

# **MEDICAL SAVINGS ACCOUNTS**

December 1994

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## *A Briefing Paper*

### INTRODUCTION

Among the myriad proposals for reforming our health care system, an idea called “medical savings accounts,” or MSAs, has been gaining increasing attention. Also known as medisave accounts, medical IRAs, and individual medical accounts, the MSA concept relies on market forces, individual responsibility, and tax incentives rather than governmental intervention to attempt to control the cost of health care.

According to the National Center for Policy Analysis, a Dallas think tank that is a proponent of MSAs, “Medical Savings Accounts would be tax-free personal accounts used to pay medical bills not covered by insurance. Regular deposits could be made by individuals or their employers, but they would be the property of individuals. Money not spent would grow tax free and could be used for medical expenses or rolled over into an IRA or private pension plan after retirement, or would become part of the owner's estate.”<sup>1</sup> Medical savings accounts are intended to be combined with an employer-purchased catastrophic health insurance plan with a large deductible. The MSA would cover small medical expenses, up to the amount of the deductible, and health insurance would cover larger expenses.

Senator Phil Gramm, sponsor of medical savings account legislation in the current Congress, provides the following example of how MSAs would work: “Suppose a family of four receives the equivalent of \$4,500 from an employer for comprehensive health coverage. The family might be paying \$500 directly for its share of the policy, including the deductible. A young couple with two children could have the same policy with a high, \$3,000 deductible for about \$2,000 in annual premium payments. So under the medical-savings-account approach, the employer would buy the high-deductible policy for \$2,000 and then put the difference – \$2,500 – into the employee's medical savings account. The medical savings account could be set up in a bank, an insurance company, or any other financial institution. The employee would now have \$3,000 in the medical savings account to meet the \$3,000 deductible.”<sup>2</sup>

The foundation for medical savings accounts is that our current health care payment system leads to cost inflation. Typical health care insurance currently provides coverage with very low deductibles and copayments. As a result, only about 20 percent of health care expenditures are paid directly by patients. This may provide an incentive for patients to overutilize health care services, thereby leading to health care cost inflation. If patients had to pay for more of their health care

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<sup>1</sup> National Center for Policy Analysis, “Personal Medical Savings Accounts (Medical IRAs); An Idea Whose Time Has Come,” Media Backgrounders No. 128, July 22, 1993.

<sup>2</sup> P. Gramm, “Why We Need Medical Savings Accounts,” *New England Journal of Medicine*, 330:24 (June 16, 1994), pp. 1752-1753.

expenses with their own money, they would use fewer services and health care costs would be reduced. Some of the assumptions behind this theory are questionable, and will be discussed in greater detail below. But in essence, the medical savings account concept represents an attempt to put traditional free market mechanisms in control of the health care system.

## LIMITED EXPERIENCE AVAILABLE

Most of the published literature on medical savings accounts are articles or issue papers by proponents of the concept, focusing on the theory behind the approach and providing examples of how MSAs would work. No empirical studies of the impact of medical savings accounts on health care costs, quality or access are available.

One of the theoretical advantages of the medical savings account concept results from exempting MSAs from taxation. Such tax advantages would presumably encourage employees to contribute to these accounts, and would remove some of the incentives which currently exist for maintaining high levels of employer-paid health insurance.<sup>3</sup> However, only seven states provide MSA tax exemptions, and the exemptions in these states were only recently enacted. The federal government does not currently provide a federal income tax exemption for MSAs, although several bills have been proposed in Congress. Federal tax exemption would provide the strongest incentive for MSAs, in that individual and corporate tax rates at the state level are substantially lower.

With only a few companies actually using MSAs for their employees, and without the incentive of a tax exemption for MSAs, particularly an exemption from federal taxes, it is difficult to judge how MSAs would work in practice.

## HISTORY OF THE CONCEPT

The theory behind MSAs appears to have developed within the last 20 years or so. A 1977 paper by health economist Martin Feldstein proposed a concept he called “major-risk insurance.”<sup>4</sup> Major-risk insurance would involve a government-sponsored health insurance system, with a large deductible (for example, 10 percent of family income). The idea was to “make almost all families significantly sensitive to the costs of additional health spending, while still limiting each family's maximum out-of-pocket expenditure to 10 percent of income or less.”

A 1981 article by Miron Stano proposed “individual health accounts,” which he described as follows: “Rather than contributing premiums into an insurance pool, employers and individuals

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<sup>3</sup> Medical savings accounts proponents argue that the current system leads to over-insurance, because employers' health insurance costs are tax deductible but employees' out-of-pocket expenditures usually are not. Because coverage of health insurance costs through employer-paid health insurance is paid with pre-tax dollars, it is more attractive than self-insurance of such costs by the employee (with after tax-dollars).

<sup>4</sup> M. Feldstein, “The High Cost of Hospitals – And What to Do About It,” *The Public Interest*, 48 (Summer 1977), pp. 40-54.

would be required to contribute, subject to both minimum and maximum amounts, into individual (interpreted as an appropriately defined family unit) health accounts handled by a qualified administrative organization.”<sup>5</sup> Stano envisioned that such accounts would entirely replace traditional health insurance. If an individual exhausted all of the funds in his or her account, further health care expenses would be paid for out of a public “National Health Fund.”

Stano makes note of press accounts of the time regarding the employee health care program offered by the Office of Education in Mendocino County, California. This program was apparently very similar to the medical savings account concept, and involved an employer-provided health insurance plan with a \$500 deductible, and savings accounts for each employee into which the employer made annual deposits of \$500. Stano believed that his “individual health account” proposal was superior to this approach, however, because “it completely eliminates conventional health insurance together with all its attendant inefficiencies.”

