CBO MEMORANDUM

A REVIEW OF REPORTED EMPLOYER EXPERIENCES WITH MEDICAL SAVINGS ACCOUNTS

January 1997

CONGRESSIONAL BUDGET OFFICE

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SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

This memorandum reports on the experiences of several firms that have offered health insurance plans combining high-deductible insurance with medical savings accounts or other compensation. It was prepared to provide information for Congressional Budget Office cost estimates and to respond to numerous inquiries from Congressional staff. Larry Ozanne and Meta Brown wrote the memorandum under the direction of Rosemary Marcuss and Frank Sammartino of the Tax Analysis Division and Joseph Antos and Linda Bilheimer of the Health and Human Resources Division. Michael Gutowski, Edwin C. Hustead, Len M. Nichols, and Judy Xanthopoulos gave valuable comments on an earlier version of the memorandum. The manuscript was edited by Marlies Dunson, and Simone Thomas prepared it for publication.

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CONTENTS

TABLES

SUMMARY AND INTRODUCTION

Recent Congresses have considered a variety of legislation that would allow people to combine tax-advantaged medical savings accounts (MSAs) with health insurance policies that have high deductibles. (The combination of the MSAs and high-deductible insurance is referred to here as MSA plans.) Most recently, the 104th Congress voted and the President signed legislation establishing a demonstration in which a limited number of small employers, the self-employed, and the previously uninsured would be allowed to establish MSA plans with full tax advantages.[1] Other bills considered by recent Congresses would allow all employers to establish MSA plans, create an MSA option within Medicare, and create an MSA option for federal employees.

The tax advantages voted for MSAs in the demonstration are a combination of those already allowed for employer-provided health insurance and individual retirement accounts (IRAs). As with employer-provided health insurance, employer contributions to MSAs would be exempt from payroll and individual income taxation; spending from the accounts for medical care would retain the exemptions. Like IRAs, contributions by individuals (allowed when employers do not contribute) would be deductible, and interest earnings would be tax-exempt. Also like IRAs, withdrawals for unqualified purposes—in this case for nonmedical purposes—would be subject to

1. Section 301 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 1936.

income taxation and a penalty, and the penalty would be waived once the account holder reached retirement age.

MSA plans are intended to reduce low-valued spending on medical care. The high-deductible insurance component of those plans would cause employees to face the full-market cost of care over a wider range of services, which should encourage them to balance more carefully the benefits and costs of seeking care. The employer's contribution to an MSA, or some other form of compensation to employees who accept insurance with a higher deductible, would provide those employees with additional resources that could be used to either offset a portion of the increased deductible or meet other needs. The tax advantages proposed for medical spending through the MSA, however, would dilute some of the incentive to control spending provided by high-deductible insurance alone.

MSA plans provide an alternative set of incentives from those of managed care plans. Managed care plans have become widespread in recent years and include a range of alternatives from limited fee-for-service policies to health maintenance organizations. Managed care plans typically retain low copayments; they try to reduce medical spending by including the insurer in decisions about which care to provide and by using the insurer's size to negotiate volume discounts for services. Nonetheless, some features of managed care could be incorporated into MSA plans.

In addition to reducing low-valued medical spending, MSA plans may lower administrative costs by reducing the amount of claims that need to be processed for insurance coverage. The plans may also reduce the number of uninsured employees by appealing to young healthy workers who now go uncovered rather than pay for low-deductible insurance.

A concern raised by proposals for MSA plans is that their widespread use could raise the price and reduce the availability of existing insurance policies, particularly in the individual and small group insurance markets. If MSA plans attracted many firms with healthier workers away from low-deductible, fee-for-service policies and managed care plans, insurers would have to raise the price of those policies or reduce their availability. That process is commonly referred to as adverse selection.

How successful MSA plans will be at reducing medical spending and avoiding the fallout from adverse selection is difficult to determine. Reductions in medical spending must be broadly measured to include spending by and on behalf of employees. Observed reductions in spending by employers that are offset by increased spending by employees or other payers, for example, would overstate true reductions in spending, depending on the extent of the offset. The impact of MSA plans on the price and availability of health insurance should be observed for an entire

market where many firms and individuals are considering MSA plans, not just within a firm where employers restrict choices.

Because fully tax-advantaged MSA plans are new, there is no nationwide representative data with which to study their effects. To help evaluate proposals for MSA plans, the Congressional Budget Office has been asked to review the experiences of firms that have offered MSA-type plans to their workers. This memorandum compiles existing information on the experiences of several such firms.

Firms began trying MSA-type plans mostly within the past decade as a means of restraining rising medical costs. The number of firms trying those plans has grown in recent years as the idea gained popularity and as a few insurers and benefits consultants began helping firms set up such plans. The total number of firms with MSA-type plans is unknown. The experiences of about 20 firms have been reported in a variety of publications and in testimony before Congress. Seven of the most frequently cited and well-documented cases are reviewed in this memorandum: Morris County Hospital, Forbes, Inc., RCI, Inc., Dominion Resources, Inc., the Rubber Manufactures Association, Golden Rule Insurance Co., and DuPont.

