

## **Medicare Medical Savings Accounts (MSAs)**

- **Most people over 65 and the young disabled could enroll in enrolled in the Medicare MSAs.** Such a proposal would offer MSAs as a health insurance option for 97.7% of the nation's elderly. Additionally, 4.8 million persons with disabilities could join MSAs.
- **The government, not employers, would make contributions to Medicare MSAs.** Because Medicare MSAs are designed primarily for an older population who do not work, and, therefore, do not have employee health benefits, the individual would rely on the government, and not an employer, to make a contribution to the MSA on their behalf.
- **Medicare MSA plans use a high deductible catastrophic health plan in conjunction with the MSA.** This is the same as the MSA plan for the non-Medicare population. Medicare MSA plans require the individual to pay first dollar coverage for health services.
- **The financial incentives to reduce utilization under MSAs may not affect the Medicare population.** While first dollar coverage may encourage healthier individuals to use fewer medical services, but in the Medicare population, which is generally in need of more medical care, the enrollee is more likely to use medical services because of their age or disability. The Medicare population uses more medical services than the non-Medicare population, and therefore, they would be liable for costs sooner than those not covered under Medicare.
- **Enrollees Medicare MSAs may be among the healthiest and wealthiest of all Medicare beneficiaries.** They will also have little or no risk aversion, meaning that they are more willing to risk getting sick and needing medical services and high out-of-pocket expenses, in favor of savings in the short term. They will also expect to incur less out-of-pocket costs with an MSA plan, rather than a traditional fee-for-service (FFS) plan.
- **There are many arguments in favor of Medicare MSAs.** Medicare MSAs would give beneficiaries another option instead of the traditional fee-for-service (FFS) health plan or managed care (HMO) health plan. According to some proponents of Medicare MSAs, Medicare costs would not increase; costs will either remain constant or decrease, depending on whether favorable or adverse selection is experienced. If MSAs experience favorable selection, the healthier beneficiaries would enroll in MSAs, and the less healthy would remain in the traditional plans. Conversely, if those people that enroll in MSAs are less healthy than those that remain in the traditional plans, MSAs experience adverse selection.

- **There are many arguments against expanding Medicare choice to include MSAs.** The Medicare population tends to be sicker than the rest of the population, which makes Medicare MSAs more risky. It will also involve direct government outlays to individuals, and there is no way, as of now, for the government to account for how the money will be spent, and to ensure that it will be used solely for legitimate medical expenses. Also, as the risk aversion level increases and the person gets older and sicker, it is less and less beneficial for any Medicare beneficiary to enroll in an MSA. Additionally, it is the least costly (to the government) Medicare beneficiary that would choose an MSA plan, thus exacerbating the problem by taking them out of the traditional FFS pool, and thereby creating a situation where the most healthy Medicare beneficiaries would receive a higher payment on their behalf, and the less healthy a lower payment. If a large number of people enroll in the MSA plan then the problem will magnify, leaving those most in need with higher co-payments and deductibles for the traditional FFS care.
- **There are several ways to reduce the risks of introducing MSA plans to the Medicare population.** Limit the areas in which they will be introduced. Phase-in MSAs to ensure that selection is always under control. Limit disenrollment from the MSA plan which would ensure that people would not leave the MSA plan, which is less costly, in favor of the traditional FFS plan when they become ill. Limit the types of Medicare beneficiaries that could enroll in the MSA plan. Reduce the reimbursement rate for younger, healthier enrollees and increase it as they become older and less healthy.

## Medical Savings Account Evaluation

**Summary Description** While there has been significant debate on the merits of Medical Savings Accounts, there is virtually no empirical evidence to help inform this debate. This evaluation of the small group and self-employed markets is intended to provide nationally representative data on employer and employee behavior, insurance costs and coverage. In addition, data would be generated that would help policy makers anticipate the effect of MSAs on tax revenues, health care costs and health care utilization.

To estimate the effects of tax-favored MSAs coupled with catastrophic health care coverage in the small group and self-employed market, a fixed number of MSAs would be authorized nationally. A sample of firms would be drawn from those eligible to offer MSA-appropriate catastrophic coverage and comparison firms to yield nationally representative information for firms and employees. Impacts on employer behavior would be estimated by 1) comparing the characteristics of MSA-eligible and control group firms, and 2) analyzing coverage and contribution decisions made by participating firms before and after they choose to offer MSAs. Impacts on employees would be estimated by comparing a sub-sample of employees in firms eligible to offer an MSA option with a sub-sample of employees in control group firms. Following is a brief outline of the research design:

1. **Key Research Questions** The study will focus on the following research topics:
  - o How do employers respond?
    - How many and what types of employers offer MSAs?
    - How do MSAs affect the array of insurance options available to employees, as well as and contribution levels?
  - o Which employees participate?
    - Do MSAs disproportionately attract particular employees (e.g. those with higher/lower income or those in good vs. poor health)?
    - How much do employees typically contribute to their MSA accounts, and how does this affect utilization?
  - o How would the market be affected?
    - Which insurers market MSA-linked catastrophic coverage, and what level(s) of cost sharing do they promote?
    - How would MSAs affect the supply and cost of other insurance choices?
    - How would health care costs be affected?
  - o How is tax revenue affected?
    - Based on employer and employee participation and contribution rates, what is the tax revenue effect of MSA legislation?
  - o How are out-of-pocket costs affected?
    - How do MSAs affect enrollees' out-of-pocket spending?
  - o Interaction between Managed Care and MSAs:

To what extent do employers and employees opt to combine MSAs with managed care products vs. Fee-for-service products?

o Effect on Utilization and Health Status:

- How do MSAs affect health care utilization decisions, including use of primary and preventive health services, and individual health status?

2. **Study Structure**

- o Sample of Firms: nationally representative sample of firms eligible to offer MSAs and comparison firms drawn to match MSA-eligible firms from sample frame used by Census Bureau.

- o Total cap on number of MSA accounts: To be determined

- o Length of Demonstration: 4 years(1/98 - 1/02)

- o Report Dates: Interim Report January 2000, Final Report, not later than September 2002

- o Frequency of Data Collection: annual

- o Administrative Data Sources: Vendor Reports

- o Survey Data: Employers (MSA-eligibles and Comparisons), Employees (MSA selectors, MSA non-selectors, and comparisons)

3. **Administration**

- o The study would be administered by DHHS through a contract with an independent research organization. An advisory committee would be selected to advise the independent contractor on evaluation design issues. Members would have expertise in the areas of health insurance, health economics, tax policy and research design.

4. **Methods**

A. Data Collection

- o Data on employer behavior (e.g., take-up rates, employer contributions), insurance premiums, and the insurance options offered by the firm would be

collected directly from the firm.

- o Data on employee behavior and demographics would be collected from a survey of employees. Data on utilization of medical care and out-of-pocket costs would be collected from insurer claims data as well as the employee survey.
- o Tax effects would be estimated based on relevant information from the employer and employee surveys.
- B. Length of Demonstration The Demonstration would last four years and baseline and annual follow-up data would be collected from both firms and individuals.
- E. Estimated Cost of Study \$24.4 million (see attached breakdown).