In 1984, the government of Singapore required that its citizens put 6 percent of their salaries into Medisave accounts. Since the 1950s, Singapore has had a compulsory savings account program for its workers. The program mandates contributions to a government-controlled “Central Provident Fund” (CPF). Employees can draw on their CPF accounts to purchase a house, pay for college expenses, provide for retirement or survivor benefits, or buy life insurance. The funds in a Medisave account “may be used only for treatment at a government hospital or an approved private hospital. Strangely, Medisave funds cannot be used to purchase outpatient care, including physicians' services or expensive outpatient renal dialysis and long-term care.”<sup>6</sup>

Also in 1984, the National Center for Policy Analysis and others began to advocate the creation of medical IRAs to fund the health care expenses of retirees. The NCPA proposal involved “a system in which individuals will be allowed to make annual contributions to qualified accounts called Health Bank IRAs. After a 30-year period, sufficient funds would accumulate in these accounts to allow individuals to pay for their own medical expenses and/or to purchase private health insurance for their retirement years.”<sup>7</sup> Workers would receive a full tax credit for such contributions. In 1985, Rep. D. French Slaughter, Jr., introduced legislation to provide for such a system, although his bill would have only allowed a tax credit for 60 percent of employee contributions. Rep. Claude Pepper introduced another medical IRA bill the same year, which would have allowed \$2,000 annually in contributions to a tax-deferred account. The Slaughter/NCPA proposal was designed to replace Medicare. Rep. Pepper's bill would have helped seniors fund health services not covered by Medicare. Neither proposal was enacted.

## EXAMPLES OF THE MSA APPROACH IN PRIVATE INDUSTRY

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<sup>5</sup> M. Stano, “Individual Health Accounts: An Alternative Health Care Financing Approach,” *Health Care Financing Review*, 3:1 (September 1981), pp. 117-125.

<sup>6</sup> J.C. Goodman and G.L. Musgrave, *Controlling Health Care Costs With Medical Savings Accounts*, National Center for Policy Analysis, Dallas, Texas. Appendix B, “Medisave Accounts in Singapore.”

<sup>7</sup> C. Cain, “Medical IRAs Weighed as Retirement Option,” *Business Insurance*, February 17, 1986, p. 28.

Despite the fact that MSA contributions are still subject to federal and most state income taxes, several companies have instituted MSA or similar programs for their employees. The best known of these are the Golden Rule Insurance Co. and Dominion Resources, Inc.

Golden Rule, based in Indianapolis, is one of the largest sellers of individual health insurance in the country. Its employees have the option of either a traditional health insurance plan with a \$500 deductible, or a plan with a \$3,000 family deductible. If they choose the high deductible plan, Golden Rule deposits \$2,000 annually into a medical savings account. Ninety percent of Golden Rule's employees choose the MSA option.<sup>8</sup>

Dominion Resources is a utility holding company in Virginia. It also offers its employees a choice between a traditional low-deductible health plan and a plan with a \$3,000 deductible and an MSA. Dominion contributes \$1,620 per year to the MSAs of those employees who choose this option.<sup>9</sup>

Forbes magazine in New York provides its employees with a health plan that is similar to the MSA concept. A \$1,200 account is established each year for each employee. For every \$1 in medical claims that an employee files, the employee loses \$2 from the account. The employee gets to keep any balance in the account at the end of the year.<sup>10</sup>

Quaker Oats, Knox Semiconductor, and several other companies also have health plans that utilize elements of the MSA approach.<sup>11</sup>

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<sup>8</sup> "Consumer-First Health Care," *The Wall Street Journal*, July 21, 1994, p. A14.

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Gramm; and S. McEachern, "Employees Pay More, Get More," *Business & Health*, 10:1 (January 1992), pp. 52 and 54.

## MEDICAL SAVINGS ACCOUNT LEGISLATION

As noted earlier, seven states have enacted legislation which exempts medical savings accounts from state taxes. Many other states, including Oregon, have considered such legislation. Legislation is also being considered in the U.S. Congress. Table 1 contains a summary and comparison of the seven state MSA statutes and two of the best-known of the MSA bills considered in Congress in 1994.

Table 1 indicates a number of similarities among various state and national MSA programs. All but one of the statutes contain a maximum limit on annual contributions to the MSA, usually \$3,000; but only Mississippi requires a minimum annual contribution to the MSA. Most of the bills require the purchase of a catastrophic health insurance plan with a large deductible as a precondition for setting up an MSA. Four of the seven state programs require that the employer contribute to employee MSAs. At a minimum, the amount contributed by the employer must equal the amount that the employer saves in health insurance premiums by purchasing a high-deductible health plan, as compared to the cost of a low-deductible, comprehensive insurance policy. All but one of the statutes provide for a tax exemption for contributions to MSAs, and for any withdrawals from the MSA which are used to purchase health care. Michigan, however, provides a tax credit for MSA contributions that is equivalent to about three-quarters of the personal income tax rate in that state. Four of the state programs, Idaho, Illinois, Michigan and Mississippi, are slated to expire in several years if not extended by their legislatures. The Idaho, Illinois and Michigan statutes also require a report to their state legislatures on the impact of the program.

Unlike the program in Singapore, *none* of these statutes would *require* the establishment of medical savings accounts, by either employers or individuals. All of the statutes provide a definition of an allowable medical expenditure. In most cases, the definition is based on section 213(d) of the IRS code, the section which currently defines which medical expenditures are tax deductible. All the statutes provide that the MSA is the property of the employee, and several contain specific provisions for "rolling over" MSA funds when a worker changes employers. Only one bill, the Gramm proposal which was recently considered by the Congress, sets minimum benefit requirements for the catastrophic insurance plans that would be coupled with MSAs.

Although seven states have passed legislation authorizing the creation of tax-exempt medical savings accounts, dozens of other states have considered such legislation and have declined to enact it. A number of these states have required that the concept be studied. The Kansas legislature passed a medical savings account bill this year, but it was vetoed by the Governor, who claimed that the proposal would have meant a substantial loss of tax revenues to the state and would have benefited only people with higher incomes.

Minnesota is the only state that has thus far issued a formal feasibility study of medical savings accounts, although a number of state legislatures have required the preparation of such reports. The report, issued by the Minnesota Department of Health in February 1994, concluded that:

Table 1

COMPARISON OF STATE AND NATIONAL MEDICAL SAVINGS ACCOUNT LEGISLATION

	Date enacted or signed	Effective date	Maximum contribution allowed	Minimum contribution required	Required purchase of a catastrophic plan?	Employer contribution required?	Tax status of the account
Arizona	4/94	12/31/94	<ul style="list-style-type: none"> <li>• \$2,000 individual</li> <li>• \$3,000 for a couple</li> <li>• \$4,000 for a family of 3 or more</li> </ul> (Annually adjusted for inflation.)	None	No	No	Contributions are exempt from state taxes. Withdrawals from the account are exempt if used for medical care, but if not used for medical care are considered taxable income.
Colorado	6/94	1/1/95	\$3,000	None	No	No	Same as Arizona, above.
Idaho	1994 (Date not known.)	1994 tax year (Sunsets 1/1/99.)	\$3,000 (Annually adjusted for inflation.)	None	Yes (Defined as a plan with a \$1,000 - \$3,000 deductible. Annually adjusted for inflation.)	Yes (Must contribute the amount saved in insurance premiums to the MSA, up to \$3,000 per year. Inflation adjusted.)	Contributions are exempt from state taxes. Withdrawals are exempt if used for medical care. Non-medical withdrawals plus the interest earned in the year of the withdrawal are taxable income, and are also assessed a 10% penalty.
Illinois	8/94	Currently in effect (Sunsets 1/1/2000.)	<ul style="list-style-type: none"> <li>• \$6,000 for a couple filing a joint return</li> <li>• \$3,000 for all others</li> </ul> (Annually adjusted for inflation.)	None	Yes (Defined as a plan with a \$1,000 - \$3,000 deductible. Annually adjusted for inflation.)	Yes (Must contribute the amount saved in insurance premiums to the MSA, up to \$6,000 per year for a couple filing a joint return and \$3,000 for all others. Inflation adjusted.)	Contributions are exempt from state taxes. Withdrawals are exempt if used for medical care. Non-medical withdrawals plus the interest earned in the year of the withdrawal are taxable income, and are also assessed a 10% penalty.
Michigan	7/94	1994 tax year (Sunsets 1/1/99.)	\$3,000 (Annually adjusted for inflation.)	None	Yes (Defined as a plan with a \$1,000 - \$3,000 deductible. Annually adjusted for inflation.)	Yes (Must contribute the amount saved in insurance premiums to the MSA, up to \$3,000 per year. Inflation adjusted.)	3.3% tax credit for contributions to the MSA (personal income tax rate in Michigan is 4.6%). Non-medical withdrawals are deducted from the year's tax credit.

	Date enacted or signed	Effective date	Maximum contribution allowed	Minimum contribution required	Required purchase of a catastrophic plan?	Employer contribution required?	Tax status of the account
Mississippi	3/94	1994 tax year (Sunsets 1/1/98.)	None	Two-thirds of the difference in premium for the high deductible health plan associated with the MSA, compared to a standard comprehensive health plan.	Yes (Defined as a plan with a \$1,250 - \$2,500 deductible for an individual, or \$1,750 - \$3,500 for a family. Annually adjusted for inflation.)	No	Contributions are exempt from state taxes. Withdrawals from the account are exempt if used for medical care, but if not used for medical care are considered taxable income.
Missouri	1993 (Date not known.)	Currently in effect	To be set by regulation. (Regulations for this statute have not yet been adopted.)	To be set by regulation.	Yes (Plan specifications to be set by regulation.)	Yes (Must contribute the amount saved in insurance premiums to the MSA.)	Contributions are exempt from state taxes. Withdrawals from the account are exempt if used for medical care, but if not used for medical care are considered taxable income.
U.S. – Gramm/Santorum bill (S. 1807/H.R. 3918)	Not Enacted.	N/A	\$3,000 (Annually adjusted for inflation.)	None	Yes (Defined as a plan with at least a \$3,000 deductible.)	No	Contributions are exempt from federal taxes. Withdrawals from the account are exempt if used for medical care, but if not used for medical care are considered taxable income. Non-medical withdrawals which leave a balance of less than \$3,000 in the account are charged a 10% penalty.
U.S. – Jacobs bill (H.R. 4410)	Not Enacted.	N/A	Contributions in excess of the plan's deductible are not eligible for tax credit.	None	Yes (Defined as a plan with a \$1,000 to \$5,000 deductible.)	No	30% tax credit for MSA contributions and health care expenditures. A 10% surcharge would be added to the tax due on non-medical withdrawals by people under age 59.

The establishment of state tax-exempt medical savings accounts is not feasible in Minnesota at this time, especially given the current health care reform climate and the high degree of penetration of managed care arrangements in many areas throughout the state... The emphasis in medical savings accounts on individual autonomy and personal economic gain, primarily for a small percentage of healthy, wealthy “young immortals,” is largely incompatible with the policy goals of universal health coverage and managed care.<sup>12</sup>

In Oregon, the 1993 session of the legislature considered a bill which would have allowed for the creation of “individual medical accounts” which would be exempt from state taxes (House Bill 3387). The House Committee on Revenue and School Finance's Subcommittee on Income Taxation held several hearings on the bill and eventually amended the bill to provide that the concept would be studied by a special interim committee of the legislature. The bill was later tabled, however, because “the Speaker of the House was not anxious to appoint a task force or assign legislators to work on this bill because of the time and cost involved.”<sup>13</sup> Ultimately, a section was included in SB 5530 which requires that the Oregon Health Plan Administrator prepare a report on individual medical accounts by January 1, 1995.

## ASSUMPTIONS BEHIND THE MEDICAL SAVINGS ACCOUNT CONCEPT

### ***Consumer Driven Demand***

The medical savings account concept is based on the idea that the individual consumer controls demand for medical care, and that the current system of third-party reimbursement encourages overutilization by consumers. “When patients pay only a fraction of the real cost of the health care they receive, they have an incentive to over-consume. Since we pay only 23 cents out-of-pocket for every dollar of medical care we receive, we have an incentive to continue consuming until medical care is worth only 23 cents on the dollar to us.”<sup>14</sup> Medical savings accounts are supposed to correct such perverse incentives by making individuals responsible for their routine health care expenditures. With an MSA and a high-deductible catastrophic policy, most medical care encounters would be paid for through the MSA, which is the individual's own money. Individuals would presumably be careful about spending their own money. They would have a financial incentive to avoid any unnecessary utilization of care and to search for the best price for care.

A corollary to these arguments is that the greatest opportunities for health care savings are in the areas of routine primary and preventive care. The MSA concept continues to insure the non-routine, expensive health care services. It is only the less expensive and more predictable services that are

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<sup>12</sup> Minnesota Department of Health, Health Care Delivery Systems Division, *Medical Savings Accounts: A Feasibility Study for the Minnesota Legislature*, February 1994.

<sup>13</sup> Minutes of the House Committee on Revenue and School Finance, Subcommittee on Income Taxation, May 28, 1993, p. 3.

<sup>14</sup> Goodman and Musgrave, p. 2.

paid for by the consumer from medical savings account funds, so these are presumably the main areas in which utilization will be reduced and costs will be saved.

