms have discovered that they can establish a tax-favored cash account even though they might not be eligible for a HIPAA MSA.¹⁴ The funds are allocated to, but not actually owned by, the employee, and the company doesn’t pre-fund the account except as a bookkeeping notation. The firm can take medical expenses as a business deduction as

they are paid, but may not deduct unused allocations. Because there is no “constructive receipt” of the money, it is tax-free to the employee. The employee can see the funds build up over time, but cannot cash out balances until terminating employment, at which time the balances may be used to prepay continuation coverage or for long-term care insurance.

A Drumbeat of Criticism

“Despite the advantages of MSAs, there has been a steady drumbeat of criticism.”

Despite the advantages of the MSA approach to health care financing, there has been a steady drumbeat of criticism. Sen. Ted Kennedy (D-Mass.) was the most vociferous as he filibustered against his own bill¹⁵ on June 10, 1996, saying “MSAs are likely to raise health insurance premiums through the roof ... they will destroy the insurance pool...”¹⁶

A day later he said, “Medical savings accounts have become the Trojan horse that could destroy health care reform.... They will raise premiums for the vast majority of Americans.” And on June 14, 1996, he said, “The small business sector ... is the most vulnerable to the disruptions that medical savings accounts would cause.”

About a year later, the Director of Health Policy Analysis for Consumers Union, Gail Shearer, wrote to the *Wall Street Journal* that “premiums for traditional health insurance will increase by as much as 300 percent if MSAs are allowed without limit into the health insurance market.” She added, “The MSA demonstration program ... threatens to poison the entire health insurance market....”¹⁷

The drumbeat continues to this day. A recent paper by the Center on Budget and Policy Priorities claims that, because of adverse selection, “premiums for conventional insurance could more than double if MSA use becomes widespread” and could “jeopardize health insurance coverage for substantial numbers of Americans...”¹⁸

These charges are certainly dramatic and would be alarming — if there were any factual basis for them. But there is none. Not one of the assertions quoted is supported by research. To the extent the critics footnote their charges, they usually quote one another, creating an ever more impassioned circle of hysteria.

The core charge is that MSAs will result in “adverse selection.” It is alleged that the healthy and the wealthy will opt for MSAs, “depleting the insurance pool” of the good risks and leaving only high-risk people in “traditional” insurance.

It is puzzling that these same critics have been sanguine about the erosion in “traditional” insurance that has resulted from the growth of managed care. According to the Kaiser Family Foundation, “traditional” insurance now covers a mere 7 percent of all workers, down from 73 percent in 1988 and 27 percent in 1996.¹⁹ Meanwhile, premiums for “traditional” coverage have

escalated, rising from 21 percent higher than HMO premiums in 1997 to 32 percent higher in 2001.²⁰ [See Table I.] One might think that those who are so anxious about the future of “traditional” or “conventional” health insurance would be protesting the growth of managed care as well. In fact, they are not.

“Most of the criticism stems from a poor understanding of MSAs.”

Most of the criticism stems from either a poor understanding of the dynamics of health insurance or an ideological commitment to creating a national health insurance system in the United States. In either case, there is little foundation for the criticism and evidence aplenty that contradicts the charges. The assertions against MSAs are generally that:

- Cost savings from raising deductibles are exaggerated.
- MSAs will not change patient behavior.
- MSAs will be attractive to “the healthy and the wealthy” at the expense of everybody else.
- MSAs will encourage people to avoid needed preventive care.
- MSAs will pull the best risks from “the insurance pool,” raising costs for those who remain.
- MSAs will not help control costs over the deductible, where the need is greatest.

We will examine these charges one at a time.

Are Cost Savings from Raising Deductibles Exaggerated?

Critics are skeptical that raising a deductible will save very much in health insurance premiums, certainly not enough to fund an MSA very well. Yet the same organizations acknowledge the value of increasing deductibles for other kinds of insurance. The month before Consumers Union’s Gail Shearer

“Premiums for ‘traditional’ coverage have escalated.”

TABLE I

Health Insurance Premiums, 1997 - 2002

	1997	1998	1999	2000	2001	2002(e)
Health Maintenance Organizations	\$3,448	\$3,477	\$3,774	\$4,139	\$4,472	\$5,053
Point of Service	\$3,825	\$3,963	\$4,068	\$4,498	\$4,855	\$5,438
Preferred Provider Organization	\$3,580	\$3,773	\$3,996	\$4,456	\$4,716	\$5,282
Individual	\$4,176	\$4,479	\$4,792	\$5,462	\$5,896	\$6,780

Source: Ken Sperling, Hewitt & Associates

wrote to the *Wall Street Journal* complaining that MSAs would poison the entire health insurance market, her parent organization published an article in *Consumer Reports* encouraging readers to raise their deductibles for home and auto insurance because “the first rule to apply to any insurance... is to buy coverage that protects against a broad range of risks, getting only enough protection to insure what you could not afford to cover with your own assets.”²¹

This principle is even more true for health insurance than it is for home and auto insurance, because home and auto claims are large and infrequent, while claims against a health insurance policy are usually for small amounts of money and are complicated to process. In fact, raising a health insurance deductible can save substantial amounts of premium.

There are several reasons why the premium savings are so large. The most obvious is that the insurer will pay less in potential claims. But since relatively few people have a claim in any given year, this is only a portion of the savings.

MSAs also greatly reduce a problem endemic to the entire health insurance industry: soaring administrative costs. One study estimated the administrative savings from switching to a national system of MSAs could amount to \$33 billion annually.²² It is far less expensive for a provider to present a bill and be paid at the time of service than it is to file a claim and wait, often for weeks or months, to be reimbursed by an insurer.²³ Immediate payment saves both administrative overhead and the time value of the funds.

