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Medical Savings Accounts

Universal, Accessible, Portable, Comprehensive Health Care for Canadians

by Cynthia Ramsay

THE FRASER INSTITUTE

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Executive Summary

Medical savings accounts (MSAs) are health accounts that are established in conjunction with high-deductible health insurance. They can be set up by individuals, employers, or by the government. The most common type is the American employer-funded MSAs. In this type of health plan, employers purchase a high-deductible, or catastrophic, insurance policy for their employees, which is much cheaper than a traditional insurance package. Employers then deposit a portion of the funds saved into MSAs for their employees, who then use these funds to purchase medical care. Once these funds have been exhausted, the employees are responsible for the payment of their medical care up to the cap where the catastrophic insurance begins. All of the MSA funds belong to the employee, including any funds remaining in the account after a specific period (usually a year).

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 percent. 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.

Opponents of cost sharing point out that, because of consumer ignorance, individuals may delay seeking care or forgo efficacious preventive care when faced with medical expenditures (*i.e*. when medical care is not free). This may subsequently result in higher medical expenditures if, for example, the illness has reached a more advanced stage. As well, it is often argued that, again due to consumer ignorance, physicians (suppliers) are able to induce demand. For these reasons, they argue, publicly funded health care and government intervention in the market are not only justifiable but necessary. However, studies have shown that, on the whole, cost sharing reduces the use of health care services with little or no net adverse effect on people's health and there is great uncertainty whether supplier-induced demand is a large problem in the health care sector.

Canadian governments could easily provide individuals with catastrophic insurance and deposit funds into MSAs. The size of the government contribution could vary from the whole to a fraction of the catastrophic insurance policy's deductible, depending on a person's health, age, and income level. When faced with medical expenses, individuals would first use the money in their MSA (which can be used only for health-related expenses). At the end of the year, any funds remaining in a person's MSA may be withdrawn, left to accumulate in a separate account for future medical expenses, or rolled over into a retirement savings plan.

The latter two options allow for capitalization of the health care market. Any funds invested today gain interest and can be used in the future for the more expensive care most individuals will need when they are older. This is the contrary of the current system, in which the tax dollars of today pay for health care today and, because health care funds are spent immediately, there is no opportunity for them to be invested and to grow.

Medical savings accounts can encourage more prudent use of the health care system and introduce competition into the medical market-place 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.

Introduction

This year has brought more pressure to bear on the Canadian health care system.[1] People have died in emergency rooms while waiting for care. Elective surgeries have been canceled. Doctors have organized work stoppages to protest government-imposed caps on their earnings. The list goes on. What is happening to what is thought to be one of the best health care systems in the world?

When our "one tier" health care system began mere decades ago, Canada's population had a large percentage of young people, its economy was growing rapidly, and the high-technology medical revolution had not yet started. Times have changed. Our population is aging and the cost of modern medical technology is rising (Kirkman-Liff 1994). As well, interest payments on our governments' debts are consuming tax dollars once available for health, education, and other programs.

Luckily, most of our governments have realized the folly of spending more than their income and the battle to eliminate budget deficits has led both federal and provincial levels of government to reduce their expenditures, including the expenditure for health care. From 1975 to 1991, health expenditures jumped from 7.1 percent of our national income, or gross domestic product (GDP), to 10.2 percent (Health Canada 1997). Since 1991, health expenditures by governments as percent of GDP have been decreasing and they are now at about 9.5 percent of GDP. Unfortunately, this decrease has been largely the result of cost-cutting measures such as the closing of hospitals, the capping of physician fees, and other measures that reduce patient access to the health care system. Thus, the health care system is under increasing pressure, and we see the effects of this in overcrowded emergency rooms and hospital waiting lists that refuse to decrease despite intermittent efforts on the part of governments.

To this point, every political party in power has been reluctant to alter our very popular health care system significantly. However, here, too, times have changed. Only 43 percent of Canadians believe that our health care system is very good or excellent, and 45 percent of Canadians feel that the care being delivered by our health care system is of a lower quality care than that of five years ago.[2] In another survey, 42 percent of Canadians are distrustful of the reforms that have been initiated by governments across Canada; they feel that health care reform is just another term for "spending cuts."[3]

Health care reform

Health care reforms can attempt to influence either the supply side or the demand side of health care. Supply-side measures attempt to affect the behaviour of physicians, hospitals, and other providers of care. Demand-side reforms attempt to alter the behaviour of the recipients of care, the patients.

While there are many supply-side reforms that are effective in controlling health care costs and improving the quality of care, rationing has been the predilection in Canada. For example, if a medication is not on a provincial formulary, it is less likely to be prescribed, or if a hospital bed is not available, an elective surgical procedure will be delayed. These types of cost-containment measures are attractive to policy makers because the costs are not easily seen by patients: patients will not necessarily know if they are not receiving the best medication available and they may not know that their surgery could have taken place earlier had there been a bed available.