Proponents of the MSA concept also claim that MSA participants will be more likely to obtain preventive health care services and to engage in healthy lifestyles, because such choices would result in financial rewards to the individual.

The claims above rest on several assumptions, including:

- The present payment system, in which most medical care expenses are covered by insurance and not paid for directly by the consumer, is the main reason behind increasing health care costs.
- The consumer of health care services is the main person responsible for deciding which services are utilized.
- Health care consumers have or can readily obtain the knowledge necessary to make appropriate choices regarding the utilization of health care services.
- Free market mechanisms are the best method for distributing health care resources.
- The main area of waste in the current health care system, and the principle area to target for savings, is routine primary care.

There are arguments for and against each of these assumptions. Proponents of MSAs make their case from classic economic principles: “When consumers face artificially low prices for health care services, they overconsume those services. If the out-of-pocket cost is zero, they tend to consume health services until their value at the margin is zero.”<sup>15</sup> Many economic theorists agree with this argument.<sup>16</sup>

However, other researchers claim that consumer-driven overutilization is only a minor contributing factor to health care cost increases. Newhouse, for example, argues that all of the increase in utilization that could likely result from low-deductible, first-dollar insurance coverage occurred during the period in which such coverage became prevalent in the U.S., from the end of World War II through the late 1970s. Once comprehensive, first-dollar health insurance was established as the norm, it ceased to have any significant influence on further increases in health care costs.<sup>17</sup> Newhouse believes that the principal cause of increasing health care costs is the increased

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<sup>15</sup> J.C. Goodman and G.L. Musgrave, *Patient Power*, as abridged by M.D. Tanner (Washington: Cato Institute, 1994), p. 130.

<sup>16</sup> See, for example, the articles by Feldstein and Stano which were cited earlier.

<sup>17</sup> J.P. Newhouse, “An Iconoclastic View of Health Cost Containment,” *Health Affairs*, 12 (Supplement 1993), pp. 152-171.

capability of medicine. This idea is supported by other researchers.<sup>18</sup>

Medical savings account proponents also claim that huge cost savings would result from MSAs. Goodman and Musgrave estimate that “after extending catastrophic health insurance to the currently uninsured, the net total savings are \$168 billion – almost one-fourth of what the United States now spends on health care.”<sup>19</sup> Two factors should be weighed in considering such claims. First, the calculations of these cost savings rely on the assumption that consumer-driven utilization is the major cause of increasing costs. As discussed above, some experts dispute this assumption. Second, these cost savings would result primarily from decreased utilization of routine health care services by consumers. Medical savings account proponents assume that there is so much unnecessary utilization now that large reductions in use can occur without any adverse impact on health status. As will be discussed below, this may not be true, especially for certain vulnerable populations.

### ***Cost Sharing and Utilization***

There is good evidence that increases in patient cost-sharing, such as increases in an insurance policy's deductible, will result in significant reductions in utilization. The most thorough research on this issue was the Rand Health Insurance Experiment, conducted from 1974 through 1982. The Rand researchers state that “we found that the more people had to pay for medical care, the less of it they used. Adults who had to share the cost of care made about a third fewer ambulatory visits and were hospitalized about a third less often.”<sup>20</sup>

But there is some reason for concern that both necessary and unnecessary utilization may be reduced as a result of increased cost sharing. The Rand researchers found that in general, higher cost-sharing had no significant impact on the health status of patients, but they warn that “our results must be used with caution to derive policies for special groups in the population. In our study, poor families were protected by an income-related ceiling on their out-of-pocket medical expenses. The aged and those too disabled to work were not included in the experiment, and in any event additional medical care for such persons may provide benefits that a young, relatively healthy population does not experience.”<sup>21</sup> A 1988 review of the literature found that cost sharing appears to act as a barrier to needed health care for young children, preventative services (such as immunizations, pap smears, and physical exams), vision care, dental care, treatment of hypertension, mental health care, and coverage of prescription drugs.<sup>22</sup>

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<sup>18</sup> See, for example, U.S. General Accounting Office, *Hospital Costs; Adoption of Technologies Drives Cost Growth*, HRD 92-120, September 1992.

<sup>19</sup> Goodman and Musgrave, *Controlling Health Care Costs...*, p. 27.

<sup>20</sup> R.H. Brook, J.E. Ware, et al., “Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial,” *New England Journal of Medicine*, 309:23 (December 8, 1983), pp. 1426-1433.

<sup>21</sup> *Ibid.*

<sup>22</sup> Oregon Office of Health Policy, Department of Human Resources, *Cost Sharing: Its Impact*

There is also an issue of equity in regard to increased cost-sharing for low income persons. A recent study by the Urban Institute looked at spending patterns for health care. The authors found that health care spending consumed a greater percentage of income for low income persons than for those with higher incomes. However, the actual amount spent per person in low income households was less than the average for higher income households.<sup>23</sup> A study by the Economic Policy Institute produced similar results. These authors found that “in 1987, low-income families spent over 20 percent of income for health care, while families with the highest incomes paid about 10 percent... Out-of-pocket spending was the most regressive type of financing with low-income families paying a share of income which was over eight times the share paid by those with high incomes. This occurred even though spending by the poor was limited by their low incomes.”<sup>24</sup>

### ***Provider Driven Demand***

By making each individual responsible for their routine health care expenditures, the MSA concept implicitly assumes that the individual is the one who decides when to get care and what kind of care to get. This may sometimes be the case, but often it is not. Clearly a person in a medical emergency – a heart attack, stroke, or serious injury is not in a position to shop for the best price or critically examine the options for treatment. Such emergency cases are only a small fraction of all medical care encounters, but there are many other instances in which the provider, rather than the patient, decides which services will be used.

There is some research evidence to support the idea that provider-generated demand, rather than consumer behavior, is responsible for much overutilization of health care services. For example, several studies have shown that physicians who own medical equipment tend to order more tests or procedures using the equipment and to charge more for these services than other physicians.<sup>25</sup> Certainly if economic incentives operate for consumers, to either induce or restrain the utilization of services, we can expect that economic incentives will also work for providers. But the medical savings account concept changes these incentives only for the consumer.

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*on Health Care Costs, Access, Quality, Preventive Care, and Health Outcomes; A Summary of Findings from National Research*, December 20, 1988.

<sup>23</sup> J. Holahan and S. Zedlewski, “Who Pays for Health Care in the United States? Implications for Health System Reform,” *Inquiry*, 29 (Summer 1992), pp. 231-248.