“MSAs greatly reduce soaring administrative costs.”

One of the most common complaints health care providers make about insurance companies is the extreme complexity of the billing requirements, with many carriers demanding unique systems.²⁴ To avoid these burdens, one organization of physicians based in Washington state is charging cash-paying customers half or less of what it charges insured customers. The difference in fees is due solely to the reduced overhead from not having to bill the insurers.²⁵

Whether filed in paper format or electronically, claims are costly and complex to process and adjudicate. They involve confirming that:

- The patient is (or is not) a covered insured.
- The provider is (or is not) a network provider.
- The service billed is (or is not) covered under the insured’s contract.
- The service is (or is not) appropriate for the diagnosis.
- The insured has fulfilled his or her deductible and coinsurance responsibility.

Next, the claim is forwarded for “repricing,” depending on the provider’s network status and agreed-upon discount. Finally, the check is cut and forwarded to the provider, an EOB (Explanation of Benefits) is sent to the insured and data are entered and a summary report sent to the employer. Additionally, there will be:

- Periodic audits to confirm the services billed were actually received.
- Utilization review efforts to ensure appropriate care.
- Customer and provider service departments to answer questions about claims status, and sometimes to explain why a claim has been denied.
- Appeals procedures to reconsider the payment of denied claims.

Reviewing the foregoing, it isn't hard to understand why the cost of processing a small claim can exceed the cost of the claim itself.

Depending on the particular plan, a Medical Savings Account program enables patients to pay small claims from an MSA in one of three ways: (1) they can pay directly at the point of service with a debit card or paper check written on the MSA account, (2) they can approve a bill and have their health plan pay it from the MSA, or (3) they can pay cash and send the receipt to their MSA administrator for reimbursement. At least in theory, there is little reason for the insurance company to get involved in the claim until the patient's total expenses approach the deductible.²⁶

Do MSAs Change Patient Behavior?

Another reason why high deductibles lower costs is that they lead to a change in behavior on the part of the insured.

Some critics have suggested that health care is a unique consumption good.²⁷ They argue there is no "personal benefit" from consuming excess health care services, unlike the excessive consumption of food, which is a "personal choice." Yet there is plenty of empirical evidence that over-consumption always occurs when health care is a free good.

Moral Hazard. The concept that people who are insured tend to engage in riskier behavior is known as "moral hazard." People with low-deductible auto policies are likely to drive less carefully than people with higher deductibles. Similarly, an owner of a run-down warehouse that is insured is far more likely to see it burn down than a warehouse owner who does not carry fire insurance.

In health care, moral hazard blends with another concept — "induced demand." People who have low-deductible health insurance coverage are far more likely to consume a wide range of services, many of them of questionable value. Having a higher deductible encourages people to think twice before consuming services because a greater portion of the cost is borne by them.

The RAND Experiment. For example, the well-known RAND Health Insurance Experiment randomly assigned several thousand families to different plans with different cost-sharing provisions over an eight-year period.²⁸ One

"When health care is free, people tend to over-consume it."

plan had free care, another had 25 percent coinsurance, another had 50 percent coinsurance and another 95 percent coinsurance. In each of the cost-sharing plans, the total out-of-pocket expense was capped at \$1,000 (this study was conducted in the late 1970s, so the \$1,000 deductible adjusted for today's prices would be closer to \$2,500). The results were profound, if unsurprising. Project director and Harvard University professor Joseph Newhouse writes, "Use of medical services responds unequivocally to changes in the amount paid out of pocket.... Per capita expenses on the free plan are 45 percent higher than those on the plan with a 95 percent coinsurance rate...."²⁹ He adds, "The more families had to pay out of pocket, the fewer medical services they used."³⁰ Importantly, the lower use of services did not have a negative effect on health outcomes.

MSAs vs. Managed Care. Managed care, too, is a response to the willingness of people to consume excessive health care services when they can. Unlike the RAND Experiment and MSAs, managed care tries to control the use of services from the supply side. Managed care sets up obstacles to acquiring the care the patient demands by the use of "gatekeepers," utilization controls, benefit limitations, provider limitations and provider incentives to undertreat. In general, patients can't get care because it isn't available, not because they have chosen to avoid it. It is small wonder patients are unhappy. The whole purpose of a managed care organization is to keep patients from the care they desire.

By contrast, Medical Savings Accounts control expenses from the demand side. MSAs encourage people to think twice about the care they want, because they know there is a price to be paid for wasteful consumption. It is up to the patient in consultation with his or her family and physician to make the value judgments about whether a particular service is worth the cost. These judgments and decisions are not imposed from the outside, but reflect the values and priorities of the individual.

"When people spend from their MSA they are spending their own money rather than someone else's money."

Will MSAs Attract "the Healthy And the Wealthy" at the Expense of Everybody Else?

The complaint that MSAs will benefit the healthy and wealthy at the expense of the rest of us is a catchy sound bite well suited for Washington spinmeisters. Unfortunately, it is no more true for having been so frequently repeated. Whether or not one chooses an MSA depends in part on available alternatives. But it is impossible to examine the likelihood of a selection simply by looking at a single choice. Side-by-side comparisons must be made.

Traditional Indemnity vs. MSAs: Comparing Plans. A "traditional indemnity" plan is also known as a "fee-for-service" (FFS) or "major medical" plan. It is characterized by a small deductible (usually \$250 to \$500) and "coinsurance" (typically 20 percent of claims). Both are paid by the insured up to some "stop-loss" level (\$1,500 or so).