### Rough Estimate of MSA Evaluation costs

#### 1) Small Employer Survey

##### Firms with MSAs

- Draw Sample of 1,500 firms \$ 25,000
- Carry out interviews (one baseline interview and one follow-up interview totaling \$600 per employer) \$ 900,000

##### Comparison Group

- Draw Sample of 1,500 firms \$ 50,000
- Carry out interviews (one baseline interview and one follow-up interview totaling \$800 per employer) \$1,200,000

#### 2) Survey of Employees in Small Firms

##### Employees with MSAs

- Draw Sample of 3,000 individuals \$ 25,000
- Carry out interviews (2 interviews per year for 4 years, at \$250 per interview) \$6,000,000

##### Comparison Group

- Draw Sample of 3,000 individuals \$ 50,000
- Carry out interviews (2 interviews per year for 4 years, at \$275 per interview) \$ 6,600,000

#### 3) Survey of Self-employed Individuals

- Draw sample of 1,500 self-employed individuals \$ 25,000
- Carry out interviews (one baseline interview and one follow-up interview at \$600 per employer; 1 additional interview in year 1 at \$250 to collect "employee" data; 2 interview per year at \$250 per interview during years 2-4) \$ 3,525,000

##### Comparison Group

- Draw Sample of 1,500 firms \$ 100,000
- Carry out interviews (one baseline interview and one follow-up interview at \$800 per employer; 1 additional interview in year 1 at \$275 to collect "employee" data; 2 interviews per year at \$275 per interview during years 2-4) \$ 4,087,500

- 4) Prepare, analyze and report on data \$ 1,800,000

**Total Evaluation Costs \$24,387,500**

## **Quote on Medicare MSAs**

**“Reject calls for Medicare Medical Savings Accounts (MSAs) which the Physician Payment Review Commission estimates will cost Medicare \$1,400 per MSA enrollee, further segmenting the market and bankrupting the Medicare program.”**

***Families USA***  
**10/96**

**Congress of the United States**

JOINT COMMITTEE ON TAXATION

Washington, DC 20515-6453

**MEMORANDUM**

**TO:** Phil Moseley  
Lindy Paull  
John Buckley  
Jon Talisman  
Chip Kahn  
Ed Kutler  
David Nexon  
Chris Jennings

**FROM:** Kenneth J. Kies  
Chief of Staff

**DATE:** August 2, 1996

**RE:** Treatment of Medicare Beneficiaries under MSAs

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A question has arisen as to whether individuals covered by Medicare are eligible to have a medical savings account ("MSA") under the provisions of the conference agreement to H.R. 3103 (the "Health Insurance Portability and Accountability Act of 1996").

Under the conference agreement, as under the original House bill provision, in order to be eligible to make contributions to an MSA in a year, an individual must be covered under a high deductible plan and no other health plan (other than certain types of plans that may provide incidental health care coverage, such as credit insurance). A high deductible plan must have an annual deductible of at least \$1,500 in the case of single coverage and \$3,000 in the case of family coverage. These amounts are indexed for inflation.

Medicare does not meet the definition of a high deductible plan, so that any one with Medicare coverage would not be entitled to make contributions to an MSA. This is the case whether Medicare is the primary or secondary payor. In the latter case, although an individual may have an employer-sponsored high deductible plan, they would also have Medicare coverage, and thus would not be eligible to make MSA contributions because the high deductible plan would not be the individual's only health-plan coverage.

An issue has arisen as to whether Medicare coverage is a health plan, because the MSA provisions do not explicitly define the term health plan. The term is used elsewhere in the

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**Memorandum****August 2, 1996****Page 2**

Internal Revenue Code, Code section 106 provides that gross income of an employee does not include employer-provided coverage under an accident or health plan and Code section 105 provides that amounts received under an accident or health plan for employees are excludable from income. The applicable regulations provide that a health plan is a plan which provides for the payment of amounts in the event of sickness and that a health plan may either be insurance or not insurance.<sup>1</sup> Thus, the key in defining what constitutes a health plan is the nature of the benefits provided.

Medicare clearly provides payments to individuals for sickness, and provides the same type of benefits that are typically provided under plans treated as health plans under Code sections 104 and 105. Moreover, the Treasury Department has explicitly recognized that Medicare Part B provides health coverage, it has ruled that payments under Part B are excludable from gross income under section 104, which provides that payments under health insurance are excludable from gross income.<sup>2</sup> Similarly, Part B premiums are deductible as premiums for medical insurance under section 213 of the Code. Thus, not only does Medicare coverage constitute health coverage, but it also meets the narrower definition of "medical" care. Because Medicare provides medical coverage, it clearly provides health coverage, which is more encompassing.<sup>3</sup>

Medicare coverage would thus preclude an individual from having an MSA because they would be covered by a health plan that is not a high deductible health plan.

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<sup>1</sup> Treas. Reg. secs. 1.105-5 and 1.106-1.

<sup>2</sup> Rev. Rul. 70-341, 1970-1 C.B. 31.

<sup>3</sup> The IRS has ruled that taxes paid for Medicare are not deductible under section 213 because they are not premiums for insurance. As noted above, a health plan need not be insured.

**Health Insurance Portability and Accountability Act of 1996  
(H.R. 3103) -- Conference Agreement**

***Title I -- Improved Availability and Portability of Health Insurance Coverage***

This title addresses a number of interrelated issues in the group health plan and individual insurance market. These include: limitations on preexisting condition exclusions; portability of prior satisfactions of preexisting condition exclusions; guaranteed renewability; prohibition on excluding individuals from coverage because of health status; and, guaranteed availability of individual policies for certain previously insured individuals under group health plans.

Title I addresses these issues with respect to employer group health plans and health insurance issuers offering groups health insurance coverage. The bill ensures the portability of health insurance for individuals moving from one group health plan to another by prohibiting group health plans and issuers of group coverage from imposing a preexisting condition exclusion that exceeds 12 months for conditions for which medical advice, diagnosis, or treatment was received or recommended within the previous six months.

Preexisting conditions could not be applied to newborns, adopted children, or pregnancy. A preexisting condition limitation period would be reduced by the length of the aggregate period of any creditable prior coverage. The bill assures that, once covered, the condition will not be excluded from future coverage if the individual meets the requirements of the bill. These provisions assure that individuals who have the opportunity to move to new jobs will not have to face limitations in their coverage for preexisting medical conditions that affect them or their families.

Title I also addresses the small group market. It provides for guaranteed availability of coverage to employees in the small group market. Each issuer that offers coverage in the small group market would have to make all health insurance policies available to small employers and accept for enrollment every eligible individual within the same employer. The bill also assures people in group health plans in both large and small employers that they cannot be excluded from coverage or from renewing their coverage based on their health status.

Title I would also ensure portability of health insurance for eligible individuals moving from group to individual coverage. The goals of these provisions are to guarantee that eligible individuals are able to obtain health insurance and to receive credit for their prior coverage toward the new coverage's preexisting condition exclusion period. This

is accomplished by giving States flexibility to achieve the guarantee of group to individual coverage through a variety of means that may include health insurance coverage pools or programs, mandatory group conversion policies, open enrollment by one or more health insurance issuers, guaranteed issue, or any combination thereof.

If a State does not elect to implement its own availability mechanism, or if the Secretary has found that a State's mechanism was not reasonably designed to meet the availability goals of the Act, federal guaranteed availability requirements would apply.

***Title II -- Preventing Health Care Fraud and Abuse; Administrative Simplification; Duplication and Coordination of Medicare benefits.***

This title creates a Health Care Fraud and Abuse Account within the Federal Hospital Insurance Fund. Monies derived from the newly coordinated health care anti-fraud and abuse programs, civil monetary penalties, fines, forfeitures assessed in criminal and civil cases would be transferred into the trust fund. Mandatory appropriations are also established for the Federal Bureau of Investigation (FBI), Inspector General, and the Medicare Integrity Program to modernize and strengthen Medicare's fraud and abuse activities.