<sup>24</sup> E. Rasell, J. Bernstein, and K. Tang, *The Impact of Health Care Financing on Family Budgets*, Economic Policy Institute Briefing Paper, Washington, D.C., April 1993.

<sup>25</sup> B.J. Hillman, C.A. Joseph, et al., “Frequency and Costs of Diagnostic Imaging in Office Practice – A Comparison of Self-Referring and Radiologist-Referring Physicians,” *New England Journal of Medicine*, 323 (December 6, 1990), pp. 1604-1608; J.M. Mitchell and J.H. Sunshine, “Consequences of Physicians' Ownership of Health Care Facilities – Joint Ventures in Radiation Therapy,” *New England Journal of Medicine*, 327 (November 19, 1992), pp. 1497-1501; and A. Swedlow, G. Johnson, et al., “Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians,” *New England Journal of Medicine*, 327 (November 19, 1992), pp. 1502-1506.

## ***Informed Consumers***

The creation of an informed health care consumer has been a goal of health planners for many years. The medical savings account concept tries to achieve this goal by giving the consumer a financial incentive to become better informed and more involved in medical decision-making. Advocates of MSAs argue that MSA participants would demand better information on the health care marketplace, and this demand would lead to the development and publication of considerable data on the price and quality of health care services. This would strengthen the role of market forces in health care, and empower health care consumers. However, it should be noted that recent efforts to create consumer score cards have been occurring independent of efforts to develop MSAs.

The consumer's knowledge can never be expected to equal that of health care providers. If a doctor tells a patient that the patient needs an MRI, and that a less expensive CT scan or X-ray will just not do, it is unlikely that the patient would question the doctor's judgment. If a doctor refers a patient to a particular hospital or laboratory, it's unlikely that the patient will try to compare prices and find a better deal. Although an MSA program could lead to better informed and more involved health care consumers, it seems likely that there would continue to be a considerable knowledge gap between the highly-trained health care professional and the consumer.

## ***Routine Care as the Target for Savings***

An additional assumption of the medical savings account concept is that routine, low-cost medical care is the best area to target for cost savings. Such care would be paid for by the consumer with funds from the MSA, while more expensive care would continue to be covered by health insurance. However, analysts of the MSA concept in the Minnesota Department of Health point out that "health care expenditures are unevenly distributed across the population and it is not at the level of \$3,000 or less that most health services are consumed. Currently, most of the expenditures are for those who are seriously or chronically ill, in other words, those whose annual health care expenditures total far more than \$3,000. About 5 percent of the population accounts for one-half of all health care expenditures."<sup>26</sup> Some health care experts estimate that no more than 5 percent of physician revenues could be eliminated by getting rid of unnecessary physician services.<sup>27</sup>

There is also a substantial amount of evidence that much of the overutilization that exists in the current health care system is associated with high-cost medical services. For example, research has indicated that for some types of surgery, up to 30 percent of the procedures currently performed may be unwarranted.<sup>28</sup>

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<sup>26</sup> Minnesota Department of Health, p. 17.

<sup>27</sup> W.B. Schwartz and D.N. Mendelson, "Eliminating Waste and Inefficiency Can Do Little to Contain Costs," *Health Affairs*, 13:1 (Spring I 1994), pp. 224-238.

<sup>28</sup> L.L. Leape, "Unnecessary Surgery," *Health Services Research*, 24 (August 1989), pp. 351-407.

## ***MSAs and Managed Care***

Managed care is the predominant type of coverage in Oregon's health care market. There are reasons to be concerned about the way in which MSAs might fit with managed care. For one thing, MSAs are designed to be used with a fee-for-service payment system. Health care consumers are expected to pay for each service they receive, using the funds from their MSAs. Managed care plans, however, almost always operate on the basis of capitated or other prospective payment mechanisms, through which the plan receives a flat rate of payment for all the care delivered to a plan member during a specified time period.

Medical savings accounts could also cause adverse selection problems for managed care plans and traditional health insurance policies. One recent article warns that "Individuals who foresee few medical needs during the year are more likely to choose MSA coverage because they do not expect to incur expenses and will perceive their Medisave deposits as pure savings. Persons electing MSA coverage, thus, are more likely to have lower health care costs than persons electing the more generous FFS [fee-for-service] plans and (possibly) the HMO plans. This will cause medical claims for more generous plans to be higher than they otherwise would be, and medical claims for MSA-catastrophic plans to be lower."<sup>29</sup>

The growth of managed care plans in recent years may also mean that there is less unnecessary utilization in the health care system. As noted earlier, MSA proponents expect these plans to save money by giving health care consumers a strong incentive to reduce their utilization of health care services. They point to the Rand Health Insurance Experiment, which demonstrated dramatic reductions in utilization as a result of higher deductibles. But it should be pointed out that the Rand study was conducted at a time when fee-for-service medicine was the norm. In the 1980s, managed care and prospective payment became widely distributed, and had a dramatic effect on health care utilization. In 1983, the year after the conclusion of the Rand study and the year in which prospective payment was initiated by Medicare, the hospital use rate in Oregon was 756 patient days per 1,000 population.<sup>30</sup> By 1991, Oregon's hospital use rate was down to 539 patient days per 1,000 population.<sup>31</sup>

The Rand study included a population in Seattle which utilized a health maintenance organization. Results from this population indicated that HMOs were just about as effective as cost-sharing in reducing the utilization of health care services.<sup>32</sup> Because a large percentage of the Oregon population is now covered through managed care plans, we can expect that much of the reduced

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<sup>29</sup> G.A. Jensen and R.J. Morlock, "Why Medical Savings Accounts Deserve a Closer Look," *Journal of American Health Policy*, May/June 1994, pp. 14-23.

<sup>30</sup> Oregon State Health Planning and Development Agency, *Hospital Utilization in Oregon*, February 8, 1985.

<sup>31</sup> Oregon Office of Health Policy, *Oregon Hospital Statistics, 1987-1991*, April 1993.

<sup>32</sup> Jensen and Morlock.

utilization that could occur as a result of increased cost-sharing through MSAs has already been achieved. The Rand study's results may therefore overestimate the impact that increases in cost sharing would have today.

## IMPLEMENTATION OF MEDICAL SAVINGS ACCOUNTS : ISSUES AND OPTIONS

If a decision were to be made to initiate a medical savings account program, a number of questions would need to be addressed concerning how such a program would be implemented.