As the name implies, a fee-for-service plan pays providers a fee for providing a service. The payment may be based on a fixed fee schedule or may be a “usual and customary” fee. “Managed care” efforts are minimal and patients are free to choose their own providers, although utilization review programs are increasingly common in FFS plans.

In contrast, a typical MSA program, as enabled by Congress in 1996,³¹ starts with a deductible of approximately \$2,000 for an individual or \$4,000 for a family. In this case, the individual (or the employer) may deposit as much as \$1,300 into the MSA. A family may deposit as much as \$3,000.³² These deposits are excluded from taxable income if made by the employer (thus avoiding income and payroll taxes) and are deductible if made by the account holder (avoiding income tax alone).

Consider an individual with a \$1,300 MSA deposit and a \$2,000 deductible. When this individual enters the medical marketplace, the first \$1,300 of expenses are paid from the MSA. The next \$700 is paid out of pocket. And beyond \$2,000, all expenses are paid by the health plan.³³ Thus in this example, the patient’s out-of-pocket risk is limited to \$700. However, if not all of the \$1,300 MSA deposit is spent, the remainder stays in the account and is added to the next year’s MSA balance.³⁴ So after a few years, most people’s MSAs will exceed \$2,000 and there will be no out-of-pocket risk.

“The money in an MSA may be invested and build up tax-free over time.”

The money in the MSA may be invested and build up tax-free over time. Money in the MSA may be used to pay for health care expenses at any time without penalty. It may also be withdrawn to pay for other needs, but the account holder has to pay taxes plus a 15 percent penalty on any amount withdrawn.

The essential idea behind the MSA is that the money saved on premiums can be deposited in the savings account. By going from a \$250 deductible FFS plan to a \$2,000 deductible MSA plan, an individual might save enough to cover the maximum \$1,300 contribution. Whether that happens depends on local market conditions, the attitude of the insurance company, risk factors associated with the insured and a lot of other factors. But the idea of saving \$1,300 in premiums by raising the deductible by \$1,750 is not unrealistic.³⁵

Most MSA programs use a “Preferred Provider Organization” (PPO) for the insured portion of the coverage, thereby gaining the benefit of whatever cost savings may be available for higher-cost claims. Although PPOs are customarily considered to be part of managed care, they are more like traditional FFS plans than Health Maintenance Organizations (HMOs). They use deductibles and coinsurance and pay providers on a fee-for-service basis, although they usually negotiate discounted rates from their “preferred” network of providers. PPOs direct their patients to the preferred providers by charging a higher coinsurance rate for going “out of network.”

Most people will spend less money out-of-pocket with an MSA than they would with a traditional FFS, including high and low utilizers and high-

TABLE II
Total Spending and Out-of-Pocket Costs under Four Scenarios

<u>Health Care</u>	<u>Out-of-pocket costs</u>			
Spending	Plan A	Plan B	Plan C	Plan D
\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
250	250	250	0	0
500	300	500	0	0
750	350	550	0	0
1,000	400	600	0	0
1,500	500	700	500	0
2,000	600	800	1,000	500
2,500	700	900	1,000	1,000
3,000	800	1,000	1,000	1,000
3,500	900	1,100	1,000	1,000
4,000	1,000	1,200	1,000	1,000
5,000	1,200	1,400	1,000	1,000
6,000	1,400	1,500	1,000	1,000
8,000	1,750	1,500	1,000	1,000

“The typical MSA plan benefits both the sick and the healthy.”

and low-income earners. Because plan design may vary, we will look at four different scenarios to illustrate this point.

- Plan A is a \$250 deductible FFS plan with a 20 percent coinsurance on the next \$7,500 of claims.
- Plan B is a \$500 deductible with a 20 percent coinsurance on the next \$5,000 in claims.
- Plan C is an MSA with a \$2,000 deductible and a \$1,000 contribution in the account.
- Plan D is an MSA with a \$2,500 deductible and a \$1,500 contribution to the account.

As Table II shows, in these hypothetical scenarios there is only a small range of expenses for which the MSA out-of-pocket exposure is greater than the traditional FFS program — claims between \$2,000 and \$3,500. But because out-of-pocket expenses are usually paid with after-tax dollars,³⁶ if MSA deposits are tax-preferred, the range is even smaller than the amount reflected and depends on the marginal tax rate of the insured.

The notion that the unhealthy and the unwealthy do better in a traditional FFS indemnity plan than they would in an MSA is false. People with few expenses do better under the MSA regardless of their income, and people with very high expenses do better with the MSA, again regardless of their income.

“Sick people gain from MSA plans because their out-of-pocket expenses are typically lower.”

The Urban Institute Study. An early Urban Institute (UI) study supports these conclusions. The study estimated “winners and losers” if everyone switched to an MSA program. It concluded that 80 percent of the population would be financial winners. That number of financial winners would be much higher but UI included the highest utilizers among the losers, though just barely.³⁷ The UI study concluded that the primary losers in an MSA scenario would be those with annual expenses ranging from \$2,000 to \$5,250. It also found that, “on average, lower wage workers would benefit from switching to MSA/catastrophic plans.”

HMO vs. MSA. If an MSA is better for the unhealthy and unwealthy when compared to a traditional FFS or PPO plan, what about when compared to an HMO? An HMO environment presents an entirely different dynamic and set of choices than an FFS plan. As a rule, HMO premiums are lower than the MSA/high deductible insurance plan combination and involve lower cost-sharing. A lower-income person would probably prefer the HMO, all other things being equal. As it turns out, however, all other things are not always equal.