The other provisions of Title II relate to health care fraud and abuse and include the following: establish a national health care fraud and abuse control program to coordinate federal, state, and local law enforcement to combat fraud with respect to health plans; establish a Medicare Integrity Program; require the Secretary to provide beneficiaries with an explanation of each item or service for which payment was made under Medicare; require the Secretary to establish a program to encourage individuals to report suspected cases of fraud and abuse in the Medicare program; extend certain criminal penalties for fraud and abuse violations under the Medicare and Medicaid programs to similar violations in federal health care programs; require the Secretary to issue written advisory opinions with respect to activities subject to fraud and abuse sanctions for a period of four years; require the Inspector General to issue fraud alerts; require the Secretary to exclude from Medicare and State health care programs for a minimum of five years individuals and entities who have been convicted of felony offenses relating to health care fraud or controlled substances; provide an additional exception to the anti-kickback provisions for risk-sharing arrangements; establish a criminal penalty for the fraudulent disposition of assets in order to obtain Medicaid benefits; apply the provisions under the Medicare and Medicaid programs which provide for civil monetary penalties for specified fraud and abuse violations to similar violations involving other Federal health care programs; clarify the level of intent required for imposition of civil monetary penalties; establish an additional civil money penalty for false certification for home health services; and, revise criminal law with

respect to health care fraud, theft or embezzlement, false statements, obstruction of criminal investigations of health care offenses, and money laundering related to health care fraud.

The main provisions of Title II related to administrative simplification would improve the Medicare and Medicaid programs and the efficiency of the health care system by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health care information. The Secretary is required to adopt appropriate standards for financial and administrative transactions and data elements exchanged electronically. The Secretary is also required to submit recommendations on standards with respect to the privacy of individually identifiable health information. If Congress fails to enact privacy legislation, the Secretary is required to develop standards.

Title II also contains provisions on duplication and coordination of Medicare-related plans. These provisions would modify the anti-duplication provisions contained in OBRA 1990. Anti-duplication provisions would specifically state that a policy which pays benefits to or on behalf of an individual without regard to other health benefit coverage would not be considered to duplicate any health benefits under Medicare, Medicaid, or a health insurance policy. Policies offering only long-term care, nursing home care, home health care, or community based care, or any combination thereof would be allowed to coordinate benefits with Medicare and not be considered duplicative.

### *Title III -- Tax Related Health Provisions*

Beginning in 1997, Medical Savings Accounts (MSAs) are available to employees covered under an employer-sponsored high-deductible plan of a small employer and self-employed individuals. Taxpayers (including the self-employed) are allowed to make tax-deductible contributions within limits to an MSA if they satisfy various requirements, including being covered by a high deductible health plan. The earnings on amounts contributed to the MSA would be tax-free. The amounts could be withdrawn from the MSA tax and penalty free if used for specified medical purposes.

The maximum annual contribution that can be made to an MSA for a year is 65 percent of the deductible under the high deductible plan in the case of individual coverage and 75 percent of the deductible in the case of family coverage. During the four year pilot period, 1997-2000, the number of taxpayers benefiting annually from an MSA contribution is limited to a threshold level (generally 750,000 taxpayers).

Title III increases the health insurance deduction for self-employed individuals from 30% to 80% by the year 2006. Title III also provides for: a medical expense deduction for payment of qualified long-term care insurance premiums and expenses; tax-free accelerated health benefits; and, tax-exempt status to certain State-established high risk insurance pools; tax-exempt status to certain State-established organizations providing workers' compensation reinsurance; certain State-established organizations to be eligible for benefits as Blue Cross/Blue Shield organizations; and penalty free IRS withdrawals for medical expenses that exceed 7.5 percent of the adjusted gross income and for health insurance premiums for unemployed individuals.

***Title IV -- Application and Enforcement of Group Health Plan Requirements***

The Internal Revenue Code of 1986 is amended for enforcement purposes of group health plans requirements.

***Title V -- Revenue Offsets***

These provisions establish new rules for taxing taxpayers who: (1) expatriate, or (2) own corporate owned life insurance, as well as repealing a special interest allocation rule enacted as part of the 1986 Tax Reform Act.



DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
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Number of Pages: 5 inclusive

Date: 7/31/96

TO: Chris Jennings | 456-7431 | 456-5585  
Name FAX number Confirmation no.

FROM: Gillian Hunter | 622-1318  
Name Phone no.

Sender's FAX Number: (202) 622-0236

Location: Room 4112 MT

Sender's Confirmation Number: (202) 622-2659

Comments/Special Instructions: Here are the MSA Scenarios  
(Using the 10% formula). Eric's instruct tells him that  
\* Using 13/6 in the formula would not change the numbers  
much. Call him if you have questions. H

NOTE: THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR RESTRICTED AS TO OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. If the recipient of this message is not the addressee (i.e., the intended recipient), you are hereby notified that you should not read this document and that any dissemination, distribution, or copying of this communication except insofar as necessary to deliver this document to the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone, and you will be provided further instruction about the return or destruction of the this document. Thank you.

UNCLASSIFIED

**MSA Participation Scenarios**

100% Uniform

|  |               |         |
|--|---------------|---------|
| Participation Limit:   |               | 750,000 |
| Enrollment Relative to Limit:                                  |               | 100%    |
| Total Enrollment if No Cap:                                    |               | 750,000 |
| Account Opening Cutoff:  | at cap cutoff | 10 0    |
| Date of Cutoff if Cap Hit:                                     | 11/1/XX       | 10 0    |
| Maximum eligibility for opening MSA:                           |               | 12 0    |
| End of Data Period 1st Year:                                   | 06/30/97      | 6 0     |
| End of Data Period:  | 6/30/XX       | 6 0     |
| Percent of Noncontributors from Previous Year (for all years): |               | 10 %    |
| Within Year Sign-up Rate                                       | Uniform       | 0       |

**Faster Participation**

|  | 1997        | 1998        | 1999        | 2000    |
|--|-------------|-------------|-------------|---------|
| Threshold for 1st Year                               | 450,000     |             |             |         |
| Cap for Other Years                                  |             | 600,000     | 750,000     | 750,000 |
| Assumed Take-up Rates                                | 70%         | 80%         | 100%        | 100%    |
| Projection of Participation at End of Year if No Cap | 625,000     | 600,000     | 750,000     | 750,000 |
| Count at 6 Months                                    | 262,500     |             |             |         |
| Count end of first year                              | 525,000     |             |             |         |
| Projected Count for 2nd Yr                           |             |             |             |         |
| Nov 1 As Projected from Data:                        |             | 578,750     |             |         |
| - Est. of 2nd Yr Actives from 1st Yr                 |             | 472,500     |             |         |
| - Count to 6/30/98                                   |             | 63,750      |             |         |
| Projected Count for 3rd Yr                           |             |             |             |         |
| Nov 1 As Projected from Data:1                       |             |             | 715,000     |         |
| - Est. of 3rd Yr Actives from 2nd Yr                 |             |             | 540,000     |         |
| - Count to 6/30/99                                   |             |             | 105,000     |         |
| Projected Count for 4th Yr                           |             |             |             |         |
| Nov 1 As Projected from Data:1                       |             |             |             | 737,500 |
| - Est. of 4th Yr Actives from 3rd Yr                 |             |             |             | 675,000 |
| - Count to 6/30/00                                   |             |             |             | 37,500  |
| Is Cap Hit?  | No          | No          | No          |         |
|  | 450 vs. 263 | 600 vs. 578 | 750 vs. 715 |         |

**Notes on the illustration of the cap.**

In the first year:

$[\text{actual enrollment in 6 months}] * (10 \text{ months}/6\text{months}) = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

The Nov 1 projection will exceed 750,000, if enrollments as of 6/30 exceed the 450,000 threshold.

