

The Catholic University of America, Columbus School of Law
CUA Law Scholarship Repository

Scholarly Articles and Other Contributions

Faculty Scholarship

1999

Medical Savings Accounts: Windfalls for the Healthy, Wealthy, and Wise

Regina T. Jefferson

The Catholic University of America, Columbus School of Law

Follow this and additional works at: <https://scholarship.law.edu/scholar>



Part of the [Health Law and Policy Commons](#), and the [Retirement Security Law Commons](#)

Recommended Citation

Regina T. Jefferson, Medical Savings Accounts: Windfalls for the Healthy, Wealthy, and Wise, 48 CATH. U. L. REV. 685 (1999).

This Article is brought to you for free and open access by the Faculty Scholarship at CUA Law Scholarship Repository. It has been accepted for inclusion in Scholarly Articles and Other Contributions by an authorized administrator of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

ARTICLES

MEDICAL SAVINGS ACCOUNTS: WINDFALLS FOR THE HEALTHY, WEALTHY & WISE

*Regina T. Jefferson**

INTRODUCTION

As the average life expectancy lengthens,¹ ensuring that Americans set aside sufficient dollars for their retired years has become an increasingly important aspect of national economic policy and individual saving practices.² Contemporary medical and technological advancements allow

* Associate Professor of Law, The Catholic University of America, Columbus School of Law. I wish to thank Jennifer Winter and Benjamin Ogletree for their very valuable research assistance on this project.

1. In 1990, roughly 31.2 million people in the United States were age sixty-five or older. See JENNIFER CHEESEMAN DAY, U.S. DEP'T OF COMMERCE, P25-1092, POPULATION PROJECTIONS OF THE UNITED STATES, BY AGE, SEX, RACE, AND HISPANIC ORIGIN: 1992 TO 2050, at xiv tbl.G (1992) [hereinafter CENSUS: 1992-2050]. The elderly population is expected to increase dramatically in the twenty-first century as the post-World War II baby-boom generation reaches retirement age. See Nina J. Crimm, *Tax Plans for the Twenty-First Century: Medical Incentive Vouchers Address the Needs of Academic Health Centers and the Elderly*, 71 TUL. L. REV. 653, 662 (1997) (noting that as the post-World War II baby-boomers enter their "golden years" in the second decade of the twenty-first century, elderly Americans will comprise a greater percentage of the overall population than ever before). In fact, the elderly population is projected to double by the middle of the twenty-first century. See *id.* The average life expectancy of Americans increased from forty-seven years to seventy-four years—a difference of twenty-seven years—since the beginning of the twentieth century. See *id.* at 657. The Census Bureau anticipates that the average life expectancy for females and males will be 82 years and 74.2, respectively, by the year 2020. See *id.* at 663 n.46.

2. Cf. Senator J. Robert Kerrey, *Welfare Reform: Economic Security for the Next Century*, 9 STAN. L. & POL'Y REV. 13, 14 (1998) (arguing that many contemporary income-support programs are outdated and incapable of providing income security in the modern era). Government-sponsored programs, including Medicare and Medicaid, absorb less than 60% of the health care expenditures attributable to the elderly. See Crimm, *supra* note 1, at 660. For example, Medicare currently does not cover in-home and nursing home health care costs. See *id.* at 660 n.30. As a result, such expenses must be paid out-of-pocket, imposing a significant financial burden that depletes the retirement savings and security of the growing elderly population. Cf. CONGRESSIONAL BUDGET OFFICE, TRENDS IN HEALTH SPENDING: AN UPDATE 14 (1993) [hereinafter HEALTH SPENDING] (reporting that the elderly allocated in excess of 10% of their income to health care ex-

people today to enjoy not only longer, but healthier, more fulfilling lives.³ Thus, financial preparation for immediate and future health care expenses also has emerged as a critical element of many individuals' personal savings goals.⁴ However, the rapidly rising cost of health care makes it extremely difficult for most individuals to effectively accomplish this goal.⁵

In 1996, Congress responded to growing national concern about the cost and availability of health care by enacting the Health Insurance Portability and Accountability Act (HIPAA or "the Act").⁶ The

penses between 1984 and 1991). Consequently, the retirement savings of the baby-boomer population may be insufficient to cover even anticipated post-retirement expenditures, much less the inordinate expenses attributable to long-term catastrophic medical care. See Crimm, *supra* note 1, at 661.

3. The increase in life expectancy among Americans is due in significant part to the reduction in mortality rates which, in turn, is attributed to technological developments in medicine. See Dorothy P. Rice & Jacob J. Feldman, *Living Longer in the United States: Demographic Changes and Health Needs of the Elderly*, 61 MILBANK MEMORIAL FUND Q. 362, 367-71 (1983) (suggesting that the decline of mortality rates is attributed to developments in research and understanding of disease etiology, the use of innovative diagnostic and surgical procedures, tempered lifestyles, etc.); see also Joann Babiak, *Health-Care Access for the Elderly of Industrialized Nations: Fallen and Can't Get Up?*, 4 ILSA J. INT'L & COMP. L. 221, 224-25 (1997) (explaining that because of improvements in living environments, "individuals in industrialized countries are generally able to predict with certainty that they will attain old age"). Specifically, advances in preventative medicine and healing techniques, reduced smoking, lower cholesterol levels, and stress management are responsible for increasing adult life expectancy. See Crimm, *supra* note 1, at 664 & n.51 (citing the reduction in the overall occurrence of heart disease and strokes as major contributors to increasing the longevity of Americans' lives). As a result, the 65 and older age group has increased at nearly double the rate of growth of the younger populations. See *id.* at 657. This trend is expected to accelerate significantly after the year 2000. See Kerrey, *supra* note 2, at 15.

4. The longer people live, the more likely they are to develop health problems, requiring them to set aside enough money to pay for health care. See Crimm, *supra* note 1, at 657-58 ("As more people live longer, chronic diseases emerge as major causes of death and disability that may impair a person's ability to function and may require medical management."); see also John Gibeaut, *Senior Advisers: What Every Lawyer with Older Clients or Aging Parents Needs to Know About Protecting Their Health Care and Estates*, A.B.A. J., Apr. 1997, at 56 ("Americans are living longer, and as this elder population grows, so do the medical, financial and legal problems that often accompany old age."); cf. Kerrey, *supra* note 2, at 14 (arguing that, because of the dramatic increase in the cost of medical care, "families must have health insurance to cover their basic health needs or they risk personal bankruptcy").

5. Cf. Milt Freudenheim, *Survey Finds Health Costs Rose in '95*, N.Y. TIMES, Jan. 30, 1996, at D1 (indicating that the increase in national health care costs has been outpacing the overall growth of the national economy); Kerrey, *supra* note 2, at 14 (noting that, adjusted for inflation, national health care expenditures rose from \$134.6 billion in 1960 to \$949.4 billion in 1994).

6. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. For the remainder of the article, I will refer to the statute as the HIPAA.

HIPAA, a very popular piece of legislation, garnered bi-partisan support.⁷ It also was received well by both business and consumer advocates across the United States.⁸

The HIPAA was intended to improve the availability of affordable health care in America by enhancing portability and continuity of health care coverage, increasing long-term medical care service, and simplifying the administration of the national health care system.⁹ In enacting the HIPAA, Congress chose to add to an existing array of tax incentive programs, rather than adopt a new comprehensive governmental health care system. Interestingly, contrary to its intent of making health care more available to the general public, some provisions of the HIPAA actually widened the gap between those who can afford adequate health care and those who cannot. For this reason, some portions of the legislation were seriously opposed.¹⁰

The creation of the Medical Savings Account¹¹ (MSA) program was one of the Act's most contested provisions.¹² The MSA is a savings program for financing health care expenses that is designed to supplement traditional indemnity and medical insurance programs.¹³ Commonly re-

7. The United States House of Representatives passed the HIPAA with only two dissenting votes on August 1, 1996. See 142 CONG. REC. H9785, H9795 (daily ed. Aug. 1, 1996) (House vote on HIPAA Conference Report); Judith Havemann, *House Votes to Protect Health Insurance Access*, WASH. POST, Aug. 2, 1996, at A1. Likewise, the United States Senate passed the Act unanimously on August 2, 1996. See 142 CONG. REC. S9501, S9526 (daily ed. Aug. 2, 1996) (Senate vote on HIPAA Conference Report); Eric Schmitt, *Wages and Health Lead the Agenda as Congress Acts*, N.Y. TIMES, Aug. 3, 1996, at A1.

8. Cf. Tamara E. Russell, Note, *Trav'lin' Light: Early Retirees and the Availability of Post-Retirement Health Benefits*, 22 AM. J.L. & MED. 537, 558 (1996) (arguing that Medical Savings Accounts (MSAs), created by the HIPAA, "satisfy the policy objectives of fairness, flexibility, and stability by virtue of their structure"); Albert B. Crenshaw, *Health Care's Hot Seller: Medical Savings Accounts*, WASH. POST, May 18, 1997, at H1 (noting that tax advantages established under the HIPAA "[make] MSAs big sellers with law firms").

9. See HIPAA, 110 Stat. at 1936 (preamble); see also Craig M. Stephens, Recent Development, *The Health Insurance Portability and Accountability Act: Favorable Tax Treatment for Medical Savings Accounts*, 20 AM. J. TRIAL ADVOC. 457, 457 (1997) (explaining the Act's purpose).

10. See Havemann, *supra* note 7, at A1 (discussing the argument in Congress that "medical savings accounts would attract the healthy and wealthy and siphon off all but the poor and sick from the overall insurance pool").

11. HIPAA § 301, 110 Stat. at 2037 (codified at I.R.C. § 220 (West Supp. 1998)).

12. Dispute over MSAs was the primary roadblock that delayed the passage of health care reform. See Robert A. Rosenblatt, *Insurers Set to Give Medical Savings Accounts Big Push*, L.A. TIMES, Sept. 1, 1996, at D1; Eric Weissenstein, *MSAs Still Hindering Reform Bill Passage*, MOD. HEALTHCARE, July 8, 1996, at 8.

13. See generally I.R.C. § 220.

ferred to as a "medical IRA,"¹⁴ the MSA is structured to allow participants to pay for current medical expenses and to encourage them to save for future health care costs.¹⁵ The MSA permits funds not used in the current tax year for medical expenses to accumulate tax-free for use in future years.¹⁶

The ability to carry over unused funds is the most controversial feature of the MSA.¹⁷ The carry-over feature effectively enables account holders to use their MSAs as tax-preferred retirement savings vehicles. Unlike traditional tax-preferred retirement savings programs, however, the use of MSA funds is not limited to retirement savings purposes.¹⁸ Instead, MSA account holders are permitted to use their tax-preferred accumulated savings without penalty for either retirement savings or current medical expenses.¹⁹

On its face, the MSA program appears to be an efficacious method of tackling the overwhelming problems of long-term health care financing and the increasing need for retirement income security by encouraging individuals to take more responsibility for their health care choices and, at the same time, by providing tax incentives to save for both current

14. Stephens, *supra* note 9, at 457.

15. See I.R.C. § 220(d)(1) (Supp. II 1996) (defining an MSA as "a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder").

16. See *id.* § 220(e)(1).

17. See Todd S. Purdum, *Clinton Signs Bill to Give Portability In Insurance*, N.Y. TIMES, Aug. 22, 1996, at B12. Two of the most well publicized, but not the most controversial, provisions of the HIPAA addressed portability and pre-existing conditions. See *id.* Under the HIPAA, workers are permitted to maintain health insurance coverage if they change or lose their jobs, and insurance companies are prohibited from denying coverage to individuals who have preexisting medical conditions. See HIPAA, Pub. L. No. 104-191, §§ 701, 702, 2701, 2702, 2741, 2742, 110 Stat. 1936, 1939-46, 1955-62, 1972-83 (1996) (codified at scattered sections of 29 & 42 U.S.C.); see also Purdum, *supra*. The Act also includes a provision which allows dying individuals, particularly AIDS patients, to draw on their life insurance benefits while still living. See HIPAA § 331, 110 Stat. at 2067-69; see also Purdum, *supra*.

18. See I.R.C. § 220(f)(4)(C) (providing that any distributions made after an account holder reaches age 65 are not subject to the 15% excise penalty that typically applies to distributions used for purposes other than qualified medical expenses); see also Benjamin C. Ayers & Elizabeth Plummer, *New MSA and Health Insurance Rules Create Opportunities*, 58 TAX'N FOR ACCT. 260, 263 (1997) (suggesting that Congress authorized, perhaps unintentionally, the use of MSAs as an alternative means of securing retirement savings).

19. See Ayers & Plummer, *supra* note 18, at 260-61 (explaining that because MSAs allow the taxpayer to accumulate unused funds, they closely resemble IRAs). With IRAs, there is a 10% penalty for distributions taken prior to age sixty-five. See I.R.C. § 72(t)(1) (West Supp. 1998). There is an exception to the penalty, however, if the distribution is used for medical expenses or health insurance premiums, to the extent that they exceed the 7.5% floor of I.R.C. § 213. See I.R.C. § 72(t)(2)(B), (D).

medical expenses and retirement savings purposes.²⁰ However, the MSA is a questionable response to these concerns because its underlying policy runs counter to existing retirement income and health care goals.²¹ Moreover, the MSA program raises serious questions of fairness as it benefits relatively few, failing to provide savings opportunities for a significant portion of the population.²² As designed, the MSA disproportionately benefits the members of society who arguably least need assistance with their health care expenses or retirement savings objectives. Namely, MSAs benefit individuals with low health care expenses (the healthy), individuals with high incomes (the wealthy), and individuals who are knowledgeable about health service alternatives, their own medical conditions, and the MSA program itself (the wise).

Parts I and II of this Article review the development, general structure, and operation of the MSA program. Part III of this Article compares and contrasts the MSA to other tax-preferred retirement savings plans and explores the applicability of pension law to these arrangements. In Parts IV, V, and VI, respectively, this Article demonstrates that the MSA program disproportionately benefits the wealthiest, healthiest, and most informed members of our society. Part VII of this Article examines the impact of the MSA on the existing health care system. In Parts VIII and IX, this Article identifies various deficiencies in the MSA model that may undermine significantly its marketability as a viable health care savings program. This Article ultimately concludes that the focus and design of the MSA program presents serious doubts concerning its ability to accomplish its goals in the manner contemplated by Congress.