When we consider that a person with few expenses will actually have money left over at the end of the year to be included in the next year’s MSA, the “wealthy” charge looks absurd. A person with \$250 in expenses in the first year may have \$750 left over at the end of the year. This \$750 is far more meaningful to someone earning \$10,000 per year than it is to someone earning \$100,000 per year. It amounts to a bonus of 7.5 percent of the former person’s income, but less than 1 percent of the latter’s.

“The savings in an MSA are far more meaningful to a low-income employee than to high-income employees.”

Low-income workers might prefer to pay the added cost of the MSA program because, if they are careful in their health care spending, they will have money left over at the end of the year. As with the example above, the opportunity to save several hundred dollars in a personal account means a lot more to a lower-income worker than it does to “the wealthy.” The value the working poor put on extra cash may be much higher than the value they put on extra doctors’ visits.

This opportunity is admittedly a matter of personal choice. Not everyone places more value on cash than they do on doctors’ visits, and there are a large number of other factors that enter into the perceived value of one or the other. The proximity of services is one such factor. It is a lot easier for a low-income family with children to make use of an HMO’s services if it has facilities or participating providers close by. If the closest facility is across town or out in the deep suburbs, the value of the benefit to an inner city, low-income family is greatly diminished, and the prospect of money in the bank looks more attractive.

So, for lower-income workers, the appeal of an MSA may be a toss-up when compared to an HMO. Some will prefer one, some the other. But what about the unhealthy? Would they prefer an HMO or an MSA? Again, it is hard to say, but there is evidence in that in the Medicare program healthy beneficiaries tend to select HMO coverage and then revert to traditional Medicare when they become sick.³⁸

As we have seen with the “managed care backlash,” many people fiercely resist the idea of having a limited choice of doctors, or of having the health plan second-guess recommended services. The “unhealthy” (people with chronic or acute medical conditions) are far more sensitive to the problems of managed care than are people of average risk who encounter the health care system only rarely. Very often these “high utilizers” will have a personal network of doctors they know and trust. If one of those doctors does not participate with an HMO, or is dropped from the HMO’s network, that patient will be a good candidate for an MSA. High-utilizers are also far more likely to experience the other problems associated with managed care — trouble getting through on the phone, long waits to get an appointment and in the doctor’s office, being assigned to an inappropriate specialist, having prescribed treatments questioned and so on.³⁹

The RAND Study. A recent study by researchers at the RAND Corporation confirms this analysis.⁴⁰ The study, funded by the Department of Labor, constructed a simulation of multiple choices of health plans in a small group environment. As Table III shows, it found that those who chose an MSA were on the average the highest-risk people and considerably less wealthy than those who chose HMO coverage.

“The RAND study found that those who chose an MSA were on the average the highest-risk people and considerably less wealthy than those who chose HMO coverage.”

TABLE III

Health Care Spending and Family Income by Type of Plan Chosen

Plan	Average HC Spending	Average Family Income
Fee-For-Service	\$ 5,853	\$ 34,010
MSA	6,710	36,361
HMO	6,163	47,007
Decline Coverage	1,399	32,610
Covered by Spouse	5,641	53,120

Source: Dana P. Goldman, Joan L. Buchanan and Emmett B. Keeler, “Simulating the Impact of Medical Savings Accounts on Small Business,” April 2000, RAND Corporation.

The RAND researchers concluded, “HMOs are attractive to wealthier workers,” and “higher-income employees prefer to stay with the HMO.” They went on to debunk the myth about the healthy flocking to MSAs when they wrote, “We see that the MSA is not attractive to exceptionally good risks, as some critics have hypothesized. Instead, these healthy people prefer to decline coverage.”

In other words, the wealthiest workers prefer HMO coverage and the healthiest workers choose no coverage at all. MSAs are chosen by the least healthy and the third least wealthy of all the groups. The RAND researchers add, “We find that MSAs could be desirable to workers in firms that already offer HMO coverage or standard FFS plans. As a result, expanding MSA availability could make it a major form of insurance for covered workers in small business.”⁴¹

NBER Study. Another problem with the “healthy and wealthy” argument is it assumes there are two kinds of people, the healthy and the unhealthy, and never the twain shall meet. For instance, Catholic University law professor Regina Jefferson states in an article about MSAs: “Approximately 70 percent of Americans account for only 15 percent of national medical expenditures. Nearly 75 cents of every dollar spent on health care in the United States is attributed to only 10 percent of the population.”⁴² She implies that this small minority of people will be disadvantaged by an MSA because they will never be able to build up or replenish their funds.

These numbers may be approximately right — in a single given year. But this year’s 10 percent of high-utilizers are not the same people as last year’s 10 percent or next year’s 10 percent. In fact, most acute health care expenses involve either end-of-life care or an episodic illness that may appear for a year or two and then disappear. The vast majority of consumers will be able to build up funds in the MSA before an illness hits, and replenish those funds after it is over.

One study published by the National Bureau of Economic Research (NBER) found “that high expenditure levels typically do not last for many years.”⁴³ This study modeled an MSA-type program⁴⁴ based on the experience of a large Midwestern manufacturing firm, and found that by projecting actual claims experience over the entire worklives of the employees, even without considering any behavioral response to increased cost-sharing, 95 percent of the population would have retained at least 20 percent of their MSA contribution and 80 percent would still have at least half of what had been contributed.⁴⁵

In other words, almost everybody has some health care expenses in the course of their lives, but few if any are sick all the time. If behavioral responses (i.e., the tendency to consume fewer services when paying for them directly)

“The vast majority of people will be able to build up funds in the MSA before an illness hits, and replenish them after it is over.”

were accounted for, the authors say the results would have been more equal with fewer people spending most of their MSA funds.”⁴⁶

Do MSAs Encourage People To Avoid Needed Preventive Care?