$750000 * (6 \text{ months}/10 \text{ months}) = 450,000 \text{ threshold}$

In subsequent years:

$[.8 * \text{active enrollments in previous year}] + [(\text{new enrollments in 6 months of current year}) * (10 \text{ months}/6\text{months})] = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

Prepared at the request of David Nexon.

**MSA Participation Scenarios**

133% Uniform

|  |                   |
|--|-------------------|
| Participation Limit:   | 750,000           |
| Enrollment Relative to Limit:                                  | 133%              |
| Total Enrollment if No Cap:                                    | 1,000,000         |
| Account Opening Cutoff:  | 1 cap cutoff 10.0 |
| Date of Cutoff if Cap Hit:                                     | 11/1/XX 10.0      |
| Maximum eligibility for opening MSA:                           | 12.0              |
| End of Data Period 1st Year:                                   | 06/30/97 6.0      |
| End of Data Period:  | 6/30/XX 6.0       |
| Percent of Noncontributors from Previous Year (for all years): | 10%               |
| Within Year Sign-up Rate                                       | Uniform 0         |

**Faster Participation**

|  | 1997        | 1998        | 1999        | 2000      |
|--|-------------|-------------|-------------|-----------|
| Threshold for 1st Year                               | 450,000     |             |             |           |
| Cap for Other Years                                  |             | 600,000     | 750,000     | 750,000   |
| Assumed Take-up Rates                                | 70%         | 80%         | 100%        | 100%      |
| Projection of Participation at End of Year if No Cap | 700,000     | 800,000     | 1,000,000   | 1,000,000 |
| Count at 6 Months                                    | 350,000     |             |             |           |
| Count end of first year                              | 700,000     |             |             |           |
| Projected Count for 2nd Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             | 771,667     |             |           |
| - Est. of 2nd Yr Actives from 1st Yr                 |             | 630,000     |             |           |
| - Count to 6/30/98                                   |             | 85,000      |             |           |
| Projected Count for 3rd Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             |             | 694,500     |           |
| - Est. of 3rd Yr Actives from 2nd Yr                 |             |             | 694,500     |           |
| - Count to 6/30/99                                   |             |             | 0           |           |
| Projected Count for 4th Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             |             |             | 625,050   |
| - Est. of 4th Yr Actives from 3rd Yr                 |             |             |             | 625,050   |
| - Count to 6/30/00                                   |             |             |             | 0         |
| is Cap Hit?  | No          | Yes         | No          |           |
|  | 450 vs. 350 | 600 vs. 772 | 750 vs. 694 |           |

Notes on the illustration of the cap.

In the first year:

$[\text{actual enrollment in 6 months}] * (10 \text{ months}/6 \text{ months}) = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

The Nov 1 projection will exceed 750,000, if enrollments as of 6/30 exceed the 450,000 threshold.

$750,000 * (6 \text{ months}/10 \text{ months}) = 450,000 \text{ threshold}$

In subsequent years:

$[\text{Nov 1 active enrollments in previous year}] + [(\text{new enrollments in 6 months of current year}) * (10 \text{ months}/6 \text{ months})] = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

Prepared at the request of David Nexon.

**MSA Participation Scenarios**

167% Uniform

|  |                   |
|--|-------------------|
| Participation Limit:   | 750,000           |
| Enrollment Relative to Limit:                                  | 167%              |
| Total Enrollment if No Cap:                                    | 1,250,000         |
| Account Opening Cutoff:  | t cap cutoff 10.0 |
| Date of Cutoff if Cap Hit:                                     | 11/1/XX 10.0      |
| Maximum eligibility for opening MSA:                           | 12.0              |
| End of Data Period 1st Year:                                   | 06/30/97 6.0      |
| End of Data Period:  | 6/30/XX 6.0       |
| Percent of Noncontributors from Previous Year (for all years): | 10%               |
| Within Year Sign-up Rate                                       | Uniform 0         |

**Faster Participation**

|  | 1997        | 1998        | 1999        | 2000      |
|--|-------------|-------------|-------------|-----------|
| Threshold for 1st Year                               | 450,000     |             |             |           |
| Cap for Other Years                                  |             | 600,000     | 750,000     | 750,000   |
| Assumed Take-up Rates                                | 70%         | 80%         | 100%        | 100%      |
| Projection of Participation at End-of-Year if No Cap | 875,000     | 1,000,000   | 1,250,000   | 1,250,000 |
| Count at 6 Months                                    | 437,500     |             |             |           |
| Count end of first year                              | 875,000     |             |             |           |
| Projected Count for 2nd Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             | 964,583     |             |           |
| - Est. of 2nd Yr Actives from 1st Yr                 |             | 787,500     |             |           |
| - Count to 6/30/98                                   |             | 106,250     |             |           |
| Projected Count for 3rd Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             |             | 868,125     |           |
| -- Est. of 3rd Yr Actives from 2nd Yr                |             |             | 868,125     |           |
| - Count to 6/30/99                                   |             |             | 0           |           |
| Projected Count for 4th Yr                           |             |             |             |           |
| Nov 1 As Projected from Data:                        |             |             |             | 781,312   |
| - Est. of 4th Yr Actives from 3rd Yr                 |             |             |             | 781,312   |
| - Count to 6/30/00                                   |             |             |             | 0         |
| Is Cap Hit?  | No          | Yes         | Yes         |           |
|  | 450 vs. 437 | 600 vs. 965 | 750 vs. 868 |           |

Notes on the illustration of the cap.

In the first year,

$[\text{actual enrollment in 6 months}] * (10 \text{ months}/6\text{months}) = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

The Nov 1 projection will exceed 750,000, if enrollments as of 6/30 exceed the 450,000 threshold.

$750000 * (6 \text{ months}/10 \text{ months}) = 450,000 \text{ threshold}$

In subsequent years:

$[.9 * \text{active enrollments in previous year}] + [(\text{new enrollments in 6 months of current year}) * (10 \text{ months}/6\text{months})] = \text{projection as of Nov 1}$

If Nov 1 projection exceeds 750,000, cap is triggered.

Prepared at the request of David Nexon.

**MSA Participation Scenarios**

Participation Limit:  
 Enrollment Relative to Limit:  
 Total Enrollment if No Cap:  
 Account Opening Cutoff:  
 Date of Cutoff if Cap Hit:  
 Maximum eligibility for opening MSA:  
 End of Data Period 1st Year:  
 End of Data Period:  
 Percent of Noncontributors from Previous Year (for all years):  
 Within Year Sign-up Rate

750,000  
 200%  
 1,500,000  
 at cap cutoff 10.0  
 11/1/XX 10.0  
 06/30/97 12.0  
 6/30/XX 6.0  
 6/30/XX 6.0  
 10%  
 Uniform 0

**200% Uniform**

**Faster Participation**

|  | 1997               | 1998               | 1999              | 2000      |
|--|--------------------|--------------------|-------------------|-----------|
| Threshold for 1st Year                               | 450,000            |                    |                   |           |
| Cap for Other Years                                  |                    | 600,000            | 750,000           | 750,000   |
| Assumed Take-up Rates                                | 70%                | 80%                | 100%              | 100%      |
| Projection of Participation at End of Year if No Cap | 1,050,000          | 1,200,000          | 1,500,000         | 1,500,000 |
| Count at 6 Months                                    | 626,000            |                    |                   |           |
| Count end of first year                              | 875,000            |                    |                   |           |
| Projected Count for 2nd Yr                           |                    |                    |                   |           |
| Nov 1 As Projected from Data:                        |                    | 787,500            |                   |           |
| - Est. of 2nd Yr Actives from 1st Yr                 |                    | 787,500            |                   |           |
| - Count to 6/30/98                                   |                    | 0                  |                   |           |
| Projected Count for 3rd Yr                           |                    |                    |                   |           |
| Nov 1 As Projected from Data:                        |                    |                    | 708,750           |           |
| - Est. of 3rd Yr Actives from 2nd Yr                 |                    |                    | 708,750           |           |
| - Count to 6/30/99                                   |                    |                    | 0                 |           |
| Projected Count for 4th Yr                           |                    |                    |                   |           |
| Nov 1 As Projected from Data:                        |                    |                    |                   | 637,875   |
| - Est. of 4th Yr Actives from 3rd Yr                 |                    |                    |                   | 637,875   |
| - Count to 6/30/00                                   |                    |                    |                   | 0         |
| Is Cap Hit?  | Yes<br>450 vs. 525 | Yes<br>600 vs. 788 | No<br>750 vs. 709 |           |

**Notes on the illustration of the cap.**

In the first year:

[actual enrollment in 6 months] \* (10 months/6months) = projection as of Nov 1

If Nov 1 projection exceeds 750,000, cap is triggered.