### ***Administration***

One such question concerns who will administer the MSAs. Most of the state MSA legislation that has thus far been enacted provides for the designation of qualified trustees or account administrators. The Idaho legislation has one of the more extensive lists of who can be considered an account administrator, as follows:

“(a) A national or state chartered bank, a federal or state chartered savings and loan association, a federal or state chartered savings bank, or a federal or state chartered credit union.

“(b) A trust company authorized to act as a fiduciary.

“(c) An insurance company authorized to do business in this state or a health maintenance organization, fraternal benefit society or a hospital and professional service corporation, all regulated pursuant to title 41, Idaho Code.

“(d) A broker, insurance agent or agent regulated by the department of insurance or an investment advisor regulated by the department of finance.

“(e) A certified public accountant licensed to practice in this state pursuant to title 54, Idaho Code.

“(f) An attorney licensed to practice in this state.

“(g) An employer if the employer has a self-insured health plan under ERISA.

“(h) An employer that participates in the medical care savings account program.

“(i) A third party administrator.”<sup>33</sup>

Other state statutes often do not include parties such as insurance agents, CPAs, or attorneys on their lists of potential account administrators, but the Idaho statute should provide some idea of the types of parties that *could* be selected to administer MSAs.

### ***Withdrawals***

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<sup>33</sup> Section 41-5301(1), Chapter 53, Senate Bill No. 1548, Idaho Legislature, Second Regular Session – 1994.

Other questions related to the administration of MSAs concern the process by which a withdrawal is made, and whether there is any appeals process in the event that a request for withdrawal is denied. Another question relates to how the program would deal with medical expenses incurred at the beginning of a calendar year, before sufficient funds have accumulated in the account. Currently, flexible spending accounts under IRS Code 125 are required to be self-insured by the employer. In other words, the employer is required to pay any claims on the account up to the level of annual contributions specified by the employee, even if sufficient employee contributions have not yet accumulated in the account. Under IRS Code 125, however, the balance in a medical FSA reverts to the employer at the end of the year. This “use-it-or-lose-it” provision presumably acts to balance the effect of any losses the employer may incur from withdrawals early in the year. Medical savings accounts do not have a “use-it-or-lose-it” provision. Any balance in an MSA at the end of the year continues to be the property of the employee.

### ***Definition of Eligible Expenditures***

An important MSA implementation issue concerns how decisions are reached as to whether any particular expenditure is an appropriate medical service, eligible for a tax-free withdrawal from the MSA. Nearly all of the legislation on MSAs which has been proposed to date would define eligible expenditures using section 213(d) of the IRS Code, which is the definition of medical expenditures currently eligible for tax deductions. Most statutes provide that the account administrator is responsible for determining whether any particular expenditure falls under this definition. Some state statutes provide that tax-free withdrawals of MSA funds can be used to pay health insurance premiums (presumably for a person who has retired or has become unemployed). The Colorado bill, however, prohibits the use of MSA funds to pay for an insurance policy that covers the deductible of a catastrophic insurance plan.<sup>34</sup> Idaho's statute prohibits the use of the MSA to pay for services that are covered by another insurance plan, including auto and workers' compensation insurance.<sup>35</sup>

Several of the state statutes also have provisions concerning withdrawals from an MSA which are subject to state taxes. Typically, these provisions allow withdrawals for non-medical purposes, but count them as part of the individual's gross income. The Idaho and Illinois statutes provide for a 10 percent penalty for such withdrawals. Most bills provide that the balance in a medical savings account becomes a part of the account holder's estate in the event of the account holder's death.

### ***Requirements for Catastrophic Coverage***

None of the state statutes which have thus far been enacted contain any specifications regarding the benefits that should be included as part of an MSA's catastrophic insurance policy. At least one federal MSA bill, however, the Gramm/Santorium bill (S. 1807/H.R. 3918), has requirements for a minimum benefits package. If catastrophic plans cover an inadequate package of benefits, health care consumers could be open to substantial financial risk. The Minnesota Department of Health's

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<sup>34</sup> Section 8, 39-22-504.7(5), House Bill 94-1058, Colorado General Assembly.

<sup>35</sup> Section 41-5304(1), Chapter 53, Senate Bill No. 1548, 1994 Idaho Legislature.

study of MSAs observes that “even in the absence of a catastrophic illness or event, out-of-pocket expenses may still occur, after the MSA account balance has been spent. This is most likely for routine medication needs and outpatient primary and preventive care, which may or may not be covered by a catastrophic policy.”<sup>36</sup> Catastrophic insurance policies may or may not cover things such as mental health or substance abuse treatment, durable medical equipment, etc. One of the issues to be considered in implementing an MSA program is therefore whether or not to set a minimum standard for benefits.

### ***Minimum Employer Contribution***

Another MSA implementation issue concerns whether or not to require employers to make a minimum contribution to the MSA. Four of the seven state MSA statutes which have thus far been enacted require that the employer contribute to each employee's MSA in an amount at least equal to the amount that the employer saved in insurance premiums by changing from a low-deductible, comprehensive insurance plan to a high-deductible catastrophic plan. Such provisions make a certain amount of sense, because without such a requirement, MSAs might merely act to erode worker salaries. Employees would have to make substantial contributions to MSAs to fund health benefits that had previously been covered by employer-paid insurance. However, the inclusion of employer contribution mandates in MSA legislation would also seem to eliminate one of the major incentives for an employer to participate in an MSA program. Because the employer would no longer gain any financial advantage from participation, one could expect that participation in the program will be significantly less in those states that require employers to roll their premium savings over into the employees' MSAs.

And it is unclear whether the amount that employers save in insurance premiums will be sufficient to fully fund the \$3,000 deductible typically called for in state statutes. Golden Rule Insurance Co., the best-known example of a company which currently provides an MSA option to its employees, contributes only \$2,000 to its employees' \$3,000 annual deductible.<sup>37</sup> One report cites rates for high deductible policies that imply that annual savings per employee would be in the range of \$800 to \$1,000.<sup>38</sup> If the catastrophic plan's deductible is not fully funded by employer contributions to the MSA, then employees will either have to make their own contributions to the MSA, or bear a significant risk for out-of-pocket costs if they should incur an illness.