Critics have charged that people with MSAs will be less likely to take advantage of preventive care.⁴⁷ The opposite is actually true. Money in the savings account provides a source of funds that is not available in a traditional “fee-for-service” (FFS) plan to pay for exactly those kinds of services, and on a completely tax-advantaged basis.⁴⁸ Further, based on the experience in South Africa, if there is skimping on preventive care it does not translate to more costly procedures later on.⁴⁹ Finally, if Congress allowed more design flexibility, people could have an MSA and still have first dollar coverage for those preventive services that have been proven effective.

“People with MSAs have a source of funds for preventive care.”

Will MSAs Pull the Best Risks from “the Insurance Pool,” Raising Costs for Those Who Remain?

This criticism is closely related to the “healthy and wealthy” argument discussed above in that it makes all the wrong assumptions about who is likely to select which plan. The argument is also based on the false assumption that there is a single insurance pool in the United States.⁵⁰

The assumption is that if only the healthiest people were attracted to MSAs, they would no longer subsidize the higher costs of the rest of the population. In fact, there are tens of thousands of pools in the country and none subsidizes the other. Every self-funded employer group is its own pool, independent from all others. Every insurance company and every HMO is independent from every other insurance company. Even within a single insurance company, there are separate and independent pools for different states and different blocks of business. The Insurance Commissioner in Iowa will not allow a company to raise its rates in that state to cover losses in California. Similarly, a company’s small-group block of business is subject to entirely different rules and rating procedures than is its block of individual, non-group business.

So, if everyone at Joe’s Print Shop chose an MSA, and they were all very healthy, there would be no effect whatsoever on the premium costs of Sally’s Bakery. Joe’s Print Shop pays for the claims experience of its own employees, plus an administrative markup. If they saved money by purchasing an MSA, that would bring down Joe’s health care costs, but it would have no effect on Sally’s costs.

Can MSAs Help Control Costs over the Deductible, Where the Need Is Greatest?

“MSAs exist to control low-cost routine expenses, something managed care does not do very well.”

The critics have a point here, though a very small one. It is true that a large portion of annual health care expenses exceed the deductible of an MSA/high-deductible plan, and thus are not subject to whatever cost-constraining effects the MSA might provide. Controlling those high-cost situations is certainly important, but it does not violate the MSA concept at all. MSAs exist to control low-cost routine expenses, something managed care does not do very well. But once a patient has “broken through” the deductible, third-party insurance’s cost-controlling mechanisms will apply. Moreover, people who become active consumers when dealing with low-cost services are not likely to change their behavior just because their expenses have broken through the magical \$2,000 figure. They may continue to research their needs and demand that service providers explain the treatment options — and costs — to them. If they have become accustomed to dealing from a position of power in making health care decisions, they are likely to continue doing that. We can only imagine in what ways physicians and health centers may transform themselves to accommodate newly empowered patients, and that transformation will not cease simply because a dollar level has been reached.

The presence of an MSA with money in the account enables patients to exercise their own discretion even after the deductible is met. In South Africa, for example, to improve the management and cost of all care for diabetes, Discovery Health has contracted with local centers for excellence. Discovery Health pays the diabetic center the equivalent of U.S. \$80 per patient per month to cover all treatment costs. Discovery Health requires each diabetic patient to pay one-third of the cost. Thus the diabetic center has an economic incentive to deliver services efficiently and the patient has an incentive to fully use the program. Patients with money in MSA accounts also have more options to go outside the provider networks available under their plans or to seek treatment not covered by ordinary insurance.

Conclusion

Over the years, the United States and most other industrialized countries have moved gradually to a system of third-party payment in which health care consumers have little knowledge of the costs of their care. Currently, only about 20 percent of total national health expenditures are paid directly by consumers, and these are concentrated on services that are rarely covered by insurance — plastic surgery, vision and dental care, over-the-counter medications, long term care and in-home nursing services.

As consumers are unaware of costs, they are also unable to influence the provision of services or the course of treatment. The third party that pays the

bills ends up deciding what bills to pay and what services to provide. Only the third parties are aware of the costs, and only they are alarmed when they increase. So, it is the third-party payers that try to hold down cost increases by limiting access to care.

With the collapse of managed care, employers as well as employees are searching for ways to make health care more responsive to the needs of patients and to give consumers more control over their resources. MSAs are an attempt to bring patients back into the decision-making process by giving them more control over the resources available to them. We can expect a wide variety of MSA look-alike programs to be developed in the private sector, even without the tax advantage of official MSAs. Congress would do well to heed the experience of these experiments and open up the MSA law to encourage innovation.

“We can expect a wide variety of MSA programs in the private sector, even without the tax advantage.”