The Nov 1 projection will exceed 750,000, if enrollments as of 6/30 exceed the 450,000 threshold.

750000 \* (6 months/10 months) = 450,000 threshold

In subsequent years:

[.9 \* active enrollments in previous year] + [(new enrollments in 6 months of current year) \* (10 months/6months)] = projection as of Nov 1

If Nov 1 projection exceeds 750,000, cap is triggered.

Prepared at the request of David Nexon.



**DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220**

Number of pages to follow: 3

Date: July 31, 1996

To: Chris Jennings  
Domestic Policy Council

Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5560

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

**DEPT OF THE TREASURY OFFICE OF TAX ANALYSIS**

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

**Projected Number of Qualified Catastrophic Policies in Force and Taxpayers With Policies in Force**

|                  |                   | <b>Fully Phased In<br/>1997 Level</b> | <b>2000 Level<br/>With Termination</b> | <b>2000 Level<br/>Without Termination</b> | <b>2006 Level<br/>Without Termination</b> |
|------------------|-------------------|---------------------------------------|--|---|---|
| <b>Policies</b>  | <b>(millions)</b> | 1.3                                   | 1.2                                    | 1.1                                       | 1.4                                       |
| <b>Taxpayers</b> | <b>(millions)</b> | 1.2                                   | 1.1                                    | 1.0                                       | 1.2                                       |

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**Note: All qualified accounts assumed to have contribution**

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EXECUTIVE OFFICE OF THE PRESIDENT

25-Jul-1996 09:14pm

TO: (See Below)

FROM: Christopher C. Jennings  
Domestic Policy Council

SUBJECT: msa deal update

Senator Kennedy and Congressman Archer struck a deal on an MSA experiment late this afternoon that appears to be consistent with the President's previously stated criteria for an acceptable study. I have no paper as of this writing, but should have something tomorrow morning. The following is based on a very short oral phone call briefing. The study is:

1. Time limited (4-years).
2. Capped -- constrained to 750,000 active policies.
3. Designed to Expire at end of study period with transition rules for those who have purchased the policies during the study:
  - \* Firms who have offered can continue to do so. (This is to address administrative complexity of offering more than one health plan for a small firm. Kennedy does not mind so much b/c there is so much turnover in these small businesses (i.e. they shut down) and he does not believe there will be much of an increase in purchasers.
4. Structured to avoid adverse selection by limiting out-of-pocket exposure to consumers to a maximum \$2,250 deductible for individuals with a total out-of-pocket limit of \$3,000.
5. Structured to assure relative tax equity between MSAs and traditional plans by limiting employer contribution to accounts to 65% of the set deductible. (There was a concern that allowing much more than the savings of the purchase of MSAs to be contributed to the account would provide incentives for employers/employees to shelter income tax free in these accounts -- acutally providing an additional financial incentive to opt for MSAs.)
6. Designed to not be able to be expanded UNLESS the Congress votes affirmatives, under normal voting procedures (i.e., someone could fillibuster the bill), to expand the study permanently.

This is all I can remember for now. Needless to say, the fact that Archer and Kennedy could come to an agreement significantly enhances the likelihood that an acceptable bill will be passed by the Congress. The long-awaited conference could begin as soon as tomorrow. Since there is great pressure on both sides to complete this bill before the August recess, OMB (Nancy Ann), HHS, Labor, and Jen and I will be quickly reviewing the bill for any major problems and trying to address them as rapidly and as non-controversially as possible. (There are a number of MSA administrative issues that we and, in particular, Nancy Ann must work out with Treasury and Joint Tax.)

The two biggest outstanding non-MSA issues: An acceptable deal on group to individual portability and an acceptable compromise on mental health parity. We will keep you apprised of developments...

cj

**Distribution:**

TO: Carol H. Rasco  
TO: Laura D. Tyson

CC: Jennifer L. Klein  
CC: Jeremy D. Benami  
CC: Elizabeth E. Drye  
CC: Thomas O'Donnell

For example, in 1998, the IRS would analyze the return data from the filing of 1997 tax year returns Form 5498-MSAs filed by the trustees and would determine, based on this data, the number of taxpayers who took an MSA deduction for 1997 and who were not previously uninsured.<sup>5</sup> had an MSA contribution reported for 1997. If the IRS determines that the number of these taxpayers for the 1997 tax year exceeds the 1998 threshold level (X - 20 percent of X)<sup>6</sup>, it would be directed to publish guidance on or before November 1, 1998., advising taxpayers that only taxpayers who had previously claimed an MSA deduction (i.e., for either the 1997 or 1998 tax year) and taxpayers who were previously uninsured who had an MSA contribution for 1997 or opened an account in the first 6 months of 1998 would be entitled to make a deductible MSA contribution for the 1999 tax year.<sup>7</sup> In the event that the threshold level for the 1997 return filing year has not been exceeded, all taxpayers in the qualifying eligible group (i.e., self-employed individuals and employees working for employers with 50 or fewer employees ) would be permitted to establish MSAs during the 1999 tax year if they have the requisite high deductible health insurance. During 1999, the IRS would review returns Form 5498-MSAs filed for the 1998 tax year to determine whether the total number of taxpayers claiming MSA deductions with MSA contributions or account balances for the 1998 tax year exceeded the threshold level (X)<sup>8</sup>. In the event that the IRS determines that the threshold level has been exceeded, guidance would be published on or before November 1, 1999, advising taxpayers that no new taxpayers (other than previously uninsured individuals) would be permitted to claim an MSA deduction for the year 2000 if they have not claimed such a deduction for either 1997 or 1998, unless they had established an MSA within the first 6 months of 1999. The threshold level would be adjusted for population growth after 1999.

Based on the July 31 reports described in B.1 and the January 31 reports described in B.2, there would be two potential cutoff dates: December 31 and June 30 each year beginning December 31 of the first year and ending June 30 of the final year of the demonstration project.

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<sup>5</sup> Each income tax return on which an MSA deduction is taken would be treated as one taxpayer for purposes of the cap.

<sup>6</sup>See footnote 3.

<sup>7</sup> Unless the threshold level was exceeded in 1997, a taxpayer could make a deductible MSA contribution for the 1998 tax year, assuming he or she was in the qualifying group and was covered under a high deductible plan in 1998, even if he or she had not made a deductible MSA contribution for the 1997 tax year.