20. See Stephens, *supra* note 9, at 458 (rationalizing that “[t]he utility of MSAs appears to encourage personal responsibility in the consumer before he spends a healthcare dollar,” by allowing individuals to accumulate unspent funds for future medical expenses or retirement savings goals).

21. See discussion *infra* Parts IV, VII (arguing that MSAs do not provide savings benefits to those who are not wealthy or have the highest health risks, and actually may discourage physician consultation and preventive health care).

22. The availability of MSAs is limited in several important respects. First, MSAs are available only to “eligible individuals”; that is, individuals who are covered under a high deductible health plan, established and maintained by a small employer. See I.R.C. § 220(c)(1)(A). As defined, a small employer is an employer with an average of fifty or fewer employees during the two preceding years. See *id.* § 220(c)(4)(A). Second, Congress limited the available number of accounts subject to favorable tax treatment under the pilot program to 750,000 in 1999. See *id.* § 220(j)(2). Therefore, even an expanded program will benefit only those employees who can afford high deductibles and work for small employers. Third, the tax and saving incentives provided by the MSA program disproportionately benefit the healthiest and wealthiest population. See *supra* note 7; see also discussion *infra* Parts IV and V.

I. THE MSA PROGRAM DESIGN

The HIPAA was signed into law by President Clinton on August 21, 1996.²³ This legislation amended the Internal Revenue Code of 1986 (I.R.C. or "the Code") by adding § 220 which covers MSAs.²⁴ Under § 220, self-employed individuals and those employed by companies with fifty or fewer employees are allowed to establish MSAs.²⁵

The MSA combines a high-deductible, catastrophic medical insurance plan with a tax-free, health care savings account.²⁶ To qualify as an MSA catastrophic health care plan, a plan's deductible must fall between \$1500 and \$2250 for individual coverage,²⁷ and between \$3000 and \$4500 for family coverage.²⁸ To participate in the MSA program, an individual must be enrolled in a qualified, catastrophic health care plan, and also must establish a tax-free savings account.²⁹ Account holders are expected to use their high-deductible plans to cover major medical expenses and their tax-free savings accounts to cover ordinary, routine medical costs.³⁰ The tax-free savings account also may be used to pay a portion of the insurance deductible.³¹ Once the deductible is met, the catastrophic plan may be fully comprehensive or may contain further co-payments and restrictions.³²

Unused funds contributed to an MSA in any given year are carried

23. See Remarks on Signing the Health Insurance Portability and Accountability Act of 1996, 1996 PUB. PAPERS 1319, 1320 (Aug. 21, 1996). President Clinton signed the bill into law despite his concern that "much work remained to be done" regarding health care in America. See Purdum, *supra* note 17, at B12. He was concerned about provisions that would have expanded coverage for the unemployed and the mentally ill but were dropped from the final version of the bill. See *id.*

24. See HIPAA, Pub. L. No. 104-191, § 301, 110 Stat. 1936, 2037 (1996).

25. See I.R.C. § 220(c)(1)(A), (4)(A).

26. See H.R. REP. NO. 104-496, pt. 1, at 109-12 (1996), reprinted in 1996 U.S.C.C.A.N. 1865, 1910-13; see also Marilyn Hanzal, *Medical Savings Accounts Set to Face Decisive Test*, CHI. DAILY L. BULL., Sept. 20, 1996, at 5 (discussing the components of MSA accounts).

27. See I.R.C. § 220(c)(2)(A)(i).

28. See *id.* § 220(c)(2)(A)(ii).

29. See *id.* § 220(a), (c)(1)(a).

30. See *id.* § 220(d)(2)(A). For purposes of the MSA, the definition of "qualified medical expense" generally is consistent with the rules of section 213(d) of the Internal Revenue Code for itemized deductions. See *id.*

31. See *id.* § 220(d)(1), (2)(A) (defining "qualified medical expense" as an amount not covered by insurance); see also Mark V. Pauly & John C. Goodman, *Using Tax Credits for Health Insurance and Medical Savings Accounts*, in THE PROBLEM THAT WON'T GO AWAY: REFORMING U.S. HEALTH CARE FINANCING 274, 278 (Henry J. Aaron ed. 1996) (stating that "[p]eople obviously could and should use the funds in their MSAs for their deductibles").

32. See I.R.C. § 220(c)(2).

forward to future years and can be used as a cushion against prospective health care expenditures.³³ Alternatively, excess funds may be left in the account and withdrawn without penalty for any purpose once an account holder reaches her social security normal retirement age.³⁴ All distributions for non-medical purposes are classified as income and taxed accordingly.³⁵ These distributions also are subject to a 15% penalty.³⁶ However, distributions made for non-medical reasons *after* an account holder dies, becomes disabled,³⁷ or attains the social security retirement age³⁸ are taxed, but are not subject to the 15% penalty.³⁹

The MSA program is voluntary and tax-preferred. Congress provided substantial tax benefits in connection with the MSA program in the hope that the incentives will prove sufficiently attractive to encourage individuals to save in these arrangements.⁴⁰ The MSA program provides

33. See Stephens, *supra* note 9, at 457.

34. See I.R.C. § 220(b)(7) (West Supp. 1998). Social Security retirement ages are as follows:

<i>Year of Birth of Individual Receiving Benefit</i>	<i>Social Security Normal Retirement Age</i>
1937 and before	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943-1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 and later	67 years

See 42 U.S.C.A. § 416(I) (West Supp. 1998); CCH BUSINESS LAW EDITORS, SOCIAL SECURITY ACT EXPLAINED ¶ 518, at 197-98 (1996) (listing retirement ages).

35. See I.R.C. § 220(f)(2).

36. See *id.* § 220(f)(4)(A); see also MICHAEL J. CANAN & WILLIAM D. MITCHELL, EMPLOYEE FRINGE AND WELFARE BENEFIT PLANS § 10.2A, at 320 (1997) (explaining the MSA distribution rules for non-medical purposes before an account holder reaches age 65).

37. See I.R.C. § 220(f)(4)(B).

38. See *id.* § 220(f)(4)(C); see also *supra* note 34 (listing the applicable social security retirement ages).

39. See *id.* § 220(f)(2); see also TAX ANALYSTS, A TAX LAW BAEDERER: A GUIDE TO THE 1996 TAX CHANGES 1 (David F. Windish ed., 1996) (explaining that “[d]istributions [of MSA funds] after age 65, death, or disability are not penalized, but are included in income”).

40. See Stephens, *supra* note 9, at 458-59 (discussing the favorable tax treatment of MSAs and observing that the Act includes both employer and employee-based tax incen-

three tax benefits. First, within limits, personal contributions to an MSA are deductible⁴¹ and employer contributions are excludible from taxable income.⁴² Second, accumulated earnings in an MSA are not taxed until distribution.⁴³ Third, distributions for qualified medical expenses are tax-free.⁴⁴

Upon the death of an MSA participant, if the beneficiary of the MSA is the participant's surviving spouse, the spouse may continue the MSA as her own.⁴⁵ If the beneficiary is not the surviving spouse, the beneficiary must report the MSA balance as income in the year of the account holder's death.⁴⁶ If there is no beneficiary, the MSA balance is included on the final income tax return of the account holder.⁴⁷

II. THE MSA CONTROVERSY

The MSA concept is a fundamentally different approach to providing

tives necessary to fuel the expansion of MSAs); *see also* Ayers & Plummer, *supra* note 18, at 267 (concluding that the tax incentives provided in connection with the MSA program "greatly surpass those of the medical expense itemized deduction"). Because MSA accounts are tax exempt, *see* I.R.C. § 220(e)(1), estimates show that the MSA program will cost the United States Treasury \$3 billion in forgone revenue by the year 2006. *See* Havemann, *supra* note 7, at A1.

41. *See* I.R.C. § 220(a).

42. *See id.* § 106(a)-(b)(1). The HIPAA expanded the existing exclusions for employer contributions to accident and health plans to include MSA contributions as follows:

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) Contributions to Medical Savings Accounts—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any medical savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan . . .

HIPAA, Pub. L. No. 104-191, § 301(c)(1), 110 Stat. 1936, 2048-49 (1996) (codified as amended at I.R.C. § 106 (Supp. II 1996)).

43. *See* I.R.C. § 220(e)(1) (providing that an MSA is tax exempt).

44. *See id.* § 220(f)(1); *see also* H.R. REP. NO. 104-496, pt. 1, at 111-12, (1996), *reprinted in* 1996 U.S.C.C.A.N. 1865, 1911-13. Under the HIPAA, distributions from an MSA for unreimbursed medical expenses of the account holder, an account holder's spouse, or dependents, are not considered income. *See id.* at 111, *reprinted in* 1996 U.S.C.C.A.N. at 1912. The exclusion applies regardless of whether the payment is made directly from the MSA to the service provider, from the MSA to reimburse the account holder, or the account holder uses MSA funds to pay for medical services. *See id.*

45. *See* I.R.C. § 220(f)(8)(A) (providing that in the event a surviving spouse acquires interest in an account holder's MSA, the "account shall be treated as if the [surviving] spouse were the account holder").

46. *See id.* § 220(f)(8)(B)(i)(I)-(II).

47. *See id.*; *cf.* H.R. REP. NO. 104-496, pt. 1, at 112, *reprinted in* 1996 U.S.C.C.A.N. at 1913 (observing that "[i]n all cases, no estate tax applies").

health care insurance.⁴⁸ Unlike traditional health care protection, the MSA program is designed to motivate participating individuals to take more active roles in making decisions about their health care costs.⁴⁹ MSA proponents argue that, by giving consumers greater control over their health care funds, in conjunction with an opportunity to save their unspent health care dollars, the MSA model encourages consumers to purchase health care services more prudently.⁵⁰ These advocates anticipate that, as a result, the MSA program will curb the rising cost of medical care, making health services more affordable for all Americans in the long-run.⁵¹

Although evidence suggests that individuals are more conscientious about expenditures involving the use of personal funds, the expected benefits of the MSA program have been grossly exaggerated because many indirect costs either have been overlooked or inadequately considered.⁵² For example, proponents of the MSA fail to account fully for the potential harm that the program presents for the conventional health care system.⁵³ Proponents also have ignored completely the compliance

48. Cf. Ayers & Plummer, *supra* note 18, at 260 (noting that MSAs were intended to furnish taxpayers with “a method to defray the cost of unreimbursed health care expenses, while increasing competition for health care services”); Stephens, *supra* note 9, at 457 (explaining that MSAs were designed to control the increasing cost of medical care through the use of tax-based savings). The MSA model is therefore premised on the notion that once consumers have a personal financial stake in purchasing health care services, they will spend the money more prudently. *See id.* at 458.

49. *See* H.R. REP. NO. 104-496, pt. 1, at 69, *reprinted in* 1996 U.S.C.C.A.N. at 1869.

50. *See id.* at 110, *reprinted in* 1996 U.S.C.C.A.N. at 1911 (“Because MSAs afford people the opportunity to save unspent MSA funds for future health and long-term care needs . . . people will be more prudent in their purchase of health care services.”); Stephens, *supra* note 9, at 461 (acknowledging that supporters of the MSA program subscribe to the theory that “personal responsibility will help to end careless spending of healthcare dollars by putting responsibility for conserving funds back in the hands of the consumer—the patient”).

51. *See* H.R. REP. NO. 104-496, pt. 1, at 69, *reprinted in* 1996 U.S.C.C.A.N. at 1869 (explaining that MSAs are designed to persuade plan participants to take a more cost-effective approach to health care spending); *see also* Senator William V. Roth, Jr., *Medical Savings Accounts*, 11 J. CONTEMP. HEALTH L. & POL’Y 149, 152 (1994) (commenting that MSAs will help restrain rising health care costs by encouraging consumers to make more careful health care decisions).

52. *See* John Burry, Jr., *Monitoring Healthcare Dollars: Medical Savings Accounts: A Quick Fix that Could Destroy the American Healthcare System* (visited Sept. 30, 1996) <<http://www.citynet.net/msa.html>> (reporting Congressional Budget Office skepticism that MSAs will save money). This cite is no longer accessible, but is on file with *The Catholic University Law Review* and the author.

53. *See* *Medical Savings Accounts—A Bad Idea*, COLLECTIVE BARGAINING REP. (Winter 1996) (visited Sept. 30, 1996) <<http://www.afscme.org/afscme/bargtabl/cbr4b.htm>> (contending that because MSA participants have no incentive to seek preventive care, medical costs ultimately will escalate as diseases and illnesses will be more advanced and,

problems of having different distribution and contribution rules for traditional retirement savings plans than for MSAs.⁵⁴ Additionally, MSA proponents have not considered fully the additional administrative requirements of implementing the program for which the cost ultimately will be passed on to the health care consumers.⁵⁵ Thus, when all relevant factors are considered, the MSA program could actually increase the cost of medical care services rather than decrease them.⁵⁶ Even if all relevant costs are considered and measured accurately, it is nevertheless questionable whether the expense of the program can be justified if MSAs benefit only the wealthiest, healthiest, and most informed members of society, without providing comparable benefits to those who are less fortunate.⁵⁷

The rationale underlying health care reform in general, and MSAs in particular, is that all citizens should have access to affordable health care.⁵⁸ Concerns that the MSA both jeopardizes the existing health care program and disproportionately benefits the affluent were perceived by many commentators as serious weaknesses.⁵⁹ As a result, Congress introduced the MSA as an experimental program to be offered on a limited four-year trial basis.⁶⁰ After the trial period ends, Congress will determine if MSAs can co-exist with traditional health care plans and control health care costs without benefiting only a few.

The experimental program provides for the establishment of a limited number of MSAs⁶¹ and is scheduled to last until the year 2000.⁶² In 2000, Congress will decide whether to abolish or expand the MSA program

thus, more costly to treat once detected and diagnosed). This cite is no longer accessible, but is on file with *The Catholic University Law Review* and the author.

54. See *infra* text and accompanying notes 71-83, 102-04 (discussing the divergence between MSAs and other employer-sponsored retirement arrangements).

55. See *infra* Part VII.C.2 (discussing the additional cost of implementation).

56. See *infra* Part VIII.B (discussing a similar program in Singapore which resulted in an actual increase in medical care costs).