The reports from those seven firms were not intended to be detailed research studies in the usual sense. They include only part of the information needed to identify spending changes at the firms. They also lack adequate control groups or

counterfactual cases to determine the portion of spending changes attributable to the MSA plans. Moreover, it is not known how representative those firms are of other firms that offer MSA-type plans or those firms that would offer tax-advantaged MSA plans. Finally, because they are only isolated cases, they cannot determine the potential marketwide effects on the price and availability of other types of insurance that might arise if many employers used MSA plans. However, as long as one recognizes those limitations, the case studies provide some interesting insights.

The plans of the seven firms differed in numerous ways. Four of the firms allowed employees to choose between an MSA-type plan and a more traditional policy with a low deductible; three offered only an MSA-type plan. Some plans had high-deductible insurance but no savings account, and others had special limitations on their savings accounts. At most of the firms with MSAs, employer contributions to the accounts were taxed as wages under income and payroll taxes, and interest earnings of the accounts were taxed as income. In other words, those MSAs received no tax preference. At one firm, however, contributions and interest earnings were exempt because the plan qualified as a pension plan.

The results reported for the firms contrasted widely. Each firm measured the change in medical spending in a unique way, using some combination of data available to that firm: insurance premiums, insurance claims, MSA contributions, and MSA

withdrawals. Based on those diverse measures, the changes in spending that firms reported ranged from a slowing of growth to large reductions.

For each firm, the measured change omitted some spending by or on behalf of covered employees. The most consistently omitted spending was that paid by the employees, or by an alternative third-party payer such as a spouse's plan. The omitted spending confounded the reported spending changes in various ways, depending on the changes introduced by the particular plan and the measure of spending reported by the firm.

While spending reductions by and on behalf of employees are likely to have occurred at the firms in response to the incentives of the MSA-type plans, the magnitudes of the reductions are uncertain. The comparability of spending changes among the firms is also uncertain because of the variety of spending measures reported and the different amounts of unmeasured spending. Those measurement problems make it difficult to judge the success of the plans. They also make it difficult to compare the changes at those firms with changes that have otherwise been found to occur when firms change insurance coverage or introduce forms of managed care.

The willingness of employees to choose an MSA-type option varied widely. At the four firms offering a choice, the percentage of employees choosing the option

ranged from 4 percent to 91 percent. The variation appears to reflect the different terms on which employers offered the option as much as it reflects employees' willingness to use MSA-type plans. Although little systematic information on employee attitudes toward the plans is available, anecdotal reports from employers indicated that most employees were satisfied, including those at firms offering only one plan.

The next section reviews the experiences at the seven firms and evaluates the reported spending responses. The Congressional Budget Office then addresses the limitations of generalizing about how other firms and workers would respond to the MSA plans envisioned in legislative proposals.

REVIEW OF THE REPORTS

This review is based primarily on previously published reports from the companies, their insurers, and other analysts. The information in those sources generally comes from data the firm collects in administering its health plan. Additional information is often needed, however, to assess the extent to which total medical spending by and on behalf of employees has changed. That information goes beyond what firms can be expected to collect; an independently funded and operated evaluation would be needed to collect much of that information.

The three companies that adopted the MSA-type plans as their only coverage are reviewed first. The four that offer a choice of plans are reviewed subsequently (see Table 1).

MSA-Type Plans as Only Coverage

Morris County Hospital, Forbes, Inc., and RCI, Inc., replaced their traditional plans with MSA-type plans. The plans at Morris County Hospital and RCI combined insurance with a high deductble and employee savings accounts to pay for expenses below the deductible. The Forbes plan differed by conditioning its deductible on each employee's earnings and structuring the accounts so that they could not be used directly to pay for medical spending below the deductible.

Morris County Hospital. This rural community hospital in Kansas operated an MSA-type plan for its 50 to 60 employees from 1983 through 1991. Ron Thompson, who developed the plan, reported that in 1982 the hospital spent the equivalent of 7 percent of the payroll to provide a standard Blue Cross indemnity health insurance policy and contributed the equivalent of 6 percent of the payroll to a retirement savings plan.[2] Under his plan, which started in 1983, the hospital pooled the 13

2. Ron Thompson, "Employee Benefits: A Tale of Success" (Thompson & Associates, Council Grove, Kan., 1992); Stephen Barchet, *Medical Savings Accounts*, Evergreen Freedom Foundation (Olympia Wash.: March 1995), pp.19-24.