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NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

- ¹ P.L. 104-91, Title III (A)(220).
- ² John C. Goodman and Gerald L. Musgrave, *Patient Power* (Washington, D.C.: Cato Institute, 1992).
- ³ Letter from Robert Reischauer, Director of the Congressional Budget Office, to Rep. Pete Stark (D-Calif.), Chairman of the Subcommittee on Health, House Ways and Means Committee, September 17, 1992.
- ⁴ John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.
- ⁵ For example, a \$500 increase in the deductible may lead to a premium reduction greater than \$500.
- ⁶ See http://www.bollingerinsurance.com/newver/Home_Auto_Life/pbook.htm.
- ⁷ See Sean Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000.
- ⁸ See <http://www.destinyhealth.com>.
- ⁹ Greg Scandlen, "MSAs for Everyone, Part II," National Center for Policy Analysis, Brief Analysis No. 319, March 31, 2000. Available at <http://www.ncpa.org/ba/ba319/ba319.html>.
- ¹⁰ For information, see: <http://www.definityhealth.com>.
- ¹¹ For information, see: <http://www.myhealthbank.com>.
- ¹² For information, see: <http://www.lumenos.com>.
- ¹³ Victoria Craig Bunce, "Medical Savings Accounts: Progress and Problems under HIPAA," Cato Institute, Policy Analysis No. 411, August 8, 2001, p. 9.
- ¹⁴ "An Employer's Guide to Consumer-Directed Healthcare Benefits," Wye River Group on Health Care, October 2001. Available at http://www.ncpa.org/extra/health/wye_full.pdf. See also David F. Ogden and Michael G. Strum, "Defined Contribution Health Plans: The Shape of Things to Come?" Benefits Perspectives, Milliman and Robertson, Spring 2001. Available at http://www.milliman.com/files/Spring_final.pdf.
- ¹⁵ HIPAA was known as the "Kennedy-Kassebaum Bill" before it was enacted.
- ¹⁶ All quotes from the *Congressional Record* for the relevant dates.
- ¹⁷ Gail Shearer, Letters to the Editor, *Wall Street Journal*, April 28, 1997.
- ¹⁸ Iris J. Lav and Edwin Park, "Likely Medical Savings Account Amendment to Patients Bill of Rights Could Drive Up the Price of Health Insurance Premiums and Increase the Number of Uninsured," Center on Budget and Policy Priorities, June 13, 2001. Available at <http://www.cbpp.org/6-12-01health.htm>.
- ¹⁹ "Employer Health Benefits: 2001 Summary of Findings," The Kaiser Family Foundation and the Health Research and Education Trust, September, 2001. Available at <http://www.kff.org>.
- ²⁰ From a presentation by Ken Sperling, Hewitt Associates, to the Managed Health Care Association, May 30, 2001.
- ²¹ "Money Management Strategies," *Consumer Reports*, March, 1997.
- ²² John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991. Available at <http://www.ncpa.org/studies/s166/s166.html>.
- ²³ One software company estimates that "60 percent of all health insurance claims are still paper-based, requiring a processing time of 10 to 20 days at a cost of \$14-\$18 to process each claim." HNC Software Solutions, "Welcome to the Revolution," <http://wwwhncis.com/didyouknow/pdf/3001.pdf>.
- ²⁴ Some have suggested that eliminating this paperwork through a single-payer system would possibly free up over \$100 billion a year to pay for direct services. See Carol Stevens, "Will Administrative Savings Really Pay for Health Reform?" *Medical Economics*, October 25, 1993, p. 146+.
- ²⁵ Information on the SimpleCare program is available at www.simplecare.com.
- ²⁶ In practice, this hasn't happened to any great extent yet. Because MSA enrollment is so small, most companies currently want the MSA claim to be processed just like a regular PPO claim.
- ²⁷ Regina Jefferson, "Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise," *Catholic University Law Review*, August 1999, p. 132.

- ²⁸ Joseph Newhouse, *Free For All?: Lessons from the Rand Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).
- ²⁹ *Ibid.*, p. 41.
- ³⁰ *Ibid.*, p. 338.
- ³¹ *Ibid.*
- ³² The law allows individuals to deposit up to 65 percent of the deductible in the MSA every year. Families may contribute up to 75 percent of their deductible.
- ³³ The exception is for medical expenses paid from the MSA but not covered by the health plan.
- ³⁴ Experience suggests that, on the average, employees will spend about half their MSA deposit in any given year.
- ³⁵ For example, this writer was running a small trade association in the early 1990s. Our five-person group switched from a \$250 deductible PPO in one year to a \$1,000 deductible FFS program and saved \$973 per person in premiums.
- ³⁶ The out-of-pocket costs could be tax-advantaged if an employer has set up a Section 125 Flexible Spending Account (FSA), but since any employee money put into an FSA is forfeited at the end of the year if not used for medical expenses, relatively few employers have made them available and still fewer employees make use of them.
- ³⁷ Specifically, UI guessed that the premium for a traditional plan would be \$1,701, while the premium for a high-deductible plan would be \$1,110 — a savings of \$591. The total out-of-pocket expense (deductible and coinsurance) for the traditional plan was \$1,250, and the total out-of-pocket expense for the MSA program was a \$2,000 deductible. So the MSA holder was subject to \$750 more in out-of-pocket spending at the maximum. Subtracting the premium savings from the extra out-of-pocket costs leaves a difference of only \$159, which is a trivial amount that could be erased by a 10 percent error in the premium estimate. In fact, UI's assertion that raising a deductible by \$1,750 results in a premium savings of only \$591 is at best unreliable and unsupported. Len M. Nichols et al., "Tax Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Urban Institute, April 1996.
- ³⁸ Robert O. Morgan, Beth A. Virnig, Carolee A. DeVito and Nancy A. Persily, "The Medicare-HMO Revolving Door — The Healthy Go In and the Sick Go Out," *New England Journal of Medicine*, Vol. 337, No. 3, July 17, 1997, pp. 169-175; and Bernice Steinhardt, "Medicare: Fewer and Lower Cost Beneficiaries with Chronic Conditions Enroll in HMOs," Report GAO/HEHS-97-160, August 18, 1997, U.S. General Accounting Office, Washington, D.C.
- ³⁹ Robert Blendon et al., "Understanding the Managed Care Backlash," *Health Affairs*, July/August 1998.
- ⁴⁰ Dana P. Goldman, Joan L. Buchanan and Emmett B. Keeler, "Simulating the Impact of Medical Savings Accounts on Small Business," RAND Corporation, HSR: Health Services Research 35:1 Part 1, April 2000, pp. 53-75. Abstract available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10778824&dopt=Abstract.
- ⁴¹ *Ibid.*, p. 71.
- ⁴² Jefferson, "Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise," p. 129.
- ⁴³ Matthew J. Eichner, Mark McLellan and David Wise, "Insurance or Self-Insurance?: Variation, Persistence and Individual Health Accounts," National Bureau of Economic Research, NBER Working Paper 5640, June 1996, p. 5.
- ⁴⁴ They called it an "Individual Health Account."
- ⁴⁵ *Ibid.*, p. 6.
- ⁴⁶ *Ibid.*, p. 4.
- ⁴⁷ One author writes, "Opponents, however, argue that this price shopping will result in a neglect of preventive care, such as annual checkups." Jefferson, "Medical Savings Accounts: Windfalls for the Healthy, Wealthy & Wise," p. 123, footnote 134.
- ⁴⁸ The South African model provides first dollar coverage to "non-discretionary" spending and applies the deductible only to those services it considers discretionary. Non-discretionary includes hospital inpatient admissions and medications for chronic conditions such as diabetes and asthma. See Matisonn, "Medical Savings Accounts in South Africa." It is not hard to imagine a plan also providing first dollar coverage for proven preventive services, such as well-baby care, if there were more flexibility of benefit design allowed by Congress.
- ⁴⁹ Matisonn, "Medical Savings Accounts in South Africa."
- ⁵⁰ This is a fundamental error in many of the early critiques of MSAs. A more recent study conducted by researchers at the Agency for Health Care Policy and Research tries to correct this mistake. It says, "The MSA studies cited above treat the employment-related health insurance market as a single entity (pool)... In practice, however, the insurance market may not function as a single pool, and the insurance choices in one pool need not affect the premiums in another pool." Daniel Zabinski et al., "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection," *Journal of Health Economics* 18 (1999), p. 196.