57. See Burry, *supra* note 52 (criticizing the MSA program as only benefiting healthy and affluent people).

58. See 141 CONG. REC. H4541 (daily ed. May 3, 1995) (statement of Rep. Owens) (noting that FDR's Economic Bill of Rights included the right to adequate medical care); Crimm, *supra* note 1, at 661 (stating that "[a]ccess to quality health care by and for an aging and elderly population is an important societal expectation").

59. See Havemann, *supra* note 7, at A1 (reporting that many Democrats feared MSAs would attract only healthy and wealthy participants to the exclusion and detriment of persons who are poor and infirm).

60. See I.R.C. § 220(i)(2) (Supp. II 1996).

61. See *id.* § 220(j)(1)-(2) (Supp. II 1996).

62. See *id.* § 220(i)(2) (Supp. II 1996).

based on the outcome of the experiment.⁶³ To assess the desirability of expanding the MSA program, Congress authorized two studies.⁶⁴ The first study, conducted by the Treasury Department, will evaluate the level of participation in the MSA program and determine the effects of the program on tax revenues.⁶⁵ The General Accounting Office (GAO) will undertake the second study.⁶⁶ In connection with the second study, the Comptroller General is required to retain the services of “an organization with expertise in health economics, health insurance markets, and actuarial science to conduct a comprehensive study” to determine the impact of the MSA on the health care market.⁶⁷

While the program’s experimental status and reporting requirements reduce its duration and heighten public awareness about its effects, these characteristics do not eliminate the basis for concern about the MSA program.⁶⁸ The temporary quality neither justifies the program’s disparate impact among taxpayers nor removes its threat to the existing health care and retirement savings systems.⁶⁹ More importantly, however, the results from the studies of the pilot program could be misleading; they may not adequately predict the effects of an expanded MSA program if the composition and behavior of the experimental population is not representative of those who would participate in a permanent program.

Therefore, to the extent that the MSA experiment is used to measure

63. See Ayers & Plummer, *supra* note 18, at 263; see also *Medical Savings Accounts Might Not Be Cure-all: Small-Business Program Has Supporters, Detractors*, FLA. TODAY, Sept. 8, 1997, available in 1997 WL 14133358.

64. See HIPAA, Pub. L. No. 104-191, § 301(k)-(l), 110 Stat. 1936, 2052-53 (1996), reprinted in I.R.C. § 220 notes (Supp. II. 1996).

65. See *id.* § 301(k), 110 Stat. at 2052, reprinted in I.R.C. § 220 notes (Supp. II 1996).

66. See *id.* § 301(l), 110 Stat. at 2052-53, reprinted in I.R.C. § 220 notes (Supp. II 1996).

67. See *id.* The study explicitly is required to determine the effects on the following: (1) selection, including adverse selection, (2) health costs, including any impact on premiums of individuals with comprehensive coverage, (3) use of preventive care, (4) consumer choice, (5) the scope of coverage of high deductible plans purchased in conjunction with such accounts, and (6) other relevant items. A report on the results of the study conducted under this subsection shall be submitted to the Congress no later than January 1, 1999.

Id. The first phase of this study was completed and submitted to the GAO on December 19, 1997. See generally U.S. GEN. ACCOUNTING OFFICE, MEDICAL SAVINGS ACCOUNTS: FINDINGS FROM INSURER SURVEY, GAO/HEHS-98-57 (Dec. 1997) [hereinafter GAO MSA REPORT].

68. See Stephens, *supra* note 9, at 460-61 (predicting that the effect of preferential tax treatment attendant with the MSA program will reach well beyond the confines of tax law, implicating laws governing ERISA, Medicaid, Medicare and insurance).

69. See discussion *infra* Parts IV, V, VI, VII, and VIII (discussing disparate impact and effect on health care and retirement savings systems).

the feasibility of a permanent MSA program, the pilot must be evaluated very critically. Not only is it necessary for Congress to assess the actual experience of the pilot program, but also to anticipate effects beyond those occurring during the relatively brief experimental phase.

III. THE MSA COMPARED TO OTHER RETIREMENT ARRANGEMENTS

A. *The MSA/IRA Comparison*

MSAs were promoted as health care plans.⁷⁰ However, to the extent that an account holder is able to accumulate unused medical funds and withdraw them without penalty upon reaching retirement age, death, or disability, the MSA program functions as a traditional tax-preferred, individual retirement arrangement, or IRA.⁷¹ In fact, because of their similarity to IRAs, MSAs are referred to by some as “medical IRA[s].”⁷²

However, the label “medical IRA” is misleading. This term suggests that MSAs have a single, or at least a primary, medical savings purpose. This conclusion is incorrect. MSAs can be used as effectively for retirement savings purposes as for medical savings purposes.⁷³ Thus, it is more accurate to distinguish MSAs from traditional IRAs by emphasizing their greater flexibility than by suggesting that they have relatively limited use.⁷⁴

70. See H.R. REP. NO. 104-496, pt. 1, at 110 (1996), *reprinted in* 1996 U.S.C.C.A.N. at 1865, 1911 (characterizing MSAs as alternatives to low-deductible health insurance that are designed to encourage American consumers to be more cost-conscious in purchasing medical services); see also Elizabeth Neus, *Medical Savings Account Plan Isn't Getting Many Buyers*, Gannett News Serv., Aug. 30, 1997, available in 1997 WL 8835696 (characterizing the MSA as a “new combination savings account/health plan designed as an option for those who don't like traditional health insurance plans”).

71. See Albert B. Crenshaw, *Without a Lot of Fanfare, A Lot of Tax Legislation*, WASH. POST, Aug. 18, 1996, at H1 (describing MSAs as “IRA-like devices that allow workers to save money untaxed to pay medical expenses if they have insurance that covers only catastrophic illnesses”). Traditional individual retirement accounts (IRAs) provide tax incentives for individuals to save for retirement. Eligible taxpayers may deduct up to \$2000 a year in contributions to an IRA. See I.R.C. § 219(b)(1) (1994). The earnings on the IRA are tax-free, see *id.* § 408(e)(1), and amounts invested in an IRA are taxed when distributed. See *id.* § 408(d)(1). The tax treatment of the traditional IRA is different than the tax treatment of the new Roth IRA which is another type of IRA that receives preferential tax treatment. See *infra* note 84 (explaining the tax treatment of the new Roth IRA).

72. Stephens, *supra* note 9, at 457.

73. See Crenshaw, *supra* note 8, at H1 (advising that if an individual can avoid making large withdrawals from an MSA account, he may accumulate a “healthy nest egg”).

74. See Ayers & Plummer, *supra* note 18, at 263 (reasoning that “because there are no minimum distribution rules or excess distribution taxes, the MSAs have a distinct advantage over IRAs”).

The underlying purpose for the preferential tax treatment of employer sponsored retirement savings, including IRAs, is to foster economic security in old age.⁷⁵ To ensure that funds saved in IRAs and other tax-preferred retirement savings plans actually are used for retirement purposes, Congress places restrictions on the use of these funds.⁷⁶ Additionally, non-retirement uses of retirement funds generally are discouraged by a 10% excise tax on the taxable portion of all early distributions, unless the distributions are made on account of death, disability, or the attainment of age fifty-nine and one-half years.⁷⁷

Therefore, the MSA's distribution rules substantially deviate from traditional pension policy to the extent that they allow unrestricted, penalty-free distributions for health care expenses prior to retirement.⁷⁸ Regardless of whether the use of retirement funds for health care expenses is consistent or inconsistent with retirement income policy, pre-retirement distributions result in fewer dollars available at retirement. Thus, if individuals use MSAs as retirement instruments, their ability to withdraw the funds prior to retirement ultimately could affect their retirement income security.⁷⁹

The following example illustrates numerically how the MSA can be used as a more flexible retirement savings alternative than traditional retirement savings arrangements. Consider a self-employed taxpayer with \$2000 of discretionary income. The taxpayer establishes an MSA catastrophic plan and deposits the \$2000 in the associated savings account. If this individual has no medical expenses in the first year, or chooses not to use the savings account for such expenses, she will have \$2000 plus the

75. See Gustave Simons, *Qualifying a Plan: Tax and Legal Aspects of Pension Planning*, in HANDBOOK FOR PENSION PLANNING 47, 49 (BNA ed., 1949) (stating that preferential tax treatment with regard to contributions to retirement savings illustrates a strong congressional policy towards encouraging the establishment of pension reserves).

76. The requirements for qualified retirement plans are found in I.R.C. § 401(a). Section 1.401-1(b)(1) of the Treasury Regulations explains that a pension plan qualified under § 401(a) of the code is a plan established and maintained to provide primarily retirement benefits, and profit sharing and stock bonus plans are arrangements that primarily provide deferred compensation; accordingly, benefits such as death benefits and life and health insurance must be incidental only. Treas. Reg. § 1.401-1(b)(1). Pension plans may provide benefits for sickness, accident, hospitalization, and medical expenses subject to the requirements of I.R.C. § 401(h). See JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 151, 164 n.2 (2d ed. 1995).

77. See I.R.C. § 72(t)(1)-(2)(A)(i)-(iii) (1994).

78. See I.R.C. § 220(f)(1) (Supp. II 1996).

79. See Regina T. Jefferson, *The American Dream Savings Account: Is It a Dream or a Nightmare?*, in TAXING AMERICA 253, 261 (Karen B. Brown & Mary Louise Fellows eds., 1996) (discussing effects of early distributions on retirement savings).

tax-free buildup available for distribution at retirement.⁸⁰ This result would be the same if she had placed her \$2000 in a traditional IRA. Unlike in a traditional IRA, however, the taxpayer has penalty-free access to MSA funds needed for medical expenses prior to retirement, without first having to meet the 7.5% floor of I.R.C. § 213.⁸¹

Presumably, the MSA's flexible distribution rules are appealing especially to individuals with limited financial resources who may be reluctant to save in traditional IRAs or employer sponsored retirement plans for fear of losing access to their funds. For this reason, MSA savings may be accomplished at the expense of traditional IRA savings or employer sponsored elective contribution plans, such as 401(k) plans, in which distributions prior to retirement are more restricted.⁸² An argument could be made that increased savings is desirable in any form and, therefore, whether individuals save in MSAs or traditional retirement savings vehicles is irrelevant. However, a shift from traditional retirement savings to MSAs does not represent increased individual savings, but merely a change in savings instruments and objectives.

Moreover, the ability to use retirement savings for non-retirement purposes without restriction may have far reaching consequences.⁸³ If medical and retirement savings goals are combined for purposes of the MSA, it would seem that policymakers would be forced to consider combining these goals for all other tax-preferred retirement savings vehicles. A failure to consider such a combination would result in different distribution rules for similar tax-preferred retirement savings vehicles. This inconsistency introduces unnecessary complexity to the private pension system. Taxpayers will find it more difficult to make informed decisions regarding the available options for retirement savings, without the benefit of extensive education and training. An average taxpayer with \$2000

80. See Margaret O. Kirk, *Medical Accounts: Mixed Reviews*, N.Y. TIMES, July 5, 1998, § 3, at 6 (explaining how taxpayers can opt to not use MSA funds for medical expenditures).

81. See I.R.C. § 220(f)(1) (Supp. II 1996). Traditional IRAs allow distributions for medical expenses that are deductible under § 213 of the Code. See I.R.C. § 72(t)(2)(B). Thus, a taxpayer first must meet a floor of 7.5% of adjusted gross income, see I.R.C. § 213(a) (1994), before such amounts are available without penalty for distribution, see I.R.C. § 72(t)(2)(B) (Supp. II 1996).

82. See I.R.C. § 401(k) (West Supp. 1998). A 401(k) plan allows an employee to elect to have a portion of their compensation contributed to a qualified retirement plan. See *id.* § 401(k)(2)(A); see also Jefferson, *supra* note 79, at 264 (discussing the adverse effects of more flexible distribution rules on employer sponsored elective contribution plans).

83. See Stephen L. Ferraro, *MSAs Offer Health Care Option for Small Business*, CAP. DIST. BUS. REV., Sept. 8, 1997, at 13B, available in 1997 WL 10936080 ("MSAs represent a paradigm shift in today's health care equation.").

to invest in retirement savings today is faced with such an array of choices that making the best decision can prove quite challenging. She must consider, for example, the varying contribution limits, distribution rules, and tax treatment for traditional IRAs and Roth IRAs.⁸⁴ Both of these individual savings arrangements can be equally as effective for retirement savings, but are governed by very different taxation and distribution rules.⁸⁵ Therefore, the introduction of the MSA impacts the existing retirement system to the extent that it introduces an additional tax-preferred savings vehicle, with different rules and regulations, in which individuals may choose to save for retirement.⁸⁶

B. Pension Law and MSAs

The MSA retirement savings feature is inconsistent not only with existing pension policy, but also with existing pension law. The Employee Retirement Income Security Act of 1974 (ERISA)⁸⁷ governs employer-sponsored retirement plans.⁸⁸ In order to receive preferential tax treat-

84. The Taxpayer Relief Act of 1997, Pub. L. No. 105-34, 111 Stat. 788, established a new type of IRA, referred to as the "Roth IRA," named after its principal sponsor, Senator William Roth (R-Md.). See *id.* sec. 302, § 408A, 111 Stat. at 825 (codified at I.R.C. § 408A) (West Supp. 1998). The maximum amount that can be contributed to the Roth IRA is \$2000, the same as traditional IRAs. See I.R.C. § 408A(c)(2) (West Supp. 1998). In the traditional IRA, contributions are deductible but withdrawals on retirement are taxable. See I.R.C. §§ 219(a), 408(d) (1994). In the Roth IRA, however, contributions are not deductible, but withdrawals on retirement are tax exempt. See I.R.C. § 408A(c)(1), (d)(1)(A) (West Supp. 1998). A numerical demonstration can show that, when a taxpayer's marginal tax rate remains constant, the traditional and Roth IRA provide identical benefits. See STEPHEN B. COHEN, FEDERAL INCOME TAXATION: A CONCEPTUAL APPROACH 908 (1989 & 1998 Update at 29).