TABLE 1. REPORTED EMPLOYER EXPERIENCES WITH MSA-TYPE PLANS

Plan	Plan Description	Report of Results	Qualifications
Morris County Hospital, Council Grove, Kan[a]	No choice. MSA plus high deductible. Unspent MSA transfers to retirement account at year end. Fifty to 60 employees. Operated 1983-1991.	Employer-recorded health spending dropped from 7.0 percent of payroll in 1982 to an average of 4.4 percent over the 1983-1989 period. Terminated after ratio rose to 5.3 percent in 1990-1991.	Company did not record out-of-pocket spending, which could have increased or decreased. Reasons for cost increases in 1990-1991 and termination of plan were unclear.
Forbes, Inc., New York, N.Y.[b]	No choice. Deductible: 1 percent of income. Employer-funded annual account of $1,000 in 1992, $1,300 in 1994. Reported $1 in health claims decreases account by $2. Five hundred employees. Started in 1992.	Twenty-five percent decrease in claims paid for 1992 and 1993.	Plan discourages filing claims and company does not record employees' out-of-pocket spending.

(continued)

TABLE 1. CONTINUED

Plan	Plan Description	Report of Results	Qualifications
RCI, Inc.,[c] Brighton, Mich.	No choice. MSA plus high deductible. About 50 employees. Started in 1994.	Employer costs declined 12.5 percent in first year.	Employer costs include insurance premium and, in 1994, MSA contribution. No information is available on total health spending by and on behalf of employees. Only one year's experience.
Dominion Resources, Inc., Richmond, Va.[d]	Choice among three plans with low to high deductibles. Incentives for leading healthy lifestyle and not exceeding deductible. Two hundred employees. Started in 1989.	By 1984, 68 percent chose high deductible. Employer costs grew less than 1 percent in 1989-1994.	Out-of-pocket spending is not measured and could be increasing as workers shift to high-deductible plans. Multiple plan incentives all discourage health spending.

(continued)

TABLE 1. CONTINUED

Plan	Plan Description	Report of Results	Qualifications
Rubber Manufacturers Association, Washington, D.C.[e]	Choice among three plans with low to high deductibles. Savings account funded with high deductible policy. Fifty covered employees and retirees. Started in 1991.	No increase in company health budget in first five years. Fifty to sixty percent chose the high deductible.	No data has been reported on total health spending by and on behalf of employees.
Golden Rule Insurance Co., Indianapolis, Ind.[f]	Choice among two plans: MSA plus high deductible policy and low deductible policy. Thirteen hundred employees. Started in May 1993.	MSA option chosen by 80 percent in 1993, 91 percent in 1995. Claims 39 percent below normal in 1993.	Omitted spending may be causing total spending changes to be larger or smaller than reported.

(continued)

TABLE 1. CONTINUED

Plan	Plan Description	Report of Results	Qualifications
DuPont, Wilmington, Del.[g]	Choice among three plans: HMO with employee contribution, POS plan with employee contribution, and high deductible with credit. Started and ended in 1994.	Four percent of employees chose the high-deductible plan.	No data were available on health spending.

SOURCE: Congressional Budget Office using data from sources cited below.
NOTE: MSA = medical savings account; HMO = health maintenance organization; POS = point of service.

a. Ron Thompson, "Employee Benefits: A Tale of Success" (Thompson & Associates, Council Grove, Kan., 1992); Stephen Barchet, *Medical Savings Accounts*, Evergreen Freedom Foundation (Olympia Wash.: March 1995), pp. 19-24.

b. Malcolm S. Forbes Jr., "How Forbes Curbed Spiraling Health Care Costs," *Forbes*, January 18, 1993, p. 25; Barchet, *Medical Savings Accounts*, pp. 28-29; Vera Tweed, "Medical Savings Accounts: Are They a Viable Option?" *Business & Health*, October 1994, pp. 46.

c. Statement of Congressman Dick Chrysler, before the Subcommittee on Health, House Committee on Ways and Means, June 27, 1995; statement of Tom Erhart, Vice President Human Resources, RCI, before the Subcommittee on Health, House Committee on Ways and Means, May 25, 1995; data supplied to the Congressional Budget Office by the Golden Rule Insurance Company, October 12, 1994.

d. Barchet, *Medical Savings Accounts*, pp. 25-28; Nancy P. Johnson, "Utility Rebates $800 to Employees with Lower Health Costs," *Business Insurance*, May 14, 1993, pp. 1, 16-17; Peter L. Spencer, "New Plan Cuts Health Care Costs in Half," *Consumer's Research*, October 1993, pp.16-19.

e. Dennis F. Kelly, "More Than a Theory: Medical Savings Accounts at Work," (panel discussion at Cato Institute, Washington, D.C., September 18, 1995); personal communication to the Congressional Budget Office by Dennis F. Kelly of Plan3, Bethesda, Md., October 11, 1995; Peter J. Ferrara, "More Than a Theory: Medical Savings Accounts at Work," *Policy Analysis*, Cato Institute, Washington D.C., no. 220 (March 14, 1995), pp. 14-15.