<sup>8</sup>See footnote 3.

individuals.<sup>2</sup> If, based on this reporting, the number of MSAs established exceeds the 1997 threshold level ( $X - 30$  percent of  $X$ )<sup>3</sup>, on or before ~~December~~ ~~October 1~~, 1997 the IRS would publish guidance providing that only those eligible taxpayers who made a deductible MSA contribution for 1997 ~~or were previously uninsured~~ would be eligible to make a deductible MSA contribution in 1998<sup>4</sup>.

If the 1997 threshold level is not exceeded, all taxpayers in the qualifying eligible group (i.e., self-employed individuals and employees working for employers with 50 or fewer employees) would be permitted to make deductible MSA contributions during the 1998 tax year, if they have the requisite high-deductible health insurance.

Similar rules would apply to the annual interim reports that are required to be filed on August 1, 1998 and 1999.

## 2. Rules for ~~1999 and Succeeding Years~~ Form 5498 Annual Reporting

~~For 1999 and succeeding years, The IRS would be directed to collect data with respect to the number of taxpayers claiming an MSA deduction on their individual income tax returns and the extent to which such taxpayers were previously uninsured collect contribution, account balance data, employer identification and information about the high-deductible insurance from MSA trustees on a new Form 5498-MSA, modeled on the current Form 5498 reporting by IRA trustees. In order to accelerate the reporting date to January 31, any MSA accounts for a year must be established by year end and any contributions for a year must be made by December 31, as opposed to the following April 15. If the IRS determines that the number of taxpayers claiming an MSA deduction for a tax year with either a contribution for the prior year, or an account balance as of the end of the prior year exceeds the applicable threshold level, the IRS would be required to issue guidance to the public by no later than ~~November~~ June 1 of the year following the tax year stating that new MSAs generally may not be adopted after June 30. If this guidance is issued then only taxpayers (1) who claim an MSA deduction during the portion of the year prior to the July 1 cut-off date for the year in which the guidance is issued or for any the preceding year or (2) who were previously uninsured would be entitled to make deductible MSA contributions in tax years following the year the notice is issued, through the period of the demonstration project.~~

<sup>2</sup> Failures to report would be subject to a penalty generally parallel to section 521-523 of the bill of \$25 for each MSA up to a maximum of \$5,000. A trustee or custodian required to report could elect to do so on a company-wide or branch-by-branch basis.

<sup>3</sup> The percentage reduction should be adjusted depending on the timing of the report and the cut-off date.

<sup>4</sup> Under the compromise, contributions could be made to an MSA up until the due date for filing the individual's tax return for the year (without extensions). Thus, an MSA contribution for 1997 could be made on or before April 15, 1998.

DRAFT 7/23/96, 6:50 PM

Proposed Operation of a Cap on the Number of Taxpayers  
to Utilize Medical Savings Accounts ("MSAs")

A. Cap on Number of Taxpayers Utilizing MSAs

Under the MSA compromise proposal, only self-employed individuals and those individuals working for employers with 50 or fewer employees who are covered under employer-provided high-deductible health insurance would be eligible to utilize MSAs.

The number of taxpayers benefiting annually from a MSA deduction from the MSA provisions would be limited to a threshold level (i.e., generally X number of taxpayers). This limitation would not apply to taxpayers who were not covered under a health insurance plan for the six month period ending on the date on which coverage under a high deductible health plan commences. If it is determined in a year that the threshold level has been exceeded, no new MSA participants would be permitted in the succeeding year after the cut-off date, and only taxpayers who make a deductible MSA contribution for the year (or who made a deductible MSA contribution for any preceding tax year) or who were previously uninsured would be eligible for an MSA deduction in the succeeding tax year, through the period of the demonstration project.<sup>1</sup>

For the 1997 tax year, taxpayers would be permitted to establish MSAs provided that they are in the qualifying group of self-employed individuals or employees working for employers with 50 or fewer employees, if they have the requisite high-deductible health insurance.

B. Administration of Cap on Taxpayers Utilizing MSAs

1. Rules for ~~1998~~ interim reporting

On or before August 1, 1997, each trustee or custodian of an MSA (e.g., insurance company or financial institution) would be required to report to the Internal Revenue Service ("IRS") regarding the MSAs that have been opened during the first 6 months of 1997. The report would include the taxpayer's name and identification number, which the IRS would use to eliminate multiple counts of the same taxpayer. The total number of MSAs reported by the trustee or custodian would not include the number of MSAs established for previously uninsured

---

<sup>1</sup> [To the extent MSA contributions are made by an employer directly to an MSA on behalf of an employee, the employee would have to include the amount of the contribution in taxable income, but would be entitled to an equivalent MSA deduction. The employer contribution would be excludable from wages for employment tax purposes.] Not necessary if we don't use Form 1040

For example, in 1998, the IRS would analyze the return data from the filing of 1997 tax year returns Form 5498-MSAs filed by the trustees and would determine, based on this data, the number of taxpayers who took an MSA deduction for 1997 and who were not previously uninsured<sup>5</sup> had an MSA contribution reported for 1997. If the IRS determines that the number of these taxpayers for the 1997 tax year exceeds the 1998 threshold level (X - 20 percent of X)<sup>6</sup>, it would be directed to publish guidance on or before November 1, 1998, advising taxpayers that only taxpayers who had previously claimed an MSA deduction (i.e., for either the 1997 or 1998 tax year) and taxpayers who were previously uninsured who had an MSA contribution for 1997 or opened an account in the first 6 months of 1998 would be entitled to make a deductible MSA contribution for the 1999 tax year.<sup>7</sup> In the event that the threshold level for the 1997 return filing year has not been exceeded, all taxpayers in the qualifying eligible group (i.e., self-employed individuals and employees working for employers with 50 or fewer employees) would be permitted to establish MSAs during the 1999 tax year if they have the requisite high deductible health insurance. During 1999, the IRS would review returns Form 5498-MSAs filed for the 1998 tax year to determine whether the total number of taxpayers claiming MSA deductions with MSA contributions or account balances for the 1998 tax year exceeded the threshold level (X)<sup>8</sup>. In the event that the IRS determines that the threshold level has been exceeded, guidance would be published on or before November 1, 1999, advising taxpayers that no new taxpayers (other than previously uninsured individuals) would be permitted to claim an MSA deduction for the year 2000 if they have not claimed such a deduction for either 1997 or 1998, unless they had established an MSA within the first 6 months of 1999. The threshold level would be adjusted for population growth after 1999.

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<sup>8</sup>See footnote 3.

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<sup>3</sup> The percentage reduction should be adjusted depending on the timing of the report and the cut-off date.

<sup>4</sup> Under the compromise, contributions could be made to an MSA up until the due date for filing the individual's tax return for the year (without extensions). Thus, an MSA contribution for 1997 could be made on or before April 15, 1998.

7/23/96

NOTE RE ATTACHED DRAFTS

1. N.B.: IRS may not be able to get ready to administer MSAs with a 1997 (as opposed to a 1998) effective date.
2. The attached draft marked 6:45 PM reflects a different approach from what the conference call earlier today contemplated with respect to participants who stopped contributing (or receiving contributions) to their MSA in a prior year. (The attached alternative draft marked 6:50 PM reflects the conference call's approach.) The 6:45 draft would take a different approach by applying the cap to the larger group (i.e., including those who stopped contributing) and would likewise grandfather the same larger group after the cap applies. We're guessing there are not likely to be very many of these people, and that the ones that do stop contributing are not so likely to resume contributing in later years that it's worth the trouble of excluding them from the grandfather instead of taking the simpler course of including them.
3. Apart from the difference described in point 2 above, the two attached drafts are identical, and both are redlined against the JCT draft.
4. The attached drafts would replace the October 1 IRS notice deadline with a December 1 deadline -- not discussed in the conference call. This would reduce the gaming opportunity for those who will know about the cutoff effective December 31 and will otherwise have three months instead of one month in which to set up MSAs (potentially with nominal amounts of contributions) during that gap period in order to get grandfathered. This would also respond to IRS concerns that they may need about four months -- perhaps slightly less -- to count.
5. See footnote 3 re the percentage reductions of the cap for early years -- intended to preserve our ability to discuss the percentage amounts with them without actually rejecting their suggestions.
6. The drafts drop the quarterly reporting notion and instead would add a third August 1 report (in 1999).

