Commentary—Current MSA Theory: Well-Meaning but Futile

George C. Halvorson

Medical savings accounts (MSAs), in their current form, generally represent an increasingly visible and well-meaning, but potentially futile and sometimes counterproductive, attempt to include consumers in the major costs of care in any meaningful way.

One key part of the underlying theory is valid. Advocates of MSAs say that if consumers lose their current financial insulation from the direct costs of care, then those consumers will tend to make different decisions at some level about the nature and scope of their care. That is probably true. The problem is that the MSA benefit packages, as they are currently designed, tend to ignore the practical reality of what health care actually costs today as well as the reality of who actually uses that care. These particular realities are fairly important and have a major impact on the real-world practical value of current MSA models.

The numbers speak for themselves. Look at the actual distribution of health care costs across the population. The vast majority of people use almost no care. Seventy percent of the population, in fact, uses less than 10 percent of all care dollars. Twenty percent in any given year use no care at all.

On the other end of the expense continuum, use levels are heavy and expensive for a very small number of people. One percent of the people use up to 40 percent of all care dollars, and 5 percent use an absolute majority of all monies spent on care.

Why are these particular numbers relevant to a discussion about MSAs? Again, look at the actual economic design of MSA products. A typical medical savings account benefit package has a $1,000 upfront cash amount that can be spent on any eligible care by the recipient. When the first thousand dollars in the account is spent, a "deductible" kicks in—and the next thousand dollars comes directly from the patient's pocket.

Then, if and when the second thousand dollars is spent, a "catastrophic" insurance plan kicks in, and that insurance plan pays for the patient's remaining health care expenses. The MSA theory is, of course, that patients will spend the first thousand dollars very carefully because it is, in effect, their

money. Then, theorists believe, the next thousand dollars of out-of-pocket expenses will create real market-based purchasing incentives and consumers will make decisions that will, in their full scope and practice, create a value-based market for care.

That's the theory. How would it work in the real world of health care costs? Let's look at hospital care. Everyone knows that the prices charged at two adjacent hospitals may vary widely. With full coverage, it is also true that consumers have no reason to choose the less-expensive hospital and may even prefer the more-expensive one because it costs more and might, therefore, be seen as more "valuable."

People with an MSA plan will, we are told by the theorists, choose the less-expensive hospital over the more-expensive facility if their own money is at stake. Is that true? Not as MSAs are now designed. Think about what care actually costs and who is using the vast majority of our care dollars. That thousand-dollar deductible will buy, at best, four hours in the more-expensive hospital. It might buy five hours of care at the less-expensive hospital. Will people really shop between two hospitals if the same thousand dollars buys four hours of care at one and five hours of care at another? No—we don't buy hospital care by the hour. An MSA is actually functionally irrelevant relative to the costs of hospital care.

So what about over the other major expense area—surgery? Do we buy any significant surgery for the amount of the deductible? Not often, if at all. That much money typically will not pay for the pre-op outpatient-facility surgery support unit preparation fee—much less the actual surgeon.

What about CT scans? MRIs? Chemotherapy? All cost a lot more than the MSA benefit package deductible. Consumers would have no economic reason to price shop for any service where the base price immediately blows through the full deductible.

So who would be influenced by the $1,000 MSA deductible? Relatively few people. The 70 percent of people who already use less than 10 percent of all care dollars would be, at best, marginally affected because they will still find themselves fully insulated from any personal cost impact by the upfront $1,000 MSA cash fund. These patients have no real reason to make any different care decisions about any basic care. (They may even feel flush with

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the new money and decide to use services they might not have used otherwise.)

The really expensive people who use the vast majority of all care dollars are also not affected. These patients are the catastrophic acute care cases (heart attacks, cancer, etc.) and the chronic care patients suffering from the complications of their disease (diabetes, asthma). These are the people who spend nearly all health care dollars.

The thousand-dollar deductible is irrelevant to both of these categories of patients for obvious reasons. It is too little, too late, for both sets of patients.

But, to be fair, there is a distinct category of patients who would be consistently, directly, and personally affected by the deductible—the chronic care patients whose expenses exceed $1,000 a year. These patients would have to decide whether to spend their own money to buy their hypertension drugs, asthma drugs, and so on. These patients would, in fact, often decide to save money by avoiding care.

But do we really want these particular people to avoid their medications? Is that good medicine in any way? An early MSA study indicated that up to 20 percent of patients did not refill prescriptions under an MSA. Which 20 percent? It is important to know. These prescriptions were all written to fill a patient need—many were written to avoid later, much more expensive complications. Are these the people whose care decisions we should be disincenting?

The MSA theory makes sense only until you add the actual cost data to the equation. Then the MSA approach runs into a real problem if you assume that the goal is to actually reduce health care costs. The typical MSA benefit package is irrelevant to expensive patients; irrelevant to cheap patients; and a potentially painful disincentive for chronic care patients. Despite its undoubted good intentions, that is not really a good care-based approach.

The real opportunity in health care today is to provide best care. The real opportunity is to identify the patients who are at high risk of becoming the most expensive 5 percent of health care users. The real opportunity is to strategically intervene with each of those patients to reduce the likelihood that they will become the 40 percent users of all health care.

That is the best focus for our health care energies. That is where the real dollar opportunities are.

That is not to argue for the old benefit sets. In fact, the right benefit incentives can make a positive difference in patient care. Copays, and even reasonable deductibles, have their place. Full insulation from all care costs is obviously problematic. Medical savings account benefit packages, well

designed and targeted to support chronic disease preventive care, can soften the blow of a pure-deductible benefit set. But only if the plan is built on medical reality, not data-deficient economic theorizing.

Let's design the next generation of benefit plans based on real data, not academic theory and ideological speculation. And let's focus our maximum energy on best care—not disincenting chronic care treatment plans.