f. Letter from J. Patrick Rooney, Golden Rule Insurance Company, to Milton Friedman, Senior Research Fellow, Hoover Institution, January 4, 1994; letter from J. Patrick Rooney to John Fund of the *Wall Street Journal*, June 22, 1994; letter from Brian McManus, Golden Rule Insurance Company, to Peter Ferrara, National Center for Policy Analysis, October 5, 1995.

g. American Academy of Actuaries, *Medical Savings Accounts: An Analysis of the Family Medical Savings and Investment Act of 1995* (Washington, D.C.: American Academy of Actuaries, October 1995), p. 7.

percent of the payroll for health and retirement and used a portion of that to purchase a catastrophic insurance plan with a $3,000 deductible for each employee. The hospital placed the residual in accounts for each employee. The employee could use the account to pay for deductibles under the catastrophic policy during the year; amounts not spent were rolled over into the employee's retirement savings account at the end of the year.

The hospital obtained a ruling from the Internal Revenue Service that the plan qualified for taxation as employer-provided health insurance and a qualified profit-sharing plan. The ruling excluded employer contributions to the account from payroll and income taxation. It also allowed funds rolled over into the retirement account to accumulate tax-free until withdrawn in retirement. Thus, the plan incorporated the main tax advantages envisioned for MSAs in federal legislation.

Thompson reported that the sum of the hospital spending for insurance premiums and employee spending from the accounts was 4.7 percent of the payroll in 1983, and averaged 4.4 percent of the payroll from 1983 through 1989. That medical spending increased to 5.2 percent in 1990 and 5.3 percent in 1991. The increases in the past few years resulted primarily from sharp increases in employee spending from their medical retirement accounts.[3] In 1992, the hospital replaced the plan with a traditional comprehensive policy.

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3. Barchet, *Medical Savings Accounts*, p. 22.

Medical spending measured by the company omitted spending paid out of pocket by employees or by alternative coverage. Because of the particular changes instituted, those omissions could lead the company's measure to understate or overstate the decline in total spending by and on behalf of employees that occurred when the new plan was introduced.

The company's measure could have understated the decline in spending because the new plan allowed employees to shift what had been out-of-pocket expenses under the old plan to spending from the new medical retirement accounts. Thus, the company's measure of employee spending could have become more complete under the new plan. Furthermore, the new plan covered as broad (or broader) a range of services as the indemnity plan it replaced, so employees were not forced to shift any spending outside the plan.

The company's measure of spending could have overstated the total decline in spending because the plan contained an incentive for some employees to pay for routine medical expenses outside the plan. That incentive was the opportunity to build up retirement savings in a tax-favored account. Employees who were accumulating additional retirement savings in fully taxable accounts, and who had not spent up to the health plan's $3,000 deductible, could shift taxable retirement savings into the health retirement account. They could do that by paying medical bills from their taxable savings accounts rather than from their health retirement accounts. Such

medical payments from outside the health retirement accounts would be omitted from the company's records. The hospital's employees may have had a strong interest in building up their retirement savings because during the time the health plan was instituted, the hospital also withdrew from Social Security and the Kansas State Retirement System and shifted funding instead to the health retirement accounts.[4]

The nine years over which the Morris County Hospital plan operated provides the longest documented experience with an MSA-type plan. The experience suggests that the substantial changes observed in the initial year or two were not a temporary response to the novelty of changing plans. The rapid escalation of costs in the last few years of the plan, however, was not well explained.[5] Information for more than one year's spending under the old plan would have provided a firmer base from which to measure the change under the new plan.

Forbes. Forbes created an MSA-type plan for its 500 employees in 1992. An account of $1,000 was set aside for each employee in the first year; $1,200 in 1993; and $1,300 in 1994. Employee health insurance deductibles were set at 1 percent of employee earnings. Forbes instituted a program of incentives under which the company removed $2 from an employee's account for every $1 of the employee's

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4. Ibid., p. 20.

5. Barchet, *Medical Savings Accounts*, pp. 22-23, states that in 1989, employment increased 25 percent, and that the new employees were not well enough educated about the incentives of the plan. However, no evidence is provided that education had been important at earlier times, such as when the plan began.

medical claims. At the end of the year, the employee received the funds remaining in the account, and Forbes paid the taxes due. Unlike the normal MSA, funds from this account could not be used during the year to pay for employee copayments. Forbes reported that for 1992 and 1993, dollars paid to reimburse health claims fell 25 percent, premiums fell 27 percent, and bonuses were paid to 40 percent of employees.[6]

Forbes's two-for-one penalty on medical claims created a disincentive for reporting medical claims. Every dollar in health claims cost the employee two at the end of the year to the point at which the account was exhausted. Thus, employees gained by not reporting medical spending unless they outspent both their account and their deductible.

Forbes's employees could have reduced their claims in 1992 and 1993 by either incurring fewer expenses or by finding alternative ways to pay for the expenses. They could have paid out of pocket and been reimbursed by distributions from the account at the end of the year. If they had coverage through a spouse's plan, they might have received reimbursement from that, and a few might have had coverage through public programs. Thus, it is unclear how the reduction in claim payments reported by Forbes was divided between decreased usage and cost shifting.