Please call with comments/questions.

DRAFT 7/23/96, 6:45 PM

Proposed Operation of a Cap on the Number of Taxpayers  
to Utilize Medical Savings Accounts ("MSAs")

A. Cap on Number of Taxpayers Utilizing MSAs

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For the 1997 tax year, taxpayers would be permitted to establish MSAs provided that they are in the qualifying group of self-employed individuals or employees working for employers with 50 or fewer employees, if they have the requisite high-deductible health insurance.

B. Administration of Cap on Taxpayers Utilizing MSAs

1. Rules for 1998- interim reporting

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<sup>1</sup> [To the extent MSA contributions are made by an employer directly to an MSA on behalf of an employee, the employee would have to include the amount of the contribution in taxable income, but would be entitled to an equivalent MSA deduction. The employer contribution would be excludable from wages for employment tax purposes.] Not necessary if we don't use Form 1040

14,606

Forms

1044 2-6-95

[Back of Copy B]

CORRECTED (if checked)

|   |                                      |  |   |   |
|---|--------------------------------------|--|---|---|
| TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code |                                      | 1 Regular IRA contributions made in 1995 and 1996 for 1998<br>\$ | OMB No. 1545-0747<br><b>1995</b><br>Form 5498 | Individual Retirement Arrangement Information |
|   |                                      | 2 Rollover IRA contributions<br>\$                               |   |   |
| TRUSTEE'S or ISSUER'S Federal Identification No.                      | PARTICIPANT'S social security number | 3 Life insurance cost included in box 1<br>\$                    |   |   |
| PARTICIPANT'S name  |                                      | 4 Fair market value of account<br>\$                             |   |   |
| Street address (including apt. no.)                                   |                                      |  |   |   |
| City, state, and ZIP code   |                                      |  |   |   |
| Account number (optional)   |                                      |  |   |   |

Copy B  
For Participant

The information in boxes 1, 2, 3, and 4 is being furnished to the Internal Revenue Service.

Form 5498

(Keep for your records.)

Department of the Treasury - Internal Revenue Service

[Copy C—Back is Blank]

**Instructions to Participant**

The information in boxes 1, 2, 3, and 4 is submitted to the Internal Revenue Service by the trustee or issuer of your individual retirement arrangement (IRA) to report regular or rollover contributions made to your IRA and the value of your IRA or simplified employee pension (SEP) account.

If you or your spouse was an active participant in an employer's pension plan, your IRA contributions may not be deductible. See your Form 1040 or 1040A instructions for details.

**Caution:** If you are at least 70½, you must take minimum distributions from your IRA. If you inherited this IRA, certain minimum distribution rules apply. See Pub. 590, Individual Retirement Arrangements (IRAs).

**Box 1.**—The amount shown is the contributions for 1995 made in 1995 and through April 15, 1996, to an IRA.

**Box 2.**—This is the amount of any rollover, including a direct rollover, you made in 1995. You must report the total distribution you received from your IRA on the appropriate line of your income tax return. Subtract the part of the distribution that was rolled over and enter the taxable

remainder on the appropriate line of your income tax return. But if you have ever made any nondeductible contributions to your IRA, use Form 8606, Nondeductible IRAs (Contributions, Distributions, and Basis) to figure the taxable amount. If property was rolled over, see Pub. 590.

**Box 3.**—For endowment contracts only, this is the amount allocable to the cost of life insurance. Subtract this amount from your allowable IRA contribution included in box 1 to compute the amount allowable for your IRA deduction.

**Box 4.**—This is the fair market value (FMV) of your account at the end of the year. However, if a decedent is shown as the participant on this form, it may be the FMV at the date of death. If a decedent's name is shown as the participant and the FMV shown is zero, the executor or administrator of the decedent's estate may request a date-of-death valuation from the financial institution.

The trustee or issuer of the plan may use the other boxes on this form to give you more information about your IRA.

You are not required to attach a copy of Form 5498 to your income tax return. Keep this form for your records. For more information about IRAs, see Pub. 590.

↑ 10,785

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1044 2-6-95

IRS Form 5498

14,605

10,785

[Copy A—Back is Blank]

2828

VOID

CORRECTED

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code |                                      | 1 Regular IRA contributions made in 1995 and 1996 for 1995<br>\$ | OMB No. 1545-0747<br><b>1995</b><br>Form 5498 |
|   |                                      | 2 Rollover IRA contributions<br>\$                               |   |
| TRUSTEE'S or ISSUER'S Federal Identification no.                      | PARTICIPANT'S social security number | 3 Life insurance cost included in box 1<br>\$                    |   |
| PARTICIPANT'S name  |                                      | 4 Fair market value of account<br>\$                             |   |
| Street address (including apt. no.)                                   |                                      |  |   |
| City, state, and ZIP code   |                                      |  |   |
| Account number (optional)   |                                      |  |   |

Individual Retirement Arrangement Information

Copy A For Internal Revenue Service Center File with Form 1099.

For Paperwork Reduction Act Notice and instructions for completing this form, see instructions for Forms 1099, 1098, 5498, and W-2G.

Form 5498

Cat. No. 50010C

Department of the Treasury - Internal Revenue Service

Do NOT Cut or Separate Forms on This Page

Trustees and Issuers, Please Note—

Specific information needed to complete this form and forms in the 1099 series is given in the 1995 Instructions for Forms 1099, 1098, 5498, and W-2G. You can order those instructions and additional forms by calling 1-800-TAX-FORM (1-800-829-3676).

Furnish Copy B of this form to the participant by May 31, 1996. But furnish fair market value information by January 31, 1996.

File Copy A of this form with the IRS by May 31, 1996.

Printed on recycled paper

[Copy B—Back is Blank]

VOID

CORRECTED

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code |                                      | 1 Regular IRA contributions made in 1995 and 1996 for 1995<br>\$ | OMB No. 1545-0747<br><b>1995</b><br>Form 5498 |
|   |                                      | 2 Rollover IRA contributions<br>\$                               |   |
| TRUSTEE'S or ISSUER'S Federal Identification no.                      | PARTICIPANT'S social security number | 3 Life insurance cost included in box 1<br>\$                    |   |
| PARTICIPANT'S name  |                                      | 4 Fair market value of account<br>\$                             |   |
| Street address (including apt. no.)                                   |                                      |  |   |
| City, state, and ZIP code   |                                      |  |   |
| Account number (optional)   |                                      |  |   |

Individual Retirement Arrangement Information

Copy C For Trustee or Issuer

For Paperwork Reduction Act Notice and instructions for completing this form, see instructions for Forms 1099, 1098, 5498, and W-2G.

Form 5498

Department of the Treasury - Internal Revenue Service

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION  
OFFICE OF HEALTH POLICY



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**DRAFT**

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**COST ESTIMATES FOR MEDICAL SAVINGS ACCOUNTS (MSA) DEMONSTRATION****GENERAL ASSUMPTIONS AND COMMENTS**

- o The source of funds for this demonstration is a major concern. As there is no direct impact on HCFA's beneficiaries, funding for this demonstration should not be linked to the Medicare Trust funds. Although HCFA receives an appropriation, the source of our appropriated funds is the Trust Funds. One alternative is for the funds for this demonstration to be provided to the Treasury Department, as they are a partner with HHS on the project, and then provided to HCFA through an interagency transfer. Another alternative might be to bill general revenues as occurs with the Medicaid program.