85. Compare *e.g.* I.R.C. § 219(a), and *id.* § 408(d), with *id.* § 408A(c)-(d).

86. See Linda Stern, *Medical Savings Account Offers a Great Tax Deal*, SUN-SENTINEL (Ft. Lauderdale), Sept. 1, 1997, at 18, available in 1997 WL 11399316 (noting that consumers who "are a little bit crafty about administering [an MSA] plan . . . [may enjoy] an additional tax-free pot of money to retire on").

87. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)).

88. See 29 U.S.C. § 1003(a) (1994) (explaining the coverage of the Act). Section 1001 of the Act articulates the congressional intent under ERISA:

The Congress finds . . . that the continued well-being and security of millions of employees and their dependents are directly affected by [employee benefit plans]; . . . it is therefore desirable in the interests of employees and their beneficiaries, . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

....

It is hereby declared to be the policy of [ERISA] to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . .

Id. § 1001(a)-(b); see also *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 975-76 (5th Cir. 1991) ("Congress enacted ERISA . . . to protect working men and women from abuses in

ment, all retirement plans must comply fully with the applicable requirements and standards of ERISA.

Because MSAs may be used effectively as retirement savings vehicles, some portion of the revenue forgone in connection with the MSA program finances retirement savings. Thus, the cost of the program's savings feature, specifically the tax-free buildup of excess contributions, is justifiable only if that portion of the program comports with rules and regulations for the existing retirement income program.⁸⁹ Accordingly, the retirement savings feature of the MSA program should be evaluated under ERISA to see if that portion of the program complies with applicable pension law.

Interestingly, there has been little discussion about the applicability of ERISA to MSAs. As a result, many important questions about the impact of ERISA on the MSA program have been left unanswered. For example, it is unclear whether, or to what extent, the fiduciary rules of ERISA apply to MSAs.⁹⁰ Specifically, it is uncertain whether the MSA is an employer-funded arrangement that would satisfy the requirements of an ERISA welfare benefit plan, thereby subjecting the employer to the fiduciary duties provided under ERISA.⁹¹

Under ERISA, an employee welfare benefit plan is defined as

any plan, fund, or program . . . established or maintained by an employer or by an employee organization, . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death . . .⁹²

the administration and investment of private retirement plans and employee welfare plans.") (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1370 (11th Cir. 1982) (internal quotations omitted)); *Kornman v. Blue Cross/Blue Shield of La.*, 662 So. 2d 498, 501 (La. Ct. App. 1995) (explaining that ERISA is designed principally to safeguard "workers participating in employee benefit plans from misappropriation and misuse of funds paid into the plan and other abuses by regulating the administration of the plans").

89. See ALICIA H. MUNNELL, *THE ECONOMICS OF PRIVATE PENSIONS*, 43-61 (1982) (discussing the lost revenue or tax expenditure attributed to private pensions).

90. See *Stephens*, *supra* note 9, at 460; see also ERISA, 29 U.S.C. §§ 1001(b), 1021-31, 1101-1114 (requiring reporting and disclosure and laying out fiduciary responsibilities).

91. See *Stephens*, *supra* note 9, at 460; see also 29 U.S.C. §§ 1101-14 (fiduciary responsibilities).

92. 29 U.S.C. § 1002(1). An MSA is arguably an employee welfare benefit plan within the meaning of ERISA because the MSA is "(1) a 'plan, fund, or program' (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, [etc.] . . . benefits (5) to [plan] participants or their beneficiaries." *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982).

Therefore, the MSA could be considered an employee health benefit plan under ERISA⁹³ because the catastrophic health care feature can be viewed as a medical program established by the employer for the purpose of providing medical benefits to participants and their families. Alternatively, the retirement component of the MSA to which the health care plan is connected could be considered an employer-sponsored retirement plan.⁹⁴ The retirement feature of the MSA is structured similarly to the Simplified Employee Pension (SEP).⁹⁵ Under a SEP arrangement, the employer contributes to IRAs on behalf of covered employees in the same manner that an employer contributes to employer-deposit MSAs on behalf of covered employees.⁹⁶ Thus, the carry-over feature of the MSA functions as an employer-sponsored retirement benefit plan, indistinguishable from the SEP. Therefore, the fiduciary rules of Title I of ERISA should apply to MSAs under the theory that the program is either a welfare benefit plan, an employer-sponsored re-

However, much of the uncertainty surrounding ERISA's potential applicability to MSAs stems from the lack of judicial consensus as to the precise definition of an ERISA employee welfare benefit plan in the context of employer-sponsored insurance plans. *Compare* *Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991) (concluding that an employer's purchase of a policy, or of multiple policies, that insure a class of employees offers "substantial evidence," standing alone, that an employee welfare benefit plan is established), *and* *Donovan*, 688 F.2d at 1375 (holding an employer's purchase of a group health insurance policy to provide its employees with health coverage is evidence of, but not itself, a plan), *with* *Kornman*, 662 So. 2d at 502 (reasoning that relying solely upon whether an employer contributes insurance premiums in determining whether ERISA applies to group health insurance policies disregards other critical factors with respect to the degree of control an employer maintains over a plan), *and* *Robertson v. Gem Ins. Co.*, 828 P.2d 496, 502-03 (Utah Ct. App. 1992) (holding that an employer's "bare contribution" of insurance premiums in providing employee insurance coverage is insufficient to establish the existence of an ERISA plan).

93. *See* *Stephens*, *supra* note 9, at 460 (warning that determining whether an employer-established MSA plan would constitute an employee benefit plan within the meaning of ERISA is an important threshold consideration); *see also* *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) (explaining that although no single act, by itself, brings a plan under the ambit of ERISA, an employer nonetheless can establish such a plan "rather easily").

94. ERISA defines a retirement plan as one that is "established or maintained by an employer or by an employee organization" and that "(i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond." 29 U.S.C. § 1002(2)(A).

95. I.R.C. § 408(k) (1994 & Supp. II 1996).

96. *See* LANGBEIN & WOLK, *supra* note 76, at 151. Essentially, the SEP is an IRA which is funded by the employer. Special limitations similar to those for qualified plans are imposed on SEPs. *See id.* The SEP has an advantage over the traditional IRA because it allows larger contributions. *See id.* Although IRAs and SEPs are afforded similar preferential tax treatment to qualified plans, they are not qualified plans. *See id.* As such, SEPs are governed by statutory provisions that are separate and distinct from those applicable to qualified plans. *See id.*

tirement plan, or both.

Title I applicability would render employers who sponsor the MSA, and perhaps even insurance companies that sell the catastrophic insurance policies, ERISA fiduciaries.⁹⁷ As such, they would be subject to a duty to oversee the investment of the MSA funds.⁹⁸ In the event of a breach, ERISA fiduciaries are personally liable to the plan for any resulting losses.⁹⁹ Failure to apply the fiduciary rules of Title I to MSAs would seemingly frustrate ERISA's goal of providing greater protection to participants in employer-sponsored employee benefit plans.

The non-discrimination standard of ERISA raises similar issues of inconsistency regarding the retirement savings component of MSAs.¹⁰⁰ In order to maintain their tax-preferred status, qualified employer-sponsored retirement savings plans must comply with ERISA's complex non-discrimination rules.¹⁰¹ These rules prohibit plans from favoring highly compensated employees over non-highly compensated employees.

Although MSA legislation requires an employer establishing an employer-deposit MSA to make comparable contributions on behalf of all participating employees, because the MSA is not labeled a "qualified" retirement plan, ERISA's anti-discrimination standards do not apply.¹⁰²

97. See 29 U.S.C. § 1104 (defining ERISA fiduciary duties).

98. See *id.* § 1104(a).

99. See *id.* § 1109(a).

100. See I.R.C. § 410(b) (1994). The non-discrimination rules ensure that employers do not, beyond levels of permitted disparity, provide greater benefits to highly compensated employees than to non-highly compensated employees. See *id.*

101. See generally *id.* § 410.

102. I.R.C. § 410(b)(1) provides that as a condition of qualification, a plan must satisfy one of the minimum coverage tests set forth in I.R.C. § 410(b) and the regulations thereunder. For elective contributions plans in which participants choose whether to have the employer make contributions to the plan directly or in cash to the employee, referred to as 401(k) plans, there are additional non-discrimination requirements to ensure non-discriminatory levels of participation by non-highly compensated employees. See I.R.C. § 401(k)(3)(A) (1994 & Supp. II 1996). However, the non-discrimination requirements for MSAs are different. In order for an MSA to be considered non-discriminatory, comparable contributions must be made available to all employees. See I.R.C. § 4980E(a)-(d) (West Supp. 1998). A failure to meet the requirements of § 4980E(a) results in the imposition of a tax equal to 35% of the aggregate amount contributed to the MSAs in a given tax year. See *id.* § 4980E(b). The employer must make available comparable contributions to the MSAs of all participating employees for each year of coverage. See *id.* § 4980E(d)(1). The contributions may be the same dollar value or "the same percentage of the annual deductible limit under the high deductible health plan covering the employees." *Id.* § 4980E(d)(2)(a). For example, assume an employer maintains two different high deductible plans. Under one plan, the deductible for single coverage is \$1500 and \$3000 for family coverage. Under the second plan, the deductibles are \$2,000 and \$4,000 respectively. Further assume that the employer's contribution to the MSAs of participating employees of the first plan is \$500 for singles and \$750 for families. The amount contributed to the

Accordingly, if an employer makes the MSA available on a non-discriminatory basis, but only the highly compensated employees choose to participate, the plan would not be considered discriminatory.¹⁰³ This result is inconsistent with ERISA's treatment of other elective retirement arrangements in which plans must be non-discriminatory in both design and operation.¹⁰⁴

Finally, as discussed above, the distribution rules for MSAs are inconsistent with the distribution rules that govern other employer-sponsored retirement arrangements.¹⁰⁵ Although individuals are discouraged by the 10% excise tax from taking early distributions from other retirement arrangements (e.g., IRAs and 401(k) plans), they are actually encouraged to do so from MSAs with the tax-free treatment of distributions for medical expenditures.¹⁰⁶

Different fiduciary standards, coverage requirements, and distribution rules for MSAs result in disparate treatment among available retirement arrangements. Not only do these inconsistencies introduce an unnecessary level of complexity to the pension system as discussed above, but they also produce peculiar results. On the one hand, the burdensome rules and regulations of ERISA are imposed on employers who choose to offer qualified retirement arrangements to their employees in order to ensure that plan participants receive sufficient protection.¹⁰⁷ On the other hand, because MSAs are excepted from ERISA's rules and regulations, employers are encouraged to offer them and individuals are induced to participate in them, resulting in less protection to plan participants. Even if one concludes that the MSA's goal of encouraging

second plan will be nondiscriminatory if the contribution is either \$500 for singles and \$750 for family coverage, or \$667 for singles and \$1000 for family coverage. See CANAN & MITCHELL, *supra* note 36, § 10.2A, at 323.

103. Some plans may allow employees to choose between employer contributions to an MSA or to another health plan. See CANAN & MITCHELL, *supra* note 36, § 10.2A, at 323. Thus, if the non-highly compensated employees disproportionately elect not to receive contributions to MSAs, a plan potentially could have only highly compensated individuals participating. See *id.*

104. See, e.g., I.R.C. § 410(b)(1); see also *id.* § 401(k)(3)(A). Section 401(k) plans are nondiscriminatory if an insufficient number of non-highly compensated employees elect to participate, regardless of the availability of the benefit to non-highly compensated employees. See I.R.C. § 401(k)(3)(A) (West Supp. 1998). It should be noted that there are safe harbor rules for satisfying the nondiscrimination test for elective contribution plans. See *id.* § 401(k)(12).

105. See *supra* notes 73-81 and accompanying text (discussing the disparate distribution rules for MSAs versus other tax preferred retirement arrangements).

106. See *supra* note 77 and accompanying text (identifying the 10% excise tax on pre-retirement distributions under I.R.C. § 72(t)).

107. See I.R.C. § 401(a).

individuals to become more involved in their health care choices overrides the need for consistency between the MSA and other retirement savings programs, it is nevertheless important to acknowledge and explain the differences and similarities in these arrangements. This discussion must take place in order to maintain support for the existing retirement programs, and to avoid unnecessary confusion about the rules governing the different individual retirement savings vehicles.

C. A Comparison of MSAs and Flexible Spending Accounts (FSAs)

Some commentators have maintained that MSAs are not a new concept, but are simply a variation of existing § 125 plans, commonly known as Flexible Spending Accounts (FSAs).¹⁰⁸ Under current law, employees may contribute pre-tax money to FSAs to pay for medical expenses not covered by their health insurance.¹⁰⁹ FSA funds not used for medical expenses during a given year are forfeited by the employee at the end of the plan year.¹¹⁰ Thus, because FSA funds may not be carried over, account holders have incentives to spend as much of their FSA funds as possible before the end of the year. By contrast, excess MSA contributions may accumulate tax-free and may be withdrawn without penalty after death, disability, or when an account holder reaches retirement age.¹¹¹ Thus, FSAs and MSAs are very different concepts. They are similar only to the extent that both can be used for current medical expenses. Unlike MSAs, however, FSAs have no carry-over feature and, therefore, cannot be used effectively as long-term savings arrangements.

IV. MSAS DISPROPORTIONATELY BENEFIT THE WEALTHY

The MSA program was established as a means of furnishing savings opportunities to all Americans.¹¹² However, the program's savings feature, in connection with the self-employed MSA, benefits high-income taxpayers disproportionately and provides little or no benefit to low-income taxpayers. Consequently, as designed, the program is incapable

108. See generally I.R.C. § 125 (1994 & Supp. II 1996) (permitting exclusions for benefits provided in connection with employer "cafeteria plans" that otherwise would be included in gross income).

109. See I.R.C. § 125(g)(2) (1994) (special rule for health benefits).

110. See AMERICAN ACADEMY OF ACTUARIES, MEDICAL SAVINGS ACCOUNTS: COST IMPLICATIONS AND DESIGN ISSUES 1 (1995) [hereinafter COST IMPLICATIONS AND DESIGN ISSUES].

111. See *supra* notes 33-39 and accompanying text (discussing the tax treatment of unused MSA funds).

112. See *supra* note 9 and accompanying text (discussing improving the availability of affordable healthcare under the HIPAA).

of delivering the intended benefits to many of its anticipated beneficiaries.