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6. Malcolm S. Forbes Jr., "How Forbes Curbed Spiraling Health Care Costs," *Forbes*, January 18, 1993, p. 25; Barchet, *Medical Savings Accounts*, pp. 28-29; Vera Tweed, "Medical Savings Accounts: Are They a Viable Option?" *Business & Health*, October 1994, p. 46.

The reports on the Forbes plan did not describe the plan in existence before 1992. As a result, it is not possible to know the strength of the incentives in that plan for employees to restrain their use of medical care, which would have affected the size of the reduction in claims and premiums that Forbes was able to achieve by switching to the new plan. Also, if the new plan covered fewer services than the old plan, that would account for some of the decline in premiums. Finally, if setting the deductible at 1 percent of earnings raised the average deductible, premiums should have declined independently of any change in medical spending.

RCI. RCI is an automobile parts manufacturing firm in Brighton, Michigan, with about 50 employees in 1994. Through 1993, RCI provided its employees with a traditional fee-for-service insurance policy purchased through Blue Cross and Blue Shield. The plan had broad coverage, including prescription drugs, dental care, and vision care. For individual coverage, the deductible was $100 and the maximum out-of-pocket cost was $1,100. For family coverage, the per person deductible and maximum had to be met by no more than two members.

In 1994, RCI switched to a catastrophic policy and contributed to an MSA for each employee. The insurance, purchased from Golden Rule Insurance Company, did not provide coverage for prescription drugs, dental care, or vision care, but employees could withdraw funds from their MSA to cover those expenses. For individual coverage, the insurance had a $1,500 deductible and RCI deposited $1,200 into an

MSA. For family coverage, the deductible was $2,000 and the MSA deposit was $1,700. In each case, the plan left an out-of-pocket maximum of $300 for employees. Employees could withdraw funds from their MSA during the year for any medical expenses. At the end of the year, employees could withdraw remaining funds for general use.

The company's costs under the old plan were its premium payments, and under the new plan were the sum of its premium payments and MSA contributions. Those costs fell 11.5 percent for individual coverage and 18.9 percent for family coverage (see Table 2). RCI, reflecting the mix of individual and family coverage selected by its employees, reported that the company's health care expenditures per employee fell from $4,800 to $4,200 between 1993 and 1994—a spending decrease of 12.5 percent.[7]

RCI's spending per employee fell because the premium Golden Rule charged was far enough below the premium that Blue Cross Blue and Shield charged that the difference more than offset RCI's MSA payment under the new plan. The difference in premium quotes, however, was not a measure of the change in medical spending by and on behalf of RCI's employees: part of the premium decline simply reflected the higher deductible under the Golden Rule plan. Furthermore, premiums offered by

7. Statement of Congressman Dick Chrysler before the Subcommittee on Health, House Committee on Ways and Means, June 27, 1995; statement of Tom Earhart, Vice President Human Resources, RCI, before the Subcommittee on Health, House Committee on Ways and Means, May 25, 1995; data supplied to the Congressional Budget Office by the Golden Rule Insurance Company, October 12, 1994.

different insurance companies to one employer in a single year could have varied substantially without corresponding differences in the amount of medical care employees would have used under the different policies. For example, the premium charged by Blue Cross and Blue Shield might have reflected the average claims experience at small firms it insured in RCI's area, but RCI might have had a healthier-than-average workforce. Golden Rule could then have charged RCI lower premiums for the same coverage as Blue Cross and Blue Shield without any change in medical spending at RCI.

TABLE 2. COST OF HEALTH PLANS PER EMPLOYEE TO RCI, INC., 1994 (In dollars)

	Individual		Family	
	Traditional	MSA Plan	Traditional	MSA Plan
Premium	2,500.00	1,031.28	5,520.00	2,775.12
MSA Contribution	0	1,200.00	0	1,700.00
Total Cost	2,520.00	2,231.23	5,520.00	4,475.12
Percentage Change from Traditional Plan		-11.5		-18.9

SOURCE: Congressional Budget Office using data from the Golden Rule Insurance Company.
NOTE: Premiums for the traditional plan are for a policy from Blue Cross and Blue Shield; premiums for the medical savings account plan are for a policy from Golden Rule.

Plans That Offer a Choice

Plans used by Dominion Resources, Inc., the Rubber Manufacturers Association, Golden Rule Insurance Company, and DuPont allowed employees to choose between MSA-type plans and more traditional insurance options. Those firms reported information about who chose each option, as well as the effect of the entire plan on medical spending.