Companies Selling MSA-Qualifying Insurance Plans

American Community Mutual (Michigan) AZ, IL, IN, OH, PA, MI, MO, NE, OH.	800-233-3444
American Republic (Iowa) Individual in AL, AZ, CO, IL, IA, IN, KS, MO, ND, NE, NM, OK, PA, SC, SD, TN, TX, WI, WV, WY.	800-247-2190
Blue Cross of California/WellPoint Individual and small group in CA.	800-999-2273
Blue Cross Blue Shield of Nebraska Individual and small group in NE.	800-991-5650
Blue Cross Blue Shield of South Carolina Individual and small group in SC.	800-500-5281
Blue Cross Blue Shield of Utah Individual in UT.	800-662-0816
Blue Cross Blue Shield of Wisconsin Individual and small group in WI.	800-316-8518
Blue Cross Blue Shield of the Finger Lakes (through NY Chamber of Commerce only)	716-454-1700
Blue Shield of California Individual and small group in CA.	619-296-1551
Blue Shield of Idaho Individual in ID.	208-746-2671
Blue Shield of Northeastern New York Small group in NY.	800-322-3920
Central Reserve Life (Ohio) Individual in AL, AZ, DE, GA, IL, IN, IA, KS, KY, MI, MO, NE, NV, NM, NC, OH, OK, SC, TN, TX, UT, VA, WV.	440-572-2400
Fortis Health, Inc. (Wisconsin) Individual in AZ, AR, CA, CO, CT, DE, DC, FL, GA, ID, IL, IN, IA, KS, LA, MD, MI, MN, MO, MS, MT, NE, NV, NM, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI, WY. Small Group in AZ, DE, DC, GA, ID, IL, IN, KS, IA, LA, MI, MN, MS, MO, MT, NE, NV, OH, OK, PA, SD, SC, TN, TX, VA, WV, WI, WY.	888-846-3672

Freedom Life (Texas)	800-437-8693
Individual in AZ, AR, CO, FL, GA, IL, IN, KS, LA, MI, MS, NE, OH, OK, TN, TX, UT, VA.	
Golden Rule (Illinois)	800-444-8990
Individual and small group in AR, GA, IL, LA, MS, MO, NE, OH, PA, TN, TX, VA, WV, WI. Individual in MD, SD. Small group only in FL, SC	
Group Health, Inc. (New York)	800-322-3920
Small group in NY.	
Horizon Blue Cross Blue Shield of New Jersey	973-466-6458
Individual and small group in NJ	
LifeWise (Oregon)	800-290-1278
Individual in OR.	
Medical Savings Insurance Company	888-696-9663
Individual in AR, AZ, CA, FL, IL, IN, NE, NV, OH, OK, VA, WV	
Mega Life and Health Insurance Co. (Texas)	972-851-9006
Mid-West National Life (Texas)	972-851-9006
Mennonite Mutual Aid (Indiana)	800-348-7468
Fraternal members only. Individual and small group in PA, VA, OH, IL, IN, KS, NE, IA	
Mutual of Omaha (Nebraska)	800-775-6000
Individual in AK, AL, AR, AZ, DE, DC, FL, GA, IL, IN, IA, LA, MI, MO, MS, MT, ND, NE, NM, NV, PR, OH, OK, RI, SC, SD, TN, TX, UT, VA, WI, WV, WY.	
Trigon Blue Cross Blue Shield (Virginia)	804-354-7000
Small group in VA.	
Trustmark (Illinois)	800-366-6663
Individual in AL, AK, AR, CA, DC, DE, FL, GA, ID, IL, IN, IA, KS, LA, MI, MN, MO, MS, MT, NE, ND, NV, OH, OK, PA, SC, SD, TX, TN, UT, VA, WI, WV, WY. Small group through Star Marketing and Administration in AK, AR, AZ, DC, DE, GA, IA, ID, IL, IN, KS, LA, MI, MO, MS, NC, NE, NM, OH, OK, PA, RI, SC, TN, TX, UT, VA, WI, WV, WY.	
UniCare (California)	800-399-2273
Individual in DC, GA, TX, IL, IN, VA.	