A. *The Impact of Greater Discretionary Income*

One reason the MSA program disproportionately benefits highly compensated individuals is because it effectively expands the IRA contribution limit.¹¹³ Under current law, annual IRA contributions are limited to \$2000.¹¹⁴ By saving \$2000 in an MSA as well as \$2000 in a traditional IRA, however, a self-employed taxpayer can double the IRA limit.

Low and moderate-income taxpayers will derive significantly less benefit from an increased contribution limitation than high-income taxpayers, because households that contribute to IRAs tend to be wealthier than households that do not.¹¹⁵ Studies conducted by the Center on Budget and Policy Priorities indicate that, prior to 1986, when taxpayers at all income levels could contribute up to \$2000 to an IRA and deduct the contribution from their taxable income, 82% of all IRA deductions were taken by individuals in the top one-third income bracket.¹¹⁶ Only 8% of households earning between \$10,000 and \$20,000 made IRA contributions during the same period.¹¹⁷ Presumably, the lower IRA participation rate among low-income individuals was attributed to low earnings.¹¹⁸ Thus, it appears that low-income Americans earn insufficient wages to take advantage of the MSA program's expansion of the IRA limit.¹¹⁹ The only beneficiaries of the increased IRA contribution limit are individuals who already contribute the maximum amount to their

113. See *supra* note 71 (describing IRA contribution limits).

114. See I.R.C. § 219(b)(1) (1994). It should be noted that when contributions are made to both a traditional IRA and a Roth IRA, there is a collective limit of \$2000. See I.R.C. § 408A(c)(2) (West Supp. 1998).

115. See JAMES R. STOREY, INDIVIDUAL RETIREMENT ACCOUNT ISSUES AND SAVINGS ACCOUNT PROPOSALS CRS-5 (Cong. Res. Serv. No. IB89085, 1995).

116. See Iris J. Lav, *Senate Leadership Tax Proposals: Mushrooming Tax Cuts for High-Income Taxpayers Would Jeopardize Long-Term Budget Integrity* paras. 15-18 (visited Jan. 23, 1999) <<http://www.cbpp.org/taxrpt226.htm>> (discussing IRA beneficiaries).

117. See JAMES R. STOREY, INDIVIDUAL RETIREMENT ACCOUNTS (IRAS): LEGISLATIVE ISSUES IN THE 105TH CONGRESS CRS-6 (Cong. Res. Serv. No. 96-20 EPW, 1998).

118. See Jefferson, *supra* note 79, at 267.

119. Cf. *id.* (discussing a similar effect on low-income Americans in relation to "The American Dream Savings Account"). This discussion pertains to MSAs established by self-employed individuals. Although the disproportionate benefit to taxpayers with higher marginal tax rates occurs with respect to all deductions and exclusions, the fact that the MSA increases existing regressivity in the tax system is particularly troubling because it is a program touted to be responsive to the health needs of all Americans. See *supra* note 9 and accompanying text (citing preamble to the HIPAA).

IRAs. Consequently, the MSA program increases the disparity between the tax subsidy received by individuals who currently can afford to save and those who cannot.

B. The Effects of Higher Marginal Tax Rates

Another reason the MSA disproportionately benefits the wealthiest members of society is because of the progressive tax rate structure; the applicable tax rate increases as an individual earns more income. Thus, the benefit of an exclusion depends on the marginal tax rate of the taxpayer.¹²⁰ To illustrate, assume an employer makes a contribution of \$500 on behalf of two workers, A and B, in 40% and 20% tax brackets, respectively. If A and B were taxed on the \$500 contribution, A would pay a tax of \$200, and B a tax of \$100. However, because the contribution is excluded from each taxpayer's gross income, neither pays any tax on the \$500 contribution. Accordingly, the exclusion for MSA contributions is more valuable to A than it is to B.¹²¹ Similarly, the tax-free buildup of excess amounts in MSAs is more valuable to high-income taxpayers.

Employer-provided payments for health insurance premiums in connection with traditional health care programs also generally are excluded from an employee's gross-income.¹²² This exclusion, like the MSA exclusion, disproportionately benefits wealthy taxpayers not only because the value of the exclusion increases as income rises, but also because upper-income taxpayers typically work for organizations that provide the most generous employer health care contributions.¹²³ Therefore, the MSA does not create the inequities that exist in the current health care system with respect to disparate treatment among taxpayers in different tax brackets for employer-provided health benefits, but the MSA exacerbates the situation by allowing a tax-free buildup of unused funds in addition to an exclusion for employer-provided health benefits. This result is troubling, especially because the MSA program is marketed as a medical savings program designed to make the health care system operate more fairly and increase the availability of affordable health care to all Americans.

120. See I.R.C. § 1 (West Supp. 1998) (listing the applicable tax rates).

121. That is, 40% of \$500 equals \$200 and 20% of \$500 equals \$100.

122. See I.R.C. § 106(a) (Supp. II 1996). These expenses also are deductible by the employer under I.R.C. § 162(a) (West Supp. 1998) as business expenses.

123. See COHEN, *supra* note 84, at 145-47; see also Pauly & Goodman, *supra* note 31, at 275.

V. MSAS DISPROPORTIONATELY BENEFIT THE HEALTHY

Proponents of the MSA program maintain that catastrophic policies are relatively inexpensive and cost considerably less than traditional low-deductible plans.¹²⁴ Accordingly, they argue, an employer-deposit MSA theoretically could be funded by the difference in the cost of a high-deductible plan and a low-deductible plan without increasing an employer's overall cost.¹²⁵

Skeptics argue, however, that the cost of high-deductible plans vary and, in many instances, are more expensive than proponents suggest.¹²⁶ When premiums for high-deductible policies are not significantly less than those for conventional plans, employers who maintain their contribution levels have only small amounts available to fund employees' tax-free savings accounts.¹²⁷ As a result, in these situations neither the savings account nor the high-deductible policy will cover many of the medical expenses incurred by account holders.¹²⁸ Thus, although the primary goal of the MSA program ultimately is to make health care more affordable, in some instances participation in the MSA program may actually increase the out-of-pocket medical expenses for certain individuals, making it more difficult for them to obtain necessary medical services.¹²⁹

Individuals who spend less than the amounts contributed by employers to their MSAs will experience gains. Therefore, for the vast majority of

124. See Chris Bjornson & Douglas K. Barney, *Tax Planning for Small Businesses: A Dozen Helpful Strategies*, 43 NAT'L PUB. ACCT. 11, 18 (1998) ("High-deductible insurance will cost the company less than more traditional low-deductible plans."); see also Jim Gallagher, *A Few Pioneers Find Health Care Less Taxing*, ST. LOUIS POST-DISPATCH, July 13, 1997, § E, at 1 (noting that high-deductible plan premiums are often half those of low-deductible plans).

125. See Brad Carlson, *MSAs: Participants See Benefits to Alternative Coverage*, IDAHO BUS. REV., Mar. 17, 1997, at 1A, available in LEXIS, News Library, BusDTL File ("Theoretically a high-deductible policy would leave the owner with more money to put into the MSA . . .").

126. See Len M. Nichols, *Who Will Jump Into the MSA Pond?*, BUS. & HEALTH, Oct. 1996, at 47, 51 (arguing that the decrease in premiums charged to employers as a result of their changing to catastrophic plans would pay for less than one-half of the increase in deductibles).

127. See *News Hour: Sick Days* (PBS television broadcast, June 6, 1996), available at *Online NewsHour: Medical Savings Accounts* (visited Oct. 27, 1998) <<http://www.pbs.org/search>> (use search term "sick days") [hereinafter *Sick Days*] (statement of Gail Shearer, Consumers Union); see also Bennett Roth, *Medical Program Looks Sickly: Congress Debating Savings Accounts*, HOUSTON CHRONICLE, Aug. 16, 1998, at 1D (stating that "many people are afraid they won't have enough money in their accounts to cover regular medical expenses").

128. See *Sick Days*, *supra* note 127 (statement of Gail Shearer, Consumers Union).

129. See Kirk, *supra* note 80, § 3, at 6.

Americans, who spend approximately \$960 annually on health care, a yearly MSA contribution greater than \$960 would produce a surplus.¹³⁰ For this reason, employees with histories of little or no health care costs are more likely to prefer employer-deposit MSAs, because they stand to benefit from the carryover of unused contributions.¹³¹

Although healthy individuals stand to gain in the short-run from the ability to select medical benefits according to their own interests and risk tolerance, this flexibility could lead to a massive self-selection process, which eventually would segregate the health insurance market.¹³² The healthiest individuals will remove themselves from the larger insurance pool for traditional insurance arrangements, leaving only older and sicker individuals to be covered by these insurance arrangements. Ultimately, this situation will result in prohibitively high insurance premiums for the most vulnerable members of society, making it difficult for them to obtain adequate insurance protection.¹³³

VI. MSAs DISPROPORTIONATELY BENEFIT THE MOST INFORMED

A. Shopping for the Best Price

MSA proponents argue that because MSA funds eventually may be used for non-medical expenditures, the program provides incentives for individuals to be more selective about the services they purchase than they would be under conventional health care plans.¹³⁴ Accordingly, they contend, over time MSAs will reduce appreciably the cost of medical care.¹³⁵

130. See Burry, Jr., *supra* note 52.

131. See *id.*

132. See Michele Conklin, *Insurance Innovation: Experiment Provides For Medical Savings Accounts for Small Firms, Self-Employed*, ROCKY MTN. NEWS, Jan. 5, 1997, at B5 (arguing that healthy people who use MSAs as a savings vehicle will "split the insurance pool and drive up costs for the sick").

133. See *id.*; see also Charles Ornstein, *Few Choose Pilot Health Program: Critics Say Medical Savings Accounts Favor the Wealthy*, DALLAS MORNING NEWS, July 23, 1998, at 1D (citing the results of a 1996 Urban Institute study that premiums of traditional health plans will rise by 335% if the healthy population removes itself).

134. See Gallagher, *supra* note 124, §E, at 1 (contending that by spending their own money, and not that of the insurance company, individuals will "price-shop more" and forego unnecessary medical care). Opponents, however, argue that this price-shopping will result in a neglect of preventive care, such as annual checkups. See *id.*; see also Danshera Cords, Comment, *The Medical Savings Account Provision of the HIPAA: Is It Sound Health and Tax Policy?*, 21 SEATTLE UNIV. L. REV. 1217, 1228 (1998) (arguing that this neglect of preventive care could result in "a reduction in the general level of health of account holders").

135. See Gallagher, *supra* note 124, §E, at 1.

The underlying assumptions of this “more selective” theory are that individuals are able to compare the prices of different medical treatments, are fully informed about their medical conditions, and are fully aware of all of the available treatment options. It is unlikely, however, that the average consumer satisfies all of these conditions.¹³⁶ Most individuals are not qualified to perform cost-benefit analyses of appropriate health care procedures. Moreover, the circumstances surrounding many medical emergencies would not lend themselves to an economically driven decision-making process for individuals who are not expert in the field of medicine.¹³⁷ For example, it is unrealistic to expect the average parent of a sick child to investigate the cost of a penicillin injection in order to determine whether the benefits of such treatment justify the expense.¹³⁸

The relatively few individuals who possess significant medical knowledge may indeed benefit from an opportunity to shop for competitive prices and treatment. It is important, however, to question the wisdom of encouraging those individuals who lack medical expertise to make decisions that would withhold recommended medical treatment from themselves or others in order to save for future medical emergencies, or retirement savings goals. If the MSA program causes such individuals to make unwise health decisions, the program could be counter-productive, increasing future medical costs.¹³⁹ Although consumer education would remedy this problem, an initiative to educate the entire population of health care consumers would require considerable time, effort, and ex-

136. See David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 451 (1998) (arguing for more aggressive consumer protection regulation in the United States health care market because consumers are “weak, ignorant, poor and disorganized” and have a “limited ability to ‘shop around’”). Furthermore, by forcing individual consumers to shop for the best prices, MSAs actually may delay the receipt of timely care to those individuals. See Russell, *supra* note 8, at 560.

137. See COST IMPLICATIONS AND DESIGN ISSUES, *supra* note 110, at 3 (“Clearly, in medical emergencies, shopping around for a lower-cost provider is rarely in the cards . . .”); see also Cords, *supra* note 134, at 1227 (noting the unlikely situation of an individual who is en route to a hospital in an ambulance deciding which hospital she should go to based on cost). Additionally, once at the hospital or the doctor’s office, it is virtually certain that an individual consumer will not possess the bargaining power to receive a better price. See *id.*; see also *Medical Savings Accounts—A Bad Idea*, *supra* note 53 (arguing that under an MSA plan, “group-negotiated rates would not be possible”).

138. See Burry, Jr., *supra* note 52.

139. See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 381 (1997) (arguing also that “MSAs would not improve health expenditure efficiency because personal control of health expenditures is inconsistent with the structure of cost containment through managed care, where systemic utilization review channels spending choices”).

pense.

B. Gaming the System

The MSA not only rewards those who have expertise in the health care area, but also those who have advance notice about their medical conditions and, therefore, are able to predict more accurately their medical expenditures. Because MSA legislation limits the ability of insurance providers to impose pre-existing condition clauses,¹⁴⁰ employer-deposit MSAs allow certain individuals to “game” the system.¹⁴¹ In years in which individuals anticipate higher medical expenses, such as those associated with starting a family or undergoing elective surgery, it is advantageous for them to elect conventional plan coverage.¹⁴² In other years, when such expenses are not expected, it is advantageous for them to choose the catastrophic insurance protection under the MSA program. By using this strategy, individuals able to predict or plan their medical expenses can receive substantial windfalls.¹⁴³

Under the current health care system, an individual could utilize a similar strategy. By opting-out of conventional coverage and making contributions to an FSA in years in which the individual anticipates

140. See HIPAA, Pub. L. No. 104-191, 110 Stat. 1936, 1939-40 § 101(a) (codified at 29 U.S.C. § 1181 (Supp. II 1996)) (limiting the amount of time of any such exclusion to twelve months for individual participants who enroll in the plan in a timely manner). The HIPAA amended § 701 of ERISA in an effort to eliminate “job lock.” See Cords, *supra* note 134, at 1248. Job lock occurs when an individual with preexisting conditions is unable to obtain new health insurance, and therefore is restricted from changing jobs. See *id.* at 1248 n.197.