Dominion Resources. In 1989, Dominion Resources, a utility holding company in Richmond, Virginia, introduced a plan in which its 200 employees chose among three deductible levels: a low deductible of $200 for individual or $600 for family coverage, a moderate deductible of $500 individual or $1,000 family, and a high deductible of $1,500 individual or $3,000 family. Although Dominion self-insured, it announced a marketlike premium for each policy—the higher the deductible, the lower the premium. Dominion also set fixed company contributions for individual and family coverage that were smaller than the premiums for the policy with the highest deductible. As a result, employees paid the full increase in premiums when they chose policies with lower deductibles. Conversely, employees saved the full reduction in premiums when they chose a policy with a higher deductible. They could apply that amount to an MSA. The portion of employees choosing the highest deductible plan grew steadily: 23 percent chose it in 1991 and 68 percent chose it in 1994.

The company ran two other programs that provided financial incentives for employees to curtail unnecessary medical spending and to follow healthy lifestyles. In one program, the company shared savings in annual health care costs with employees who did not spend more than their own deductible. The savings arose when annual company spending on health care was less than the amount budgeted. Under that program, qualified employees received $800 in 1992 and $456 in 1993. In the other program, the company provided credits for healthy lifestyles that could be used to defray employee costs for insurance. In 1992, the maximum credit was almost $50 per month.

The company reported that from 1989 through 1994, its cost per employee grew at an average rate of less than 1 percent per year.[8] During that period, employer spending nationwide grew at an annual rate of about 10 percent.[9] Because data were not reported about the growth of company costs before 1989, it is difficult to determine how much of the difference between 1989 and 1994 is attributable to the new plans, rather than simply to the continuing differences between the company and the nation.

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8. Tweed, "Medical Savings Accounts: Are They a Viable Option?" p. 46; Nancy P. Johnson, "Utility Rebates $800 to Employees with Lower Health Costs," *Business Insurance*, May 14, 1993, pp. 1, 16-17; Peter L. Spencer, "New Plan Cuts Health Care Costs in Half," *Consumer's Research*, October 1993, pp.16-19.

9. Congressional Budget Office based on Hay/Huggins Company, *1995 Hay/Huggins Benefits Reports* (Philadelphia: Hay/Huggins Company, 1995) p. I-11, and earlier years; Foster Higgins, *Foster Higgins National Survey of Employer-Sponsored Health Plans: Report / 1995* (New York: Foster Higgins, 1996) and earlier years; Derek C. Liston, *Health Benefits in 1995* (San Francisco: KPMG Peat Marwick LLP, 1995) p. 11.; component of the employment cost indexes supplied to the Congressional Budget Office by the Department of Labor, Bureau of Labor Statistics, 1996.

The company's five years of slow growth suggests that the employees reduced their claims in response to the plan's incentives rather than to the novelty of the change. That period was long enough that employees might have changed their decisions about joining or leaving the firm as well. The higher costs for people choosing low-deductible policies and the company's credits for healthy lifestyles might have influenced healthier workers to seek employment with and remain at the firm longer than less healthy workers. That possible change in employees would have kept company costs from increasing as fast as average costs increased nationwide.

Dominion's costs omitted some spending paid by employees or alternative sources. That spending could well have risen faster than the company's costs. In general, people spending below the deductible do not always report claims for their spending because it will not be reimbursed. The gradual shifting of employees at Dominion Resources to the option with the highest deductible most likely increased gradually the fraction of employee spending not reimbursed and, therefore, not reported. Furthermore, since 1992, employees whose expenses would have put them just over the deductible may not have filed claims so that they could retain eligibility for a share of the company's total savings. Finally, employees who had coverage through a spouse or gained it during the period would have been more likely than other employees to switch to the policy with the highest deductible at Dominion and submit more of their claims through their spouse's plan.

The 68 percent of workers who chose the high-deductible option in 1994 is consistent with the low exposure Dominion employees had to additional expenses under the high-deductible plan. A family with major medical expenses would have paid at most $156 more under the high- than the low-deductible plan.[10] If expenses were modest, the family would have gained financially by being in the high-deductible plan.

Rubber Manufacturers Association. In March of 1991, the Rubber Manufacturers Association in Washington, D.C., was faced with a 20 percent premium increase for the coming year on its Blue Cross and Blue Shield policy (from $262,000 to $315,000). Instead, it switched to a plan with comparable benefits designed by Plan3, a benefits consulting firm in Bethesda, Maryland. Under the plan, the association budgeted $230,000 for health care costs. From that amount, it purchased a catastrophic insurance policy with a very high deductible for all of its 50 employees, retirees, and dependents and then offered them a choice of three plans with lower deductibles. Single employees chose among deductibles of $0, $250, or $1,000; employees with dependents chose from deductibles twice those amounts. The high-deductible plan included a $750 savings account for single employees, or $1,500 for employees with dependents. Employees were able to withdraw account funds to cover their deductibles but had to wait three years before withdrawing for other spending. The association used the difference between its budgeted amount and the

10. Spencer, "New Plan Cuts Health Care Costs in Half," p. 17.

cost of the catastrophic policy premiums to pay for claims between the employees' deductibles and the association's catastrophic deductible. It also used the same funds to cover the MSA deposits for employees choosing the option with the highest deductible.[11] Plan3 sold plans similar to the association's to other small employers in its area.