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute founded in 1983 and funded exclusively by private contributions. The mission of the NCPA is to seek innovative private-sector solutions to public policy problems.

The center is probably best known for developing the concept of Medical Savings Accounts (MSAs). The *Wall Street Journal* called NCPA President John C. Goodman “the father of Medical Savings Accounts.” Sen. Phil Gramm said MSAs are “the only original idea in health policy in more than a decade.” Congress approved a pilot MSA program for small businesses and the self-employed in 1996 and voted in 1997 to allow Medicare beneficiaries to have MSAs.

Congress also relied on input from the NCPA in cutting the capital gains tax rate, in creating the Roth IRA and eliminating the Social Security earnings penalty. These proposals were part of the pro-growth tax cuts agenda contained in the Contract with America and first proposed by the NCPA and the U.S. Chamber of Commerce in 1991. Two other tax changes — an increase in the estate tax exemption and abolition of the 15 percent tax penalty on excess withdrawals from pension accounts — also reflect NCPA proposals.

Another NCPA innovation is the concept of taxpayer choice — letting taxpayers rather than government decide where their welfare dollars go. Legislation to create taxpayer choice at the state level was sponsored last year by Reps. John Kasich, J.C. Watts and others. The idea is also a priority of President Bush.

Entitlement reform is another important area. With the grant from the NCPA, economists at Texas A&M University have developed a model to analyze Social Security and Medicare, and is publishing a series of studies on the future of the two entitlement programs. This work is directed by Texas A&M Professor Tom Saving, who has been appointed a Social Security and Medicare trustee. The NCPA has also established an interactive online Social Security calculator (www.mysocialsecurity.org), that allows visitors to compare their Social Security benefits with returns if they payroll taxes had instead been invested privately.

In the 1980s, the NCPA was the first public policy institute to publish a report card on public schools based on results of student achievement exams, and an NCPA task force made the case for school choice. Subsequently, the NCPA pioneered the concept of education tax credits as one route to school choice. The NCPA and Children First America have published an Education Agenda for the new administration, a book whose contributors include Nobel laureate Milton Friedman, Sen. Jon Kyl and other school choice experts.

The NCPA’s Environmental Center works closely with other think tanks to provide common sense alternatives to extreme positions that frequently dominate environmental policy debates. In 1991 the NCPA organized a 76-member task force, representing 64 think tanks and research institutes, to produce *Progressive Environmentalism*, a pro-free enterprise, pro-science, pro-human report on environmental issues. The task force concluded that empowering individuals rather than government bureaucracies offers the greatest promise for a cleaner environment. Later, the NCPA produced *New Environmentalism*, written by Reason Foundation scholar Lynn Scarlett. The study proposes a framework for making the nation’s environmental efforts more effective while reducing regulatory burdens. More recent publications include a pathbreaking study that showed the costs of the Kyoto protocol on global climate change would far exceed any benefits.

In 1990 the NCPA's Center for Health Policy Studies created a health care task force with representatives from 40 think tanks and research institutes. The pro-free enterprise policy proposals developed by the task force became the basis for a 1992 book, *Patient Power*, by John Goodman and Gerald Musgrave. More than 300,000 copies of the book were printed and distributed by the Cato Institute, and many credit it as becoming the focal point of opposition to Hillary Clinton's health care reform plan.

A number of bills before Congress promise to protect patients from abuses by HMOs and other managed care plans. Although these bills are portrayed as consumer protection measures, NCPA studies show they would make insurance more costly and increase the number of uninsured Americans. An NCPA proposal to solve the problem of the growing number of Americans without health insurance would provide refundable tax credits for those who purchase their own health insurance. The NCPA has assisted members of Congress to formulate a bipartisan tax credits proposal.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA experts appear regularly in national publications such as the *Wall Street Journal*, *Washington Times* and *Investor's Business Daily*. NCPA Policy Chairman Pete du Pont has a weekly column on the *Wall Street Journal's* OpinionJournal.com and another weekly column distributed by the Knight-Ridder Tribune news wire. In addition, his radio commentaries reach 2.2 million listeners across America.

According to Burrelle's, the NCPA was mentioned or quoted in about 15 news articles every day somewhere in the United States in 2000. The advertising dollar equivalent of all print and broadcast coverage was more than \$50 million.

The NCPA Internet site (www.ncpa.org) embraces the philosophy of one-stop shopping, linking visitors to the best available information on public policy, including studies produced by think tanks all over the world. Britannica.com named the NCPA Web site one of the best on the Internet for quality, accuracy of content, presentation and usability.

What Others Say about the NCPA

"...influencing the national debate with studies, reports and seminars."

— **TIME**

"...steadily thrusting such ideas as 'privatization' of social services into the intellectual marketplace."

— **CHRISTIAN SCIENCE MONITOR**

"The NCPA is unmistakably in the business of selling ideas...(it) markets its products with the sophistication of an IBM."

— **INDUSTRY WEEK**

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