141. See *Medical Savings Accounts-A Bad Idea*, *supra* note 53.

142. See *id.*; see also Elliot K. Wicks & Jack A. Meyer, *The Role of Medical Savings Accounts in Health System Reform* (May 1998) <<http://www.nchc.org/emerger/medicare2-0698.html>> (arguing that “[o]ver time, switchers in the aggregate may pay substantially less than their full share of the care they receive . . .”). This “bunching” of medical expenses in a given year to reap tax benefits already occurs with respect to deducting medical expenses under § 213 of the I.R.C. See Liz Pulliam, *Be Stingy With Uncle Sam: A Few Adjustments Now to Your Tax Status or Retirement Plans Can Lop Hundreds, If Not Thousands, of Dollars Off Your '98 Bill*, L.A. TIMES, Oct. 4, 1998, at D1 (advocating “scheduling medical exams and elective procedures before Dec[ember] 31 if your medical expenses for the year are already close to the deductible threshold, which is 7.5% of your adjusted gross income”). By planning to undergo certain procedures all in a given year, rather than across several years, an individual could deduct amounts from their taxes that they may not otherwise have been able to deduct. See *id.* For wealthier individuals, however, this serves as a “generous subsid[y]” for elective procedures such as plastic surgery. See COHEN, *supra* note 84, at 145 (quoting a 1980 Congressional Budget Office Study on medical care).

143. See Wicks & Meyer, *supra* note 142.

lower medical expenses,¹⁴⁴ a taxpayer could both save annual premium costs and reduce their out-of-pocket costs for expected medical expenses by paying with pre-tax dollars. However, there is less incentive to use this strategy with FSAs because, as discussed above, there is no possibility of carry-overs or potential retirement savings in the event of a year-end surplus.¹⁴⁵

C. Awareness

Finally, because the number of MSAs is limited and the program is temporary, individuals who know to act prior to the effective dates of the interim limits, or the program cut-off date, to establish their accounts could benefit at the expense of individuals who are unaware of the program, or fail to fully comprehend the complexity of the MSA pilot. MSA legislation allows no more than 750,000 accounts to be established during the experimental phase.¹⁴⁶ These accounts are awarded on a first-come, first-served basis. Additionally, there are interim limits that establish various "cut-off-dates" by which employees or self-employed individuals must set up their MSAs in order to qualify for the program.¹⁴⁷ Once an interim limit is met, no new accounts will be granted tax-exempt status, although contributions may continue to be made to existing accounts.¹⁴⁸

144. See Pulliam, *supra* note 142, at D1 (explaining that with flexible spending accounts, "you can save hundreds of dollars if you plan right"). It should be noted, however, that in certain circumstances, benefits under an FSA are considered "excepted benefits" and therefore not subject to the requirements of section 701 of ERISA. See Application of HIPAA Group Market Portability Rules to Health Flexible Spending Arrangements, 62 Fed. Reg. 67,688, 67,688 (1997).

145. See *supra* note 110 and accompanying text (explaining that FSA account holders are subject to a "use it or lose it" requirement that bars carrying-over unspent dollars to the next fiscal year); cf. Carrie J. Gavora & Robert E. Moffit, *Health Care: Improving Consumer Choice and Access*, in ISSUES '98: THE CANDIDATE'S BRIEFING BOOK ch.10 (1998), available at <<http://www.heritage.org/issues/chap10.html>> (FSA and MSA section) (arguing that the "use it or lose it" feature encourages families to spend for medical services that may be "only marginally desirable or beneficial" just so they spend all that is in their FSA account).

146. See I.R.C. § 220(j) (Supp. II 1996). Uninsured individuals who establish an MSA will not be counted in this number. See *id.* § 220(j)(3).

147. See *id.* § 220(i)(3)(C); see also BETH C. FUCHS ET AL., THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996: GUIDANCE ON FREQUENTLY ASKED QUESTIONS CRS-24 n.36 (Cong. Res. Serv. No. 96-805 EPW, 1998) (describing and explaining the provision's schedule of "cut off dates").

148. See FUCHS ET AL., *supra* note 147, at CRS-24. Because of uncertainty about the effects of the interim limits in particular, and the design of the MSA pilot program in general, Congress recently attempted to amend the HIPAA legislation. See *infra* note 197 (discussing the "Patient Protection" legislation passed by the House that would have expanded significantly the MSA program).

Thus, the MSA's structure and complexity potentially pit the unaware against the more aware. If interim limits are reached, self-employed individuals such as lawyers, doctors, and investment bankers,¹⁴⁹ who have access to financial advisors and planners, could prohibit the employees of smaller, non-professional businesses from ever establishing MSAs. Although the low levels of participation in the MSA program do not suggest that it is likely the interim limits actually will prevent individuals who desire to participate in the program from doing so, the mere possibility of rewarding the most informed population at the expense of the least informed is nevertheless a problem of perception.¹⁵⁰

VII. MSAS AND THE EXISTING HEALTH CARE SYSTEM

A. Health Care Policy

The MSA is designed to encourage cost-effective consumer behavior by increasing individual control over health care spending.¹⁵¹ Under the traditional health care model, patients rely heavily on their physicians' advice and recommendations regarding their health care treatment.¹⁵² As designed, however, the MSA program places the onus on patients to make these decisions more independently. Thus, the MSA program represents a paradigm shift away from existing health care policy.¹⁵³ This

149. MSAs presently are relatively popular among the self-employed. See Crenshaw, *supra* note 8, at H1 (noting that MSAs have been "big sellers" with law firms because of the tax benefits). For the self-employed, medical expenses under traditional health plans only could be deducted to the extent that they exceeded 7.5% of the individual's adjusted gross income. See *id.* With MSAs, however, all qualified medical expenses not covered by insurance are fully deductible to the extent that contributions to MSAs are fully deductible. See *id.*

150. See *supra* notes 147-48 and accompanying text (explaining the participation cut-off dates).

151. See *supra* notes 49-50 and accompanying text (explaining that MSAs were designed to increase individual control over medical spending, which in turn would encourage more prudent spending).

152. See ERIN DOMINIQUE WILLIAMS & LEO VAN DER REIS, HEALTH CARE AT THE ABYSS: MANAGED CARE VS. THE GOALS OF MEDICINE 169-70 (1997) (describing the traditional relationship between a physician and a patient as a "type of contract" in which both parties freely share information"); cf. John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions, The Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 6-7 (1996) (explaining that "[u]nder the traditional system . . . [t]he decision of which doctor to go to, how much care one receives and the amount charged for each service is between the patient and the doctor").

153. See Ferraro, *supra* note 83; see also Peter M. Clarke, M.D., Correspondence, *Medical Savings Accounts*, 331 NEW ENG. J. MED. 1158 (1994) (noting that placing the burden on patients to make their own decisions regarding health care will have "obvious consequences" of separating wealthy and poor patients).

shift not only alters the doctor-patient relationship, but also may have serious consequences on the delivery of medical treatment.

MSAs may cause some individuals to shun routine medical check-ups and other early-detection procedures to save money.¹⁵⁴ Financially strapped consumers will forgo the aspects of their medical care that they perceive as not urgently necessary; they will seek treatment only when their medical conditions become symptomatic or severe. However, illnesses that go undetected before they reach more advanced stages are both more difficult and expensive to treat. Therefore, the MSA program may undermine recent achievements in health care policy that emphasize the importance of prevention, health maintenance, and early detection. Those who defer early detection and preventive procedures in order to save money are likely to be less wealthy.¹⁵⁵ As a consequence, poorer individuals will suffer from certain diseases disproportionately, while wealthier individuals will continue to enjoy a full range of state-of-the-art medical services.¹⁵⁶ This result ultimately may increase the cost of medical treatment of some illnesses¹⁵⁷ and cause the health care system to be even more multi-tiered than it is today.¹⁵⁸

B. MSAs and the Rising Cost of Health Insurance Premiums

Most individuals who are covered under group and conventional health plans pay premiums in excess of the medical expenses that they incur.¹⁵⁹ This enables these plans to cover the cost of the relatively few

154. See *supra* note 136 (stating that the price-shopping caused by MSAs will cause individuals to neglect preventive care).

155. See Committee on Child Health Fin., American Acad. Of Pediatrics, *Principles of Child Health Care Financing*, 102 PEDIATRICS 994, 995 (1998) (arguing that MSAs "include economic disincentives for preventive care and favor higher income groups financially").

156. See Clarke, *supra* note 153, at 1158.

157. See *Medical Savings Accounts—A Bad Idea*, *supra* note 53 (noting that "[w]ithout preventive care, medical costs will eventually increase, since diseases and illnesses will be more advanced and, therefore, more costly to treat once detected").

158. See Clarke, *supra* note 153, at 1158 (arguing that high-income patients will receive outstanding care while low-income patients' health will suffer because they neglect diseases to save money).

159. See *Medical Savings Accounts—A Bad Idea*, *supra* note 53; see also Bryan Ford, Essay, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 121 (1994) (noting that health insurers using the "community rating" system typically charge all of their customers a premium equal to what they anticipate will be the average health expenses of the group). It is estimated that "85% of Americans spend less than \$3,000 a year on medical care, and 73% have less than \$500 a year in claims." *Consumer-First Health Care*, WALL ST. J., July 21, 1994, at A14.

individuals who experience costly illnesses or injuries.¹⁶⁰ Thus, the excess premiums paid by healthy participants are necessary to offset the cost of covering those who are sick. Studies show that even a modest self-selection process causes premiums for traditional and managed care plans to rise significantly; if as little as one-fourth of all insured individuals in traditional policy groups chose MSAs, premiums would rise by nearly two-thirds.¹⁶¹ Therefore, the removal of healthy individuals from the insurance pool eventually would drive up medical care costs for those who are unable to profit from their own health, and ultimately jeopardize the existence of conventional health insurance.¹⁶²

Although the self-selection process can benefit healthier individuals, even these individuals may be winners only in the short-run. As healthy individuals grow older and experience deteriorating health, they too will want to rely on conventional insurance for financial protection against increasing medical costs.¹⁶³ By that time, however, the cost of traditional, comprehensive health plans may be unaffordable. Consequently, the initial savings that a healthy individual enjoys by choosing an MSA today could be depleted by the cost of a single medical emergency later in life, when that individual's income is likely to be fixed. Therefore, both the healthy and unhealthy should be concerned that the MSA program threatens the viability of conventional health insurance.¹⁶⁴

C. MSAs and the Risk of Rising Health Care Costs

The MSA's failure to deliver affordable health care to all Americans, and its potential threat to the health care system does not necessarily render the MSA program void of value or its cost unjustifiable if the program is successful in curbing the rising costs of health care. However, this result is unlikely. Although supporters of MSAs believe that the

160. See Linda J. Blumberg & Len M. Nichols, *Health Insurance Market Reforms: What They Can and Cannot Do* (visited Jan. 18, 1999) <<http://www.urban.org/pubs/hinsure/insure.htm>> (stating that "[t]he principle behind insurance is to spread individual risks across a group").

161. See Len M. Nichols et al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, pt. III, question 3 (visited Jan. 18, 1996) <<http://www.urban.org/pubs/hinsure/winlose.htm>>.

162. See Blumberg & Nichols, *supra* note 160 (arguing that "insurance dropping" by low-risk individuals could lead to high prices, for which high-risk individuals do not have the ability to pay).

163. See *Medical Savings Accounts—A Bad Idea*, *supra* note 53 (explaining that healthy individuals will need comprehensive health insurance as they age).

164. See Ornstein, *supra* note 133, at 1D (quoting Gail Shearer, Director of Health Policy Analysis for Consumers Union: "Widespread MSAs will lead to premium spirals that could drive traditional policies out of the market.").

ability to accumulate unused account funds ultimately will reduce the cost of medical care,¹⁶⁵ studies have shown the MSA program will not have a significant impact on the costs of medical services.¹⁶⁶ Moreover, for the reasons set forth below, it is very likely that the cost of medical care will increase rather than decrease as a result of the MSA program.

1. Medical Health Dollars Spent on a Few

First, the MSA program targets the wrong population and the wrong medical expenditures to effectively reduce the cost of health care. The distribution of health care costs in this country is highly skewed.¹⁶⁷ Approximately 70% of Americans account for only 15% of national medical expenditures.¹⁶⁸ Nearly seventy-five cents of every dollar spent on health care in the United States is attributed to only 10% of the population,¹⁶⁹ and at least 80% of all health care expenditures are accounted for by individuals who spend more than \$2000 annually.¹⁷⁰ Consequently, a more effective way of decreasing medical care costs is to encourage the 10% of the population that spends the most to cut back on unnecessary or wasteful services.¹⁷¹ Additionally, medical expenses that typically exceed \$2000 should be the focus of any initiative for reduced medical care spending.¹⁷²

165. See Roth, Jr., *supra* note 51, at 152 (arguing that the patient choice aspect of MSAs will help to control health care costs); JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER: THE FREE-ENTERPRISE ALTERNATIVE TO CLINTON'S HEALTH PLAN 93* (1994) (contending that by allowing individuals to substitute less expensive self-insurance for more expensive third-party insurance for small medical bills, the result will be a lowering in general of the cost of health insurance). Additionally, proponents argue that the cost of health care coverage would be lowered because expensive third party insurance would be used only for catastrophic events. See *id.*

166. See Emmett B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 *JAMA* 1666, 1671 (1996) (concluding in an economic policy evaluation based on the RAND Health Expenditures Simulation Model that “[o]ur simulations show that the MSA approach is not likely to produce the reduction in health care use that its advocates foresee”).

167. See Blumberg & Nichols, *supra* note 160 (stating in the discussion of the current health insurance market that “[t]he most expensive 1 percent of our population accounts for 30 percent of all health spending”); see also Marilyn Moon et al., *Medical Savings Accounts: A Policy Analysis*, pt. III (visited Jan. 18, 1999) <<http://www.urban.org/pubs/hinsure/msa.htm>> (cautioning that the skewed distribution of health care spending must be considered in determining the potential for MSAs to reduce health costs).