The association's employees, like the employees at Dominion, switched gradually to the high-deductible plan. After five years, just over half of employees were choosing the high-deductible option. The popularity of the high-deductible option was probably a reflection of the potential for employees to come out ahead if medical bills were low and break even if medical bills were high. The maximum out-of-pocket costs under the \$250 and \$1,000 deductible options were equal when the \$750 savings account contribution was considered.

During the first five years of the plan, 1991 through 1995, Plan3 reported that the amount the association budgeted for health costs remained at the first year's amount, \$230,000. In no year did claims, MSA payments, and catastrophic insurance premiums exceed that amount. The association clearly reduced its costs. Its budgeted amount was 12 percent below what it spent in its last year under the

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11. Dennis F. Kelly, "More Than a Theory: Medical Savings Accounts at Work," (panel discussion at Cato Institute, Washington, D.C., September 18, 1995); personal communication to the Congressional Budget Office by Dennis F. Kelly of Plan3, Bethesda, Md., October 11, 1995; Peter J. Ferrara, "More Than a Theory: Medical Savings Accounts at Work," *Policy Analysis*, Cato Institute, Washington D.C., no. 220 (March 14, 1995), pp. 14-15.

previous plan, and 27 percent below what it would have spent had it continued the previous plan another year. Data on the number of people covered by the plan throughout the five years would be needed to assess the cost savings per person.

The association's savings might reflect a reduction in medical spending by and on behalf of employees, but no direct measure of the change in that spending was reported. Neither the amount spent per year under the old or new plan was available. In addition to a reduction in medical spending, the association's cost decline could have arisen if Blue Cross and Blue Shield charged the association for a higher level of expected claims than the association's employees typically incurred. Without knowing how the health experience of the association's employees compared with that of average employees insured by Blue Cross and Blue Shield, or how the experience for five years under the new plan compared with prior experience, it is not possible to determine the reasons for the cost decline.

Golden Rule. Golden Rule is an insurance company with 1,300 employees and offices in Lawrenceville, Illinois, and Indianapolis, Indiana. It specializes in selling health insurance policies to small businesses and individuals; it has pioneered the selling of MSA plans. Golden Rule began offering its employees an MSA plan as an alternative to its traditional indemnity plan in May 1993. The company continued to offer both in 1996.

Individual coverage under Golden Rule's traditional policy consisted of a $500 deductible and a 20 percent coinsurance rate above the deductible up to a maximum coinsurance payment of $1,000. For family coverage, the per person deductible and maximum had to be met by no more than three members. Employees paid 25 percent of the premiums for their traditional policy.

Individual coverage under the MSA plan in 1993 and 1994 combined a $1,000 MSA deposit with a policy that had a $2,000 deductible and no further copayments. Family coverage combined a $2,000 MSA deposit with a $3,000 deductible policy. Employees paid 25 percent of both the premiums for their catastrophic policy and their MSA deposit.

The MSA funds could be used during the year to pay for insured medical expenses below the deductible, or uninsured medical expenses such as eyeglasses, orthodontia, and psychiatric care. At the end of the year, the individual could roll any residual in the MSA into a savings account or withdraw it for general use.

Golden Rule reported that it paid slightly less per employee for coverage under the MSA plan than under the traditional policy. Most employees also paid less under the MSA plan. Employees with large or small medical bills paid less out of their own pockets under the MSA plan than they would have under the traditional

plan. Only the small fraction of employees with medical bills close to the deductible amounts in the MSA plan ($2,000 or $3,000) paid more under the MSA plan.

Golden Rule reported that 80 percent of covered employees in 1993, 90 percent in 1994, and 91 percent in 1995 chose the MSA option. The company stated that by 1995, many of those who were still choosing traditional insurance were covered by a spouse's plan.[12] Golden Rule did not allow people with dual coverage to take the MSA option because the spouse's comprehensive policy would have removed the incentive to conserve on medical spending provided by Golden Rule's MSA option. The high proportion of employees who chose the MSA plan over the traditional plan reflected in part the lower costs most employees paid under that option.

For the period from May through December of 1993, the cost of comprehensive and catastrophic premiums for Golden Rule employees was $958,558; the contributions to MSAs were $626,021, resulting in a total cost of $1,585,233. Employee claims for insurance and MSA reimbursements for the period were $824,017, or 52 percent of total cost. Golden Rule noted that the company usually expected claims to be 85 percent of premiums under the traditional policy, so that the

12. Letter from Brian McManus, Golden Rule Insurance Company, to Peter Ferrara, National Center for Policy Analysis, October 5, 1995. Some employees who declined to be covered by either of Golden Rule's plans probably had coverage through a spouse.

drop from 85 percent to 52 percent represented a 39 percent decrease in claims.[13] The claims reported were from both the 80 percent of employees enrolled in the MSA plan and the 20 percent of employees enrolled in the comprehensive policy. Although comparable spending data have not been published for 1994 and 1995, a company spokesperson stated that spending had continued at about the same rate as in 1993.[14]