### ***Populations for Whom MSAs May Not Work***

An important MSA implementation issue concerns the treatment of certain populations that might be disadvantaged by MSAs or be unable to participate in an MSA program. Consideration therefore should be given to whether or not to make special provisions for such populations. For example, low-wage, part-time or seasonal workers may find it difficult to make contributions to a

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<sup>36</sup> Minnesota Department of Health, p. 21.

<sup>37</sup> “Consumer-First Health Care.”

<sup>38</sup> Jensen and Morlock.

medical savings account. One way to deal with this might be to require that employers make contributions to the accounts of low-wage workers that are at least equal to the annual deductible of the catastrophic plan.

Persons with chronic illnesses or disabilities could be seriously disadvantaged by a medical savings account program. If such persons have medical expenses every year which exceed the catastrophic plan's deductible, they will never be able to accumulate a balance in their account. If the annual deductible is not fully funded by their employer, then they will incur ongoing out-of-pocket expenses in order to meet the deductible requirement. Even if the employer *does* fully fund their deductible, they will be disadvantaged financially relative to their co-workers, because they will not be accumulating funds in their accounts to the same extent as persons in identical jobs who do not have a chronic illness or disability. In addition, they will not have any funds available in the account to cover insurance expenses if they should become unemployed or wish to retire, and are therefore exposed to financial risks that others do not incur.

Goodman and Musgrave suggest one possible way of dealing with such situations: “Instead of the annual deductible which is common these days, health insurance could have a per condition deductible as was common earlier. With a *per condition deductible*, the person diagnosed with cancer would pay the deductible only once, and insurance would pay all of the remaining costs of the cancer treatments – even if those costs were incurred over many years.”<sup>39</sup> Such a provision can be expected to have an impact on premiums for catastrophic insurance policies, however. Although we have no information available, it is possible that the impact on premiums might be quite significant, because the financial exposure of the plan would be significantly increased.

### ***Contribution Limits***

Most state MSA bills establish an annual limit of \$3,000 on contributions to a medical savings account. An issue that arises in regard to such limits is whether they are equitable to families of various sizes. Arizona's statute specifies maximum contribution amounts that vary with family size, \$2,000 for an individual, \$3,000 for a couple, and \$4,000 for a family of three or more. Another implementation issue concerns the way in which the deductible would be applied to families of varying size. Would there be one deductible to split among all members of a family, or would each family member have to meet the deductible amount before the catastrophic plan would kick in? The answers to such questions can significantly affect the financial exposure that a family might incur under a medical savings account program.

### ***State Monitoring***

It is apparent that an MSA program will involve a significant amount of state monitoring, to assure that account administrators meet the required standards, to enforce contribution requirements, to assure that minimum benefit requirements are met (if required), and so forth. Most states that have enacted MSA programs have given the state insurance department the responsibility for implementation and monitoring. The financial impact on the budget of the implementing state

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<sup>39</sup> Goodman and Musgrave, *Controlling Health Care Costs...*, p. 17.

agency will of course depend on the particular provisions of the MSA program, and are beyond the scope of this paper to estimate.

### ***Sunset Provisions***

Finally, it should be noted that four of the seven states that have enacted medical savings account legislation have provided sunset dates for their programs. The Idaho and Michigan statutes will expire as of January 1, 1999, unless extended by the state legislatures; the Illinois statute will expire on January 1, 2000; and the Mississippi statute is slated to sunset on January 1, 1998. The Idaho and Michigan statutes both require that studies of the impact of the MSA program be prepared by January 1, 1998. A report on the impact of Illinois' MSA program must be prepared by January 1, 1999.

## ***Fiscal Impact***

The Office of the Oregon Health Plan Administrator has requested assistance from the Legislative Revenue Office in assessing the fiscal impact of enacting a medical savings account program in Oregon. This assessment will be included as an appendix to this report once it is available.

As detailed above, there are options for implementing a medical savings account program. The choices among these options will in large part determine the fiscal impact of the program. The Oregon Health Plan Administrator will be happy to work with legislators in considering these choices and in assessing the role of MSAs in Oregon's health care reform efforts.

## **ALTERNATIVES TO MEDICAL SAVINGS ACCOUNTS**

### ***Flexible Spending Accounts: An Existing Option***

An option is currently available under IRS Code 125 which is somewhat similar to the medical-savings-account concept. When medical savings account legislation (House Bill 3387) was considered by the Oregon legislature in 1993, there was apparently some concern expressed that the 125 plans may already meet many of the objectives of an MSA program, with the additional advantage of being exempt from federal as well as state taxation. The Oregon Health Plan Administrator was therefore instructed to compare the advantages and disadvantages of the MSA concept to the flexible spending accounts allowed under section 125.<sup>40</sup>

IRS Code section 125 currently allows employers to set up several types of flexible spending accounts, including accounts for dependent care, group term life insurance, group legal plans, medical care, and accounts to pay the employee's share of health insurance premiums. The employee authorizes a specific monthly payroll contribution to the account, and such contributions are made with pre-tax dollars. The money in the account is technically considered to belong to the employer, however, and to constitute an employer contribution to employee benefits, rather than wages. If the employee elects to establish a medical FSA, the employee can draw on funds in that account to pay for medical care during that calendar year. However, any funds remaining in the account at the end of the year revert to the employer. This is often referred to as the "use-it-or-lose-it" requirement. On the other hand, because the funds are considered to technically belong to the employer, IRS rules require that the employer bear the risk of any eligible withdrawals from the account. In other words, if a medical FSA with a \$100 monthly contribution is established on the first of the year, and an employee has a medical expense of \$1,200 on the second day of the year which is eligible for payment from the account, the employer is obligated to make the \$1,200 payment, even

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<sup>40</sup> Subsection (1)(b), section 6, Senate Bill 5530, Oregon Legislative Assembly, 1993 Regular Session.

though the employee has not yet contributed all of this amount to the FSA. Contributions to FSAs are exempt from both income tax and Social Security tax.<sup>41</sup>

The requirement that the employer bear the risk of payments from a medical FSA has made these plans less attractive to some Oregon employers. The two state employee health insurers, the State Employees Benefits Board (SEBB) and the Bargaining Unit Benefits Board (BUBB), at one time offered the medical FSA option, but discontinued it when the IRS adopted its rule requiring employers to bear risk. They were advised by the state Attorney General's office that the state could not legally take on a liability for claims that was not fully funded.