168. See Burry, Jr., *supra* note 52 (“No Going ‘Back to the Future’” section).

169. See *id.*

170. See Moon et al., *supra* note 167, at pt. III (arguing that, because typical catastrophic policies under an MSA have a \$2000 deductible, “a majority of spending would be protected by insurance and hence not directly subject to the incentives established by the MSA/catastrophic [program]”).

171. See Burry, Jr., *supra* note 52 (“No Going ‘Back to the Future’” section).

172. See Wicks & Meyer, *supra* note 142 (arguing in the “Concerns of the Critics” sec-

The MSA model adopts neither of these approaches. Instead, the program targets the healthiest, wealthiest, and most informed members of society, rather than the most wasteful consumers and the most costly medical procedures.¹⁷³ Aside from the out-of-pocket deductibles, which arguably will not affect a large percentage of spending, the MSA fails to provide any other incentives to reduce medical care spending.¹⁷⁴

Furthermore, technological advances are the major reason that health care costs continue to escalate.¹⁷⁵ Many of these procedures are used in connection with inpatient settings, where costs typically exceed the MSA deductibles.¹⁷⁶ Accordingly, for these services, there would be no out-of-pocket cost once an account holder met the plan deductible.¹⁷⁷

It is even more unlikely that the MSA will affect the demand for high-priced medical procedures by seriously ill individuals once their plan deductibles are met.¹⁷⁸ Facing dire circumstances, seriously ill individuals who are insulated from the full cost of medical care are particularly unlikely to make decisions about medical treatment that a rational person incurring the full cost of medical care might make.¹⁷⁹ For example, an individual suffering from a life threatening disease may choose an extremely expensive procedure, notwithstanding a very small probability

tion, that “various kinds of care management practices and rules may still be necessary” to implement and to reduce costs of the expensive medical procedures that account for 84% of the nation’s medical care expenditures).

173. See discussion *supra* Parts IV, V, VI (explaining that MSAs will disproportionately benefit healthy, wealthy, and highly informed members of the population).

174. See Moon et al., *supra* note 167, at pt. III.

175. See Crimm, *supra* note 1, at 663-64 (explaining that “[i]ncreased adult life expectancy has resulted in large part from preventative and curative medical technology”); Gina Kolata, *New Era of Robust Elderly Belies the Fears of Scientists*, N.Y. TIMES, Feb. 27, 1996, at A1 (indicating that the mortality rate from chronic diseases plummeted 46.9% between 1960 and 1990).

176. See Moon et al., *supra* note 167, at pt. III (noting also that high spending associated with inpatient services is “generally less responsive to price effects than more discretionary outpatient services”).

177. See *id.* at pt. III. It should be noted, however, that an individual still may have an out-of-pocket expense equal to the amount of any co-payment that is associated with the catastrophic insurance policy. See Crenshaw, *supra* note 8, at H1 (explaining that a qualifying policy may require co-payments, although total annual out-of-pocket expenses, including the deductible, must be limited to \$3000 for an individual and \$5500 for a family).

178. See David Rind, M.D., Correspondence, *Medical Savings Accounts*, 331 NEW ENG. J. MED. 1158 (1994) (contending that the “rate of increase in the cost of medical care for the seriously ill [will] not be substantially reduced” with the advent of MSAs); Moon et al., *supra* note 167, at pt. III (arguing that “high priced procedures and techniques may actually face less market discipline if we move to an open-ended fee-for-service policy that fully protects families above the deductible as compared with pressures on technology in a managed care context”).

179. See Rind, *supra* note 178, at 1158.

for success.¹⁸⁰ Consequently, the widespread use of MSAs will have little impact on the most expensive types of medical treatment. They will also have little impact on the behavior of the relatively few individuals who disproportionately incur medical costs that exceed the MSA deductible.¹⁸¹ Thus, the MSA program is unlikely to succeed in reducing health care costs.

2. MSAs and Increased Administrative Costs

Second, the MSA debate rarely includes any discussion about additional collection and administrative costs. There will be, however, additional costs associated with the processing of small service invoices for individual patients.¹⁸² If the MSA program is expanded, hospital outpatient departments, clinics, and other health care providers will find it necessary to restructure their billing procedures to bill patients individually, rather than collectively through insurance companies, as many of the automated systems currently are equipped to do. Without the benefit of electronic billing, service providers will incur increased costs for hiring more processors to handle the additional workload.¹⁸³ Furthermore, under an expanded MSA program, service providers would incur higher default and collection costs associated with individualized billing processes.¹⁸⁴ Amounts expended for these indirect costs ultimately will be reflected in the cost of medical care, and may well offset any reduction in expenditures that the MSA otherwise may generate.¹⁸⁵

180. *See id.*

181. *See* Wicks & Meyer, *supra* note 142 (arguing, in the "Concerns of the Critics" section, that the large majority of medical expenses are above the MSA plan deductible and, therefore, do not provide any incentive for cost-containment).

182. *See* Jeanne Schulte Scott, *MSAs: Defining Terms and Setting Boundaries*, HEALTHCARE FIN. MGMT., Sept. 1996, at 26, 28 (arguing that billing to individuals will raise administrative costs). Proponents, however, argue that MSAs will reduce administrative expenses associated with traditional health insurance plans. *See* AMERICAN ACADEMY OF ACTUARIES, ISSUE BRIEF: MEDICAL SAVINGS ACCOUNTS 3 (May 1995) (arguing that administrative savings would result from MSAs because there would be fewer claims to process); American College of Physicians, Position Paper, *Medical Savings Accounts*, 125 ANNALS OF INTERNAL MED. 333, 337 (1996) (same).

183. *See* Scott, *supra* note 182, at 28. Additional administrative expenses also may be experienced by the IRS in monitoring MSA withdrawals. *See* *Medical Savings Accounts Come Out of the Wilderness*, HEALTH LEGIS. & REG., Jan. 25, 1995, at para. 21, available in 1995 WL 8354903 (arguing also that individual account holders would be burdened with record keeping). Furthermore, providers still would have to provide verification of medical expenses to insurers for the purpose of being reimbursed for amounts that exceed the deductible. *See* American College of Physicians, *supra* note 182, at 339.

184. *See* Scott, *supra* note 182, at 28.

185. *See* Cords, *supra* note 134, at 1245 (arguing that the costs of the record keeping and reporting requirements placed on account trustees and employees may exceed other

3. A Questionable Underlying Theory

The basic theory underlying the MSA program is that American health care consumers will consume as much health care as available, unless financial disincentives are created.¹⁸⁶ This theory may be true for most goods and services; however, health care is fundamentally different from other consumption items. Generally, there is no inherent personal benefit to the consumer who purchases excessively expensive drugs, or who undergoes unnecessary medical procedures.¹⁸⁷ By contrast, if an individual spends more on food, for example, than average amounts, it can be assumed that the increased expense results from personal choice. Presumably, the correlation exists between high medical costs and medical necessity, rather than between high medical costs and personal choice.¹⁸⁸

Furthermore, because individuals typically do not know what medical treatment they need, consumers shopping for health care face considerable and inherent difficulties that do not exist in other markets.¹⁸⁹ Thus, even if individuals were likely to make health care decisions in the same manner as they make other spending choices, they would need some level of medical expertise to make informed decisions. To overcome a lack of medical education, each individual would need to invest substantial resources in receiving medical training in order to develop the skills necessary to make informed medical decisions. For many consumers this solution is inefficient and, accordingly, they will prefer to continue to rely on their physician's medical advice.

savings caused by MSAs).

186. See Senator Phil Gramm (R-Tex.), *Why We Need Medical Savings Accounts*, 330 NEW ENG. J. MED. 1752, 1752 (1994) (arguing that if we paid for our groceries through an insurance-like policy, where the policy covered the bulk of the costs, we would demand steak for our dogs instead of dog food). A related argument is that of "moral hazard," which implies that consumers consume more health services when they are insured or more fully insured. See THOMAS RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* 82 (1998). This "hazard" is due to lack of financial disincentives, as individuals are likely to consume less services if they pay the full cost of such services. See *id.* at 83.

187. See Clarke, *supra* note 153, at 1158 (disputing Senator Gramm's "grocery analogy").

188. See *id.*

189. See *Medical Savings Accounts Come Out of the Wilderness*, *supra* note 185 (quoting Congressional Research Service policy analyst Bob Lyke: "[H]ealth care providers are able to influence demand more than other producers and . . . there are limits to the reach of financial incentives affecting patients."); Wicks & Meyer, *supra* note 142 (contending that the "technical nature of modern medicine" prevents most individuals from making informed decisions regarding health care). There is little evidence that consumers possess enough information to make appropriate choices regarding health plans. See RICE, *supra* note 186, at 71 (noting that healthcare consumers do not understand such concepts as "primary care gatekeeping [and] financial incentives to providers").

VIII. THE MSAS CHANCES OF SUCCESS

A. *Design Complexities*

Even if the underlying policy of the MSA is sound, the complexity of the program could have a negative impact on its success. Both buyers and sellers may be deterred by the uncertain effects of the interim limits and the lack of permanence of the experimental program.¹⁹⁰ The overall number of accounts in the MSA program is limited to 750,000.¹⁹¹ The program also provides for interim caps on the number of accounts that may be established by specific dates within the four-year demonstration period.¹⁹² The first of several interim caps was effective April 30, 1997, and was set at 375,000 accounts.¹⁹³ The remaining two interim caps were set at 525,000 by June 30, 1997, and 600,000 by April 15, 1998.¹⁹⁴

If any of the interim limits had been reached at any time, enrollment would have ceased and no new accounts would have been allowed.¹⁹⁵ Individuals who previously had established their MSAs, however, would have been permitted to continue making contributions to, and receiving distributions from, their existing accounts.¹⁹⁶ Thus, the initial uncertainty surrounding the interim limits may have deterred some insurance companies from gearing up their promotional efforts, out of concern that they could not be guaranteed continuation of the MSA's tax deductibility feature beyond the interim dates.¹⁹⁷ Furthermore, because many indi-

190. See NATIONAL CENTER FOR POLICY ANALYSIS, MEDICAL SAVINGS ACCOUNTS: OBSTACLES TO THEIR GROWTH AND WAYS TO IMPROVE THEM (NCPA Policy Report No. 216, July 1998), available at <<http://www.ncpa.org/studies/s216/s216b.html>> [hereinafter NCPA POLICY REPORT NO. 216] (noting, in the section on problems with the MSA, that the 750,000 limit on the number of MSAs has "kept the biggest players such as Chase Manhattan Bank and Prudential Insurance out of the market").

191. See I.R.C. § 220(j)(2)(A) (Supp. II 1996).

192. See *id.* § 220(j); see also FUCHS ET AL., *supra* note 147, at CRS-24 n.36 (describing the series of cut-off dates established by the program).

193. See I.R.C. § 220(j)(1)(A).

194. See *id.* § 220(j)(1)(B), (j)(2)(A); see also Ayers & Plummer, *supra* note 18, at 262 (stating that if the number of reported MSAs exceeded 375,000 on April 30, 1997, the IRS would announce a cut off date of September 1, 1997).

195. See I.R.C. § 220(i)(1); see also FUCHS ET AL., *supra* note 147, at CRS-24 (noting that once an interim limit had been reached, the MSAs would be limited to those individuals who already had established accounts). In determining whether a limit had been reached, the law precludes the IRS from including in the number previously uninsured individuals. See I.R.C. § 220(j)(3).

196. See I.R.C. § 220(i)(1)(A).

197. See NCPA POLICY REPORT NO. 216, *supra* note 190 (noting that the largest insurance companies have not offered MSAs due to the limited market); Linda Koco, *Tax-Qualified MSA Products are on the Rise*, NAT'L UNDERWRITER, Apr. 21, 1997, at 13

viduals who sell health insurance have never dealt with financial products like MSAs, a lack of familiarity with the product may contribute to their reluctance to aggressively promote the product.¹⁹⁸ An additional factor that may discourage brokers from marketing MSAs, is that the commission for high-deductible products is often lower than that for traditional products.¹⁹⁹

Another concern that insurers have expressed about the design of MSAs pertains to the annual cap placed on the amount that account holders actually pay for medical expenses, referred to as the "out-of-pocket maximum."²⁰⁰ The MSA legislation requires that the catastrophic insurance plan pay for all covered services in excess of the out-of-pocket maximum.²⁰¹ Network plans, such as Preferred Provider Organizations (PPOs), typically give financial incentives to participants who use in-network providers as a cost control method.²⁰² However, under the MSA program, once the maximum out-of-pocket amount is reached by a participant, insurers are required to cover all approved medical services regardless of whether the services are provided in or out of the network.

("The 750,000 limit, combined with the short time line between the law's enactment and its 1/1/97 implementation and uncertainty over certain MSA reporting requirements, initially caused many insurers to hold back on market entry."). Because of the uncertainty associated with the interim limits, as well as the many eligibility restrictions placed on MSAs, Congress recently attempted to expand the program. *See generally*, BOB LYKE, MEDICAL SAVINGS ACCOUNTS: LEGISLATION IN THE 105TH CONGRESS (Cong. Res. Serv. No. 97-643 EPW, 1998) (discussing potential expansion of MSA availability). The House proposed and passed the Patient Protection Act of 1998, H.R. 4250, which eliminated limits on the number of taxpayers allowed to participate, deleted the ceilings on the deductible percentages, and expanded the program to include all employers. *See id.* at CRS-3; *see also* 144 CONG. REC. H6416-17 (daily ed. July 24, 1998) (recording the vote in which the House passed the Patient Protection Act, 216 for, 210 against). The Senate, however, tabled the motion to bring the bill to the floor, effectively "killing" the legislation for the remainder of the 105th Congress. *See* Amy Goldstein & Helen Dewar, *Senate Kills 'Patients' Rights' Bill: Managed-Care Measure a Victim of Partisanship, Clinton Scandal, Lobbying*, WASH. POST, Oct. 10, 1998, at A1 (noting that it failed to pass because, in part, philosophical differences existed, and "well-funded lobbyists" opposed the legislation).

198. *See* GAO MSA REPORT, *supra* note 67, at 7 (stating that unfamiliarity with the MSA product as well as the "need to explain the interaction of the qualified plan and the MSA" negatively affected initial MSA sales).