As in the case of the other individual firm accounts, the 39 percent decline in claims is not necessarily an accurate reading of the decline in total medical spending by and on behalf of covered employees. Claims omitted spending paid by employees or by alternative sources, and changes in such spending under the Golden Rule plans could have caused the reported change in claims to either understate or overstate the total change.[15]

If a decline in total medical spending of nearly 40 percent occurred in 1993 and continued at least through 1995, it is of considerable interest to know how the

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13. Letter from J. Patrick Rooney, Golden Rule Insurance Company, to Milton Friedman, Senior Research Fellow, Hoover Institution, January 4, 1994; letter from J. Patrick Rooney to John Fund of the *Wall Street Journal*, June 22, 1994; Tweed, "Medical Savings Accounts: Are They a Viable Option?" p. 44.

14. Personal Communication to the Congressional Budget Office by Brian McManus of Golden Rule Insurance Company, September 9, 1996.

15. The decline in claims could have understated the decline in total medical spending at Golden Rule because people covered by the MSA plan could have had more of their medical spending reimbursed by the plan than they could under the traditional policy. Both deductibles under the traditional policy and expenses not covered by the insurance could have been paid for through the MSA. However, the decline in claims could have overstated the total decline in spending at Golden Rule if enough people chose not to submit valid claims against their MSA. People with valid claims against the MSA may not have bothered to submit those claims because they would have received the MSA funds in any event when Golden Rule disbursed the accounts at the end of the year.

spending reductions were achieved. How much resulted from careful shopping for lower prices, and how much resulted from forgoing services? Which services were forgone and by whom? Is health being affected by the reductions in spending? Similar evidence from other firms reporting large reductions in medical spending would be informative as well.

DuPont. The Medical Savings Work Group of the American Academy of Actuaries reports that DuPont, headquartered in Wilmington, Delaware, created a plan for some of its employees involving a choice among three alternatives: a point-of-service plan, a health maintenance organization (HMO), and a high-deductible plan with a credit. The point-of-service plan had a $330 deductible and an employee coinsurance of 30 percent to a maximum out-of-pocket cost of $3,000; it also required an employee contribution of $101 toward the cost of the insurance policy. The HMO had no deductible but required an employee contribution of $318. The catastrophic insurance policy had a deducible of $1,000 and a 40 percent employee coinsurance to a maximum out-of-pocket cost of $4,000; instead of a required payment, employees received a credit of $498. Only 4 percent of DuPont employees chose the high-deductible option. It was discontinued as a plan option.[16]

16. American Academy of Actuaries, *Medical Savings Accounts: An Analysis of the Family Medical Savings and Investment Act of 1995* (Washington, D.C.: American Academy of Actuaries, October 1995), p. 7.

The low percentage of the DuPont workforce choosing the MSA option contrasted with the high percentages reported by Dominion Resources, the Rubber Manufacturers Association, and Golden Rule. DuPont's MSA option might have been less popular than the others' options in part because it left people who incurred large medical bills paying more relative to DuPont's other options than did the MSA options at other firms. The short duration of DuPont's experience probably was a factor as well. The share of employees choosing the high-deductible options at Dominion Resources and the Rubber Manufacturers Association grew over time. The fraction of employees who chose the MSA option at DuPont was too small to have a noticeable impact on health spending by the company's workforce.

CONCLUDING COMMENTS

The reports from firms' experiences with MSA-like plans shed little light on legislation for several reasons. First, the reports from firms trying MSA-type plans could not comprehensively measure the change in medical spending by and on behalf of employees, and therefore do not fully ascertain the extent to which medical spending declined.

Second, the plans that firms actually implemented differ from those envisioned in Congressional bills. Some of the reported changes in spending result from

those differing plan features. For instance, the spending change at Forbes was probably influenced by the $2 withdrawal from employees' account balances for each $1 of claims. Likewise, the change in spending at Dominion Resources was most likely influenced by the company's additional bonus for employees spending less than their deductibles, and its credits for employees leading healthy lifestyles. Dominion and DuPont did not require that each employee with a high-deductible policy have an MSA. Finally, only the Morris County Hospital plan was allowed to exempt from taxation employees' medical spending from their MSAs—a key element of nearly all bills that have come before Congress. That tax advantage should make people more willing to use an MSA plan, but in some circumstances, less willing to reduce their medical spending.

A third reason that spending changes at the firms might not apply to MSA plans in bills before Congress is that the reported changes in spending cannot be attributed only to the plans implemented by the firms. For example, the cost savings at RCI resulted from the reduction in premiums it paid when it switched from the Blue Cross and Blue Shield comprehensive policy to Golden Rule's catastrophic policy. Some of that reduction might have been attributable to the different pricing of insurance by the two firms rather than the change in policy coverage, as discussed in the preceding section.