Supply-side reforms lke these, however, are likely to cost more in the long run. For example, a patient who is prescribed an older, albeit cheaper, drug is more likely to have adverse side effects. The result may be a return visit to the doctor, another prescription, or an evening in an already overcrowded emergency room. All of these outcomes are more costly both to the system and to the patient than if the more effective but more expensive drug had been prescribed in the initial consultation.

Reforms that attempt to transform the supply side by restricting patients' access to the health system have received a significant amount of attention from researchers and the media. Often overlooked, however, is the demand-side of health care: patients—consumers of health care ser-

vices—are usually ignored in the reform process. This is unfortunate as health care is highly driven by demand, and as our population ages and our income levels increase, we will naturally demand more of health care services. Harsher rationing measures will be needed to curb this natural demand for health care. Rather than further endangering people's health and restricting their freedoms, governments should start examining the demand side of health care. More specifically, governments should start allowing people to direct and contribute directly to their own health care spending.

Medical savings accounts: affecting the demand for health care

An alternative to rationing and other supply-side reforms is to allot health care funds directly to the potential consumers of health care. During the national debate on health care in the United States, an idea for returning purchasing power to the patient was developed by the National Center for Policy Analysis (NCPA), which advocated medical savings accounts (MSAs). The general idea of an MSA is that employers deposit a fixed amount of money from the total dollars they already are spending for their employees' health insurance into an employee's MSA. The company then uses the remainder of the funds to buy a high-deductible (catastrophic) medical-insurance policy, which is less expensive than a low-deductible policy.

When faced with medical expenses, employees first use the money in their MSA, which can be used only for health-related expenses. For example, suppose the deductible is $2,000 per year. A person might elect to spend $500 from his or her MSA on massage therapy or nutrition counseling. If these services were not covered by the insurance plan, the person would have used up some MSA funds but would still face the full $2,000 deductible if a need arose for other health-related services during the year. At the end of the year, any funds remaining in a person's MSA may be withdrawn, left to accumulate in a separate account for future medical expenses, or rolled over into a retirement savings plan. The most important aspect of an MSA is that the money belongs to the employee, who is responsible for these funds and can reap the benefits of using the medical system more prudently.

Companies in the United States that have adopted the MSA framework (the details of each plan can vary) have demonstrated that health insurance plans of this type can save them money. Many of the employees of these companies have benefited as well: they have more control over the type of care they receive and they are rewarded for prudent use of the health care system because they retain any money remaining in their MSA at year end.

Since the concept of MSAs was introduced by the NCPA, it has been embraced by many different organizations such as the Council for Affordable Health Insurance (Bunce 1996), the American Medical Association (American Medical Association 1994) and the Family Research Council (Deeds 1995). As well, many research organizations such as the American Academy of Actuaries (1995), the National Bureau of Economic Research (Eichner, McClellan, and Wise 1996) and the RAND Corporation (Keeler et al. 1996) have researched and analyzed medical savings accounts as a measure for controlling health care expenditure.

The idea of medical savings accounts in a Canadian context was introduced by The Fraser Institute in the book *Healthy Incentives* (McArthur, Ramsay, and Walker 1996). The authors proposed that the MSA concept be adapted to the Canadian context, with the government taking over the role of the employer. MSAs would be financed from general tax revenues but most hospitals would be privatized, clinics would be privately run, and health care providers would bill patients rather than the government.

MSAs could create a more efficient and a more effective method of providing universal insurance. MSAs would be portable—the funds belong to the individual—and they would be more comprehensive than our current health care system—the funds could be used to purchase any health services the individual desired, thus offering greater consumer choice. MSAs would inform both consumers and suppliers of health care of the costs of the care purchased and they would provide both groups with incentives to use the system appropriately. MSAs would allow those who could afford it to contribute to the costs of their health care, a procedure that would add more resources to the system. As well, MSAs can be organized in such a fashion that those who cannot afford to contribute to the costs of their health care are not required to do so, thereby ensuring that all Canadians have reasonable access to quality health care when they need it, regardless of their ability to pay.

In this Critical Issues Bulletin

This Critical Issues Bulletin has three parts. The first part, *The Basics*, explores the theoretical case for MSAs. It examines the benefits and caveats of health insurance, the prob-

lem of moral hazard (insured patients demand more services than they would in the absence of insurance), and the different forms of cost sharing—deductibles, co-insurance and user fees—that have traditionally been used to control the moral hazard of health insurance. It discusses the deficiencies of these traditional forms of cost sharing, and shows how medical savings accounts provide an alternative. MSAs are described, their incentives are analyzed and then compared and contrasted with the incentives of the traditional forms of cost sharing. The second part of this Critical Issues Bulletin, *The Empirical Evidence*, explores the relevant empirical literature and attempts to assess the likelihood that MSAs can control health care expenditures and improve patient care. The third part, *Policy Recommendation: A Canadian MSA Experiment*, suggests that a majority of Canadians are willing to consider medical savings accounts, and the American evidence encourages us to believe that MSAs work. Nevertheless, the magnitude of the effects brought about be MSAs is uncertain, and a pilot project would shed light on some important issues.