199. *See* David Flaum, *Medical Savings Accounts' Pros, Cons; Ability to Choose Among Pluses*, HOUSTON CHRONICLE, Nov. 16, 1998, at 5 (discussing the difference in commissions between high-deductible insurance policies and traditional health insurance policies).

200. *See* I.R.C. § 220(c)(2)(A)(iii) (specifying that, under a high deductible health plan, an individual's out-of-pocket expenses (other than those paid for premiums) may not exceed \$3000 for self-only coverage and \$5500 for family coverage).

201. *See id.*

202. *See* GAO MSA REPORT, *supra* note 67, at 8.

Because the deductible comprises a large portion of the out-of-pocket maximum, insurers are concerned that there is insufficient financial penalty to discourage participants from going outside of the network plan.²⁰³

The MSA program's design has proven to be problematic not only for prospective sellers, but also for prospective buyers. Several insurers have reported that they have had numerous requests for information about MSAs, but relatively few sales of the product.²⁰⁴ Insurance sales persons have explained that the low sales numbers are due to a lack of understanding about the product. For example, some consumers incorrectly assume the "use it or lose it" feature of the FSA applies to MSAs.²⁰⁵ Others are confused about the use of MSA funds. One insurer recounted that a small employer established MSAs for its employees, believing that instead of paying premiums for the catastrophic plan, the premiums could be deposited in the employees' MSAs.²⁰⁶

B. A Comparative View of MSAs²⁰⁷

Like the United States, Singapore experienced health care cost inflation in the 1970s. In 1984, Singapore responded to the problem of rising medical costs by adopting an insurance scheme that resembles the United States' MSA program.²⁰⁸ Interestingly, Singapore's ten-year experience with a similar medical program has neither reduced nor controlled health care costs; in fact, its experience shows that after introducing an MSA-like program, the costs for medical care actually increased.²⁰⁹

203. See *id.*; see also NCPA POLICY REPORT NO. 216, *supra* note 192 (noting that some patients even purposefully will use providers outside the network early on to reach the out-of-pocket limit, so that they can begin having 100% of their expenses covered by the insurer).

204. See GAO MSA REPORT, *supra* note 67, at 7; see also Brian O'Connell, *Banks Prognosis for MSAs: Stable, But Improving*, BANK TECH. NEWS, Oct. 1998 (noting that many banks would not offer MSAs "because of low consumer demand and uncertainty about the program's rules"). In addition to misunderstanding the MSA program, it is argued that many consumers just do not know about it, and this lack of awareness has contributed to low sales numbers. See Flaum, *supra* note 201, at 5.

205. See GAO MSA REPORT, *supra* note 67, at 7; see also discussion *supra* Part III.C (comparing FSAs with MSAs).

206. See GAO MSA REPORT, *supra* note 67, at 7.

207. A detailed discussion of the Singapore program is beyond the scope of this article. For more information, see William C. Hsiao, *Medical Savings Accounts: Lessons From Singapore*, 14 HEALTH AFF. 260 (1995).

208. See JOHN C. GOODMAN & GERALD L. MUSGRAVE, CONTROLLING HEALTH CARE COSTS WITH MEDICAL SAVINGS ACCOUNTS App. B (NCPA Policy Report No. 168, Jan. 1992), available at <<http://www.ncpa.org/studies/s168/s1681.html>>.

209. See Hsiao, *supra* note 207, at 260. But see Thomas A. Massaro & Yu-Ning Wong,

The Singapore program, known as "Medisave," guarantees each citizen access to quality medical care. The program provides financing for health services, and at the same time responds to the "moral hazard" problem of insurance protection by providing incentives to use health care services responsibly.²¹⁰ Under the Medisave program, every worker must deposit part of his or her earnings into an individual Medisave account; from this account, hospital expenses and certain outpatient services can be paid.²¹¹ The Medisave program also has a lifetime savings feature which allows individuals to save for retirement.²¹² At death, an account holder's estate receives any remaining balance.²¹³

The Medisave program in Singapore is currently well established.²¹⁴ To the extent that the Medisave program compels individuals to save and pay for health care services with their own money, it is similar to the MSA concept. Therefore, important lessons can be learned from Singapore's experience. Accordingly, it is very useful to analyze how the Medisave project has affected both the demand for, and cost of, medical services in Singapore.²¹⁵

Positive Experience With Medical Savings Accounts In Singapore, 14 HEALTH AFF. 267, 269 (1995) (stating that the Medisave program has been successful in controlling the inflationary rate of medical costs).

210. See Hsiao, *supra* note 207, at 261; WILLIAMS & VAN DER REIS, *supra* note 152, at 124 (noting that the Medisave program's "combination of individual responsibility and government subsidies helps to keep health care affordable while giving participants an incentive to use services appropriately"). "Moral hazard" refers to a problem of insurance protection which causes those who are insured against certain risks to have incentives to use less than optimal care to avoid the insured risk. See *supra* note 186 (explaining the moral hazard problem). For purposes of defining moral hazard problems it is necessary to distinguish between two types of risks: reactive and fixed. A reactive risk is one over which the insured has some control, for example an automobile wreck due to a controllable cause, such as speeding. See Daniel Keating, *Pension Insurance, Bankruptcy and Moral Hazard*, 1991 WIS. L. REV. 65, 68 (1991). A fixed risk is "one over which the insured has no control," such as damage from floods and acts of God. See *id.*

211. See Hsiao, *supra* note 207, at 261.

212. See MUKUL G. ASHER, COMPULSORY SAVINGS IN SINGAPORE: AN ALTERNATIVE TO THE WELFARE STATE (NCPA Policy Report No. 198, Sept. 1995), available at <<http://www.ncpa.org/studies/s198/s198.html>> (stating in the section on components of the Medisave accounts that a minimum balance of \$11,000 must be left in an individual's account upon reaching age 55 to be used for medical bills during his retirement).

213. See Hsiao, *supra* note 207, at 261.

214. See *id.* at 262. "By 1992, 95[%] of the total working population [in Singapore] above age fifteen had Medisave accounts" and by 1993 "[m]ore than 80[%] of patients admitted to hospitals used their Medisave accounts to pay their hospital bills. . . . The remaining 20[%] paid their bills out of pocket, or their employers paid them." *Id.* In 1993, Singapore established "Medifund," to assist impoverished people with their hospital bills. See *id.*

215. When comparing Singapore's Medisave program to our MSA program, however,

After the Medisave program was introduced, the per capita cost of health care rose faster than it had in previous years in Singapore.²¹⁶ On average, the rate of increase for health expenditures per capita increased 2% per year, from 11% per capita to 13%.²¹⁷ Additionally, Singapore found that after the Medisave program was introduced, health care facilities reallocated the services they provided. Specifically, hospitals began purchasing more expensive equipment and offering the latest technologically advanced procedures, although these services ultimately increased the inflationary rate for medical services.²¹⁸ Hospitals adopted these practices because they recognized that high-cost services were in greater demand by physicians. Moreover, because the availability of technologically advanced procedures was viewed by the public as an indicator of the quality of care provided by the hospital, hospitals were responding to consumer demands as well.²¹⁹ Today, ten years after the Medisave program was established, Singapore has widespread duplication of costly medical equipment and advanced technological services; for example, as many as seven hospitals in Singapore have in vitro fertilization programs.²²⁰

Like the proponents of MSAs in the United States, Singapore initially believed that the rising cost of medical treatment was in large part attributable to a lack of sensitivity regarding medical cost on the parts of both patients and health care providers. However, Singapore has since discovered that the results do not support this theory. After implementing the Medisave program, Singapore is experiencing a higher rate of infla-

it is important to be aware of several demographic and cultural differences. See WILLIAMS & VAN DER REIS, *supra* note 152, at 125. For instance, Singapore has a very young population. See *id.* (arguing that “[t]he real test of [Singapore’s] health care system will come as demographic trends begin to match those found elsewhere”); see also Mas-saro & Wong, *supra* note 209, at 269 (noting that in 1990, 6.2% of Singapore’s population was above age 65, whereas 12.6% of the United States’ population was above that age).

216. See Hsiao, *supra* note 207, at 264. Singapore did not collect data on their Medisave project that would have provided easy answers to questions about the impact of the program on health care costs. See *id.* Nor is there comprehensive data available from hospitals and clinics that could provide helpful information regarding these questions. See *id.* Despite the lack of detailed data, however, there are indicators that can assist in determining whether the Medisave program helped control the escalating costs of medical care in Singapore.

217. See *id.* But see Mark V. Pauly & John C. Goodman, *Medical Savings Accounts: The Authors Respond*, 14 HEALTH AFF. 277, 278 (1995) (arguing that the Medisave program was designed not to keep health expenses from rising, but rather “to ensure that when Singaporeans enter the medical marketplace, they are able to pay the costs of their own care without relying on the charity of others or subsidies from the state”).

218. See Hsiao, *supra* note 207, at 264.

219. See *id.*

220. See *id.* at 264-65.

tion in health care than ever before.²²¹ Accordingly, Singapore's government has appointed a ministerial committee to investigate the causes of the problem and propose new solutions.²²²

It is just as unlikely that MSAs will be successful in curbing rising health care costs in the United States. The Medisave experiment proved to be a costly project in Singapore. Although differences in market conditions, program design, and patient preferences make it impossible to draw direct parallels between the MSA and Singapore's experience with its Medisave program,²²³ valuable lessons nevertheless can be learned. Perhaps the most important lesson is caution. Policymakers should proceed with great caution before instituting an expanded or permanent MSA program here in the United States.

IX. CURRENT STATUS OF MSA PROGRAM

When the HIPAA was passed, both proponents and opponents believed that MSAs would be a popular product; however, participation in the MSA program has fallen far short of the initial expectations.²²⁴ The IRS reported that only 9720 MSAs were established by the first interim cap date of April 30, 1997; MSA legislation had allowed for as many as 375,000 accounts to be established by this date.²²⁵ Between January and June of 1997, only 22,051 MSAs had been opened, a number significantly below the interim cap of 525,000 accounts set for June 30, 1997.²²⁶ The IRS's next official count was on August 1, 1998, and was based on the number of accounts created through June 30, 1998; the total number of accounts established was 50,172.²²⁷ This figure, too, is significantly below the applicable interim cap of 600,000.

221. See *id.* at 265 & ex. 2. In addition, Singapore's restrictions on the use of Medisave funds encourage individuals to "over-use hospital care and under-use less expensive alternatives." GOODMAN & MUSGRAVE, *supra* note 208, App. B (noting also that the timing of medical expenses during an individual's life may not coincide with the accrual of money in the Medisave account).

222. See Hsiao, *supra* note 207, at 265.

223. See WILLIAMS & VAN DER REIS, *supra* note 152, at 125; see also *supra* note 217 (noting that a comparison of Medisave accounts to MSAs requires one to note the cultural and demographic differences between Singapore and the United States).

224. See GAO MSA REPORT, *supra* note 67, at 7 (noting that "sales of qualified plans have not met the initial expectations of the insurance industry" (emphasis removed)).

225. See LYKE, *supra* note 197, at CRS-2.

226. See GAO MSA REPORT, *supra* note 67, at 7. Of this amount, approximately 17% previously were uninsured. See David E. Rosenbaum, *There's Been No Rush for Medical Savings Accounts, But Idea Is Gaining Favor*, N.Y. TIMES, Dec. 24, 1997, at A11.

227. See *MSA Pilot Project Is Still Going, IRS Announces*, TAX NOTES TODAY, Sept. 30, 1998, available in LEXIS, Tax Analyst's Library, Tax Notes Today File.

The low enrollment for MSAs indicates that the MSA concept has not yet been fully embraced by American taxpayers. Proponents of the MSA are hopeful, however, that as individuals become more familiar with the program, participation will increase.²²⁸ Accordingly, they are encouraged by the fact that MSA sales increased more than 100% from the first cut-off date to the second.

Whether the low enrollment is attributable to the complexity of the program's design, a lack of interest, or a temporary lag in interest cannot be determined at this point. However, low enrollment in the MSA program already has delayed the availability of information about the MSA pilot.²²⁹ Because less than half of the total number of accounts allowed have been established, the GAO advised Congress to postpone the demographics survey.²³⁰ The GAO believed that the extremely low enrollment numbers would make it infeasible to conduct the required survey.²³¹ Demographics surveys such as the one required by MSA legislation use random-digit dialing to examine the characteristics of people with and without MSAs. GAO representatives explained that, because of the low number of MSA account holders, it would require unreasonable amounts of labor and funds to randomly reach an equivalent number of MSA account holders as non-MSA enrollees.²³² Therefore, it will be some time before economists can begin to fully assess the impact of the MSA pilot project, and determine if an expanded and permanent MSA program is warranted.

CONCLUSION

As designed, the MSA program presents serious perception, equity, and social policy concerns. The program was marketed as a health care program, but in reality its purpose is two-fold—medical and retirement savings. As a savings program, the MSA disproportionately benefits individuals who can afford to save. As a health care program, the MSA disproportionately benefits individuals who are healthy and informed. Thus, rather than delivering a single health care benefit to a cross-section of the population, the MSA delivers two separate and distinct benefits to

228. See *supra* note 197 (discussing Congress's attempts to expand the MSA program, and citing as one of the reasons for its attempts the uncertainty surrounding the permanence of the pilot program).

229. See Gwen Moulton, *GAO Shelves Demographics Survey Until 325,000 Establish Accounts*, DAILY TAX REP. (BNA), Oct. 20, 1997, at G-2 to G-3.

230. See *id.* at G-3.

231. See *id.*

232. See *id.*

relatively few individuals.

Notwithstanding its limited number of beneficiaries and dual savings focus, the cost of the MSA program nevertheless could be justified if MSA were able to curb the rising cost of health care. The focus and design of the MSA program, however, raise serious doubts that this goal can be accomplished.

If one is not persuaded to withhold support for an expanded MSA program because of these arguments, it is at least important to recognize that the anticipated benefits of the MSA program cannot occur without substantial costs, complexity, and repercussions to existing markets and social programs. Therefore, while it still is too early to determine whether the MSA program will prove to be an innovative way to reduce health care costs and provide the social good of more and better health care for greater numbers of Americans, it is not too early to recognize that the MSA program provides large windfalls for individuals in American society who are the most fortunate: those who are the healthiest, wealthiest, and most informed.