The “use-it-or-lose-it” requirement of FSAs is also problematic. For one thing, it prevents employees from accumulating a balance in their accounts that could later be used to pay for long-term care or health insurance during retirement. Also, it creates a perverse incentive to spend all of the money in the account.

The primary advantage of the medical savings account concept over the medical FSA option available under IRS Code 125 appears to be the ability of the employee to continue to build an MSA over a number of years. The main disadvantage of MSAs, compared to IRS Code 125 plans, is the fact that state MSA programs cannot provide for an exemption from federal income tax.

Interestingly, both the Gephardt and the Mitchell health care reform bills recently considered by Congress eliminated the tax exemption for medical FSAs as part of the funding for health care reform. The Gephardt bill would have authorized the establishment of medical savings accounts.

### ***Medical Savings Accounts as a Part of Broader Health Care Reform Initiatives***

Medical savings account advocates usually portray the MSA concept as a complete, freestanding program for correcting the market inadequacies of the current health care system. It is certainly possible, however, to include MSAs as a component of a broader package of health care reforms.

Goodman and Musgrave suggest that MSAs could be part of a voluntary program for expanding health care coverage. They suggest that a tax credit could be offered to individuals who purchase health insurance with after-tax dollars, thereby helping people who are currently uninsured to purchase their own insurance. They also suggest that MSAs be made a part of the Medicaid and Medicare programs.<sup>42</sup> Presumably, subsidies would have to be

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<sup>41</sup> Employee Benefits Services Trust, League of Oregon Cities, “Internal Revenue Code Section 125 Plans, ‘HELP’ and Premium Conversion Plans.”

<sup>42</sup> Goodman and Musgrave, *Controlling Health Care Costs...*, pp. 20-21.

Table 2

## PROS AND CONS OF MEDICAL SAVINGS ACCOUNTS

PROS	CONS
Might save money by reducing utilization and administrative expense	Might result in patients foregoing necessary care or preventive health services
Provides for greater consumer autonomy and flexibility by giving individual consumers direct control of their health care expenditures	Returns health care reimbursement to a fee-for-service system; is inconsistent with managed care and capitated payment
Provides financial incentives for healthy life-styles	Could lead to adverse selection, with healthy people gravitating to MSAs, resulting in increased costs for other types of plans
Consistent with American cultural values such as individual choice, individual autonomy, personal responsibility, limited government, etc.	Could make needed health care too expensive for people with low incomes or chronic illnesses or disabilities
Would result in substantial financial gains for people who remained healthy	Because MSAs would primarily be set up for employed persons, and most proposals call for MSA to be voluntary, this model would do little to expand health care coverage or to achieve universal access
Would improve the portability of health care benefits	Could result in revenue loss to state government
	No clear incentives for employers to participate

made to low-income persons to allow them to maintain an MSA, although Goodman and Musgrave do not discuss this.

## PROS AND CONS OF MEDICAL SAVINGS ACCOUNTS

Table 2 summarizes the pros and cons of medical savings accounts. Most of the items listed in this table have been discussed earlier in this report, and need no further clarification. A few of the points in this table may need some explanation, however. For example, MSAs would improve the portability of health care benefits, as stated in the last item under “Pros,” by allowing health care consumers to retain the contents of their MSAs when they change jobs, become unemployed, or retire.

There is a potential loss of revenue to state government under an MSA program, as stated under the “Cons” heading because contributions to MSAs would be exempt from state income tax. Proponents of MSAs argue that there would be no impact on governmental revenues, because the

moneys placed into the MSA simply replace money that was previously spent by the employer on tax-deductible health insurance premiums. However, premium savings may not be the only source of funds for MSAs. As noted earlier, a policy decision would have to be made in initiating the program as to whether or not to require employers to contribute their premium savings to employees' MSAs. Some existing state MSA statutes contain such requirements, others do not. And there is some evidence that premium savings will not be large enough to fully fund the \$3,000 deductible that is typical of MSA proposals. If one assumes that at least some of the funds contributed to MSAs would *not* be offset by employer premium savings, then there will be at least some loss of state tax revenues as a result of implementing an MSA program.

The “Cons” list also includes an item that says that there might be no incentive for employers to participate in MSAs. For employers which currently provide health insurance benefits to their employees, their incentive to participate in an MSA program would depend on whether the MSA program *required* employers to contribute their premium savings to employees' MSAs. As discussed above, MSA programs do not necessarily have to include such a requirement, but if they did, there would be no financial gain for the employer through participation in the MSA program. But it should also be noted that there are no clear incentives to participate for employers who have not previously provided health insurance benefits. Such employers would gain no new tax advantages as a result of participation, and would have to find the funds for purchase of a catastrophic health care plan for their employees. If employers are required to contribute to the employee's MSA, they might view the program as simply an increase in the employee's compensation.

Another MSA “Con” listed in Table 2 is the claim that this model would do little to expand health care coverage to the uninsured. This claim makes sense, because MSAs are designed to be employment-based, and one would expect that they would be largely used by employers who are already providing health insurance to their employees. However, some MSA proponents note that an MSA participant could use funds from the account to purchase insurance during periods of unemployment. It is unknown how big a dent this could make in the total number of uninsured persons. For one thing, only 28 percent of the uninsured population in Oregon is unemployed.<sup>43</sup> Also, in order to purchase health insurance with MSA funds an unemployed person would have to have been employed for a length of time long enough to accrue a significant medical savings account balance. It is therefore difficult to estimate how many unemployed persons might be aided by MSAs in obtaining health care coverage, but it seems likely that MSAs would have only a minor impact on the total population of the uninsured.

In the end, opinions on MSAs will probably be based more on one's ideology and beliefs about the health care marketplace than on empirical data. Is an unregulated marketplace *always* the best mechanism for distributing scarce societal resources? Will making consumers pay for health care with their own money mean an increase in consumer choice, or a decrease in job benefits? Would MSAs result in substantial financial benefits to the great majority of participants, or would they be a way of gaining financial advantage for the healthy at the expense of the sick? Is good health a public good or an individual responsibility? Is health care a right or a privilege? These are the kind of issues that will determine whether or not one supports the idea of medical savings accounts. But they are

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<sup>43</sup> Oregon Office of Health Policy, Health Division, *Health Insurance Coverage in Oregon; Estimates for 1990 to 1992*, August 1993.

not questions that are decided by objective data. Instead, their answers are based on one's beliefs about the role of government and the proper balance between individual and societal responsibilities.