We also point out that the language in the draft legislation, "\$20,000,000 is "authorized to be appropriated," does not actually result in money being available to HCFA. This only an authorization; the money needs to be appropriated.

- o We have divided the work that would have to be performed to conduct this demonstration into two categories: **implementation activities** and **evaluation activities**. These activities could be separated into several different contracts (e.g., one contract could perform the demonstration design and evaluation tasks, while another carries out the implementation activities) or consolidated into a single contract. Using more than one contractor will cause coordination difficulties but will avoid the apparent conflict of interest of having the demonstration implementer evaluate the project's outcome. We assume that the costs would be similar regardless of the actual contracting strategy adopted by the Government.
- o Our cost estimates assume that 100,000 small businesses will participate in the project and that one million individuals will enroll in Catastrophic Health Insurance (CHI) plans and establish MSAs.
- o We assume that the Contractor will need to verify that the businesses which agree to participate meet certain qualifications--e.g., fewer than 50 employees--before employees can begin to enroll in CHIs. (The alternative is to require insurers to obtain signed assurances from businesses when they sign up.) We assume that the insurers will be required to supply the Contractor with baseline information about the participating employers. Otherwise, the Contractor will need to contact these businesses to collect baseline information. If the Contractor needs to collect baseline data directly, it is likely that costs will increase by \$2 - \$5 million dollars.
- o Our total cost estimate for the MSA is \$ **37,687,500** (\$13,300,000 for implementation activities and \$24,387,500 for evaluation activities). The cost per enrollee (using our assumption of one million enrollees) is \$37.69. However, the demonstration costs are affected most by the assumption about sample sizes required for the evaluation, and the costs of the surveys required to gather information from these samples. Expanding or reducing the number of enrollees in the demonstration will have less impact on the total costs than changes in evaluation sample sizes. We believe that the sample sizes used in our estimates are the minimal needed to provide reasonable estimates of the impact of the demonstration.
- o We have assumed that the Contractor(s) would NOT receive records on the CHI enrollees health expenditures directly from insurers or from MSA holders (e.g., banks or financial institutions). It is not clear whether this data would be available. Instead, we have assumed that expenditure data will be collected only through the interviews of sample groups. If this expenditure is available on all CHI enrollees, collecting these records from insurers or financial institutions on all 1 million enrollees, and merging it into the evaluation contractor's system and analyzing the data, would increase demonstration costs--possibly by \$10 million or more. (It is possible, but not certain, that this increase would be offset in part by cost reductions in the interviews required of enrollees.)

| REQUIRED TASKS   | ASSUMPTIONS   | ESTIMATED COSTS |
|--|---|-----------------|
| <u>Implementation Activities</u>   |   |                 |
| 1.1 Initial planning meeting(s) with HCFA/HHS.   |   | \$15,000        |
| 1.2 Establish expert panels including representatives from Federal agencies, insurers, States, small businesses.   |   | \$35,000        |
| 1.3 Conduct meetings with Treasury, HHS, insurers, States, etc. to discuss demonstration plans and obtain comments, feedback.  | We assume 3-5 meetings to discuss the project with representatives of 8-10 insurers and 20-30 States. Each meeting will be 1 day in length.   | \$150,000       |
| 1.4 Develop research design (including number of States), sampling strategy, implementation plan, etc.   | We assume that this task will require gathering and basic analysis of existing data e.g., on the number, location, and characteristics of small businesses, insurance policy characteristics and State requirements, etc., in order to develop a research design. | \$300,000       |
| 1.5 Design and test data systems and instruments and prepare operational processes for the demonstration (includes pretests, final tests, OMB Clearances, coordination with State insurance agencies, Treasury/IRS, insurers, MSA keepers—clearance process, approval processes for firms, insurance packages) |   | \$2,000,000     |
| 1.6 Disseminate information on demonstration to insurers, small businesses.  |   | \$100,000       |
| 1.7 Contractor refines the data systems and operating processes developed during the design phase as needed to implement the operational phase of the demonstration.   |   | \$100,000       |

| REQUIRED TASKS   | ASSUMPTIONS   | ESTIMATED COSTS           |
|--|---|---------------------------|
| <p><b>1.8</b> Businesses agree to participate and offer CHI/MSA plans to their employees. Insurers report information on these businesses/employers to the Contractor, either directly or through States. The Contractor verifies that the employer meets required qualifications, notifies insurer/State of approval, and establishes a baseline record on each qualified employer.</p>   | <p>We assume that the Contractor will need to verify that new businesses that agree to participate meet qualifications—e.g., fewer than 50 employees—before employees can begin to enroll and that the insurers will be supply the Contractor with baseline information about the participating employers. Otherwise, the Contractor will need to contact these businesses to collect baseline information. If the Contractor needs to collect baseline data directly, the cost of this task could increase by \$2 - \$5 million dollars.</p> <p>Based on experiences with the Choices demonstration and the Health Status Registry, we estimate cost of \$6 to establish each baseline record on a new employer.</p> <p>100,000 businesses/records X \$6 =</p> | <p><b>\$600,000</b></p>   |
| <p><b>1.9</b> Employees voluntarily enroll in CHIs and establish MSAs. Insurers report new employee enrollments to the Contractor (through States if States so elect)—the reports include baseline information on each enrollee. The Contractor verifies that enrollees are with participating businesses and that caps have not been exceeded, provides an account number, establishes a record on each new enrollee and also on each new participating employer.</p> | <p>Based on experiences with the Choices demonstration and the Health Status Registry, we estimate cost of \$6 to establish each baseline record on a new enrollee.</p> <p>1,000,000 enrollees/records X \$6 =</p>  | <p><b>\$6,000,000</b></p> |

| REQUIRED TASKS   | ASSUMPTIONS  | ESTIMATED COSTS     |
|--|--|---------------------|
| 2.0 Insurers notify Contractor of disenrollments or other changes and Contractors enters this information into its system.   | <p>We assume that 50% of enrollees will disenroll during the demonstration (including participating firms going out of businesses, etc.). We estimate that the transaction costs of processing disenrollments will be half that to establish the original records.</p> <p>We assume that there is no replacement of disenrollees (i.e., there will be a total of one million individuals who enroll over the life of the demonstration.)</p> <p>500,000 disenrollments X \$3 =</p> | \$1,500,000         |
| 2.1 The Contractor edits and cleans the data, contacts the insurers or employers to resolve missing or inconsistent data, maintains the data bases, and provides data to the Evaluation Contractor.  | \$400,00 per year X 5 years =  | \$2,000,000         |
| 2.2 Prepare Reports: Both formal (monthly/quarterly/annual reports for different purposes and audiences)--tracking progress toward caps and reporting level of activity--and more ad hoc reporting for those who ask for operational statistics. | \$100,000 per year X 5 years =   | \$500,000           |
| <b>Total Implementation Costs =</b>  |  | <b>\$13,300,000</b> |

| REQUIRED TASKS  | ASSUMPTIONS  | ESTIMATED COSTS |
|---|--|-----------------|
| <u>Evaluation Activities</u>                                    |  |                 |
| 3.1 Draw samples of participating small firms.                  |  | \$25,000        |
| 3.2 Carry out interviews of the small firm sample.              | <p>A sample of 1,500 businesses will receive a baseline interview and one later follow-up phone interview. We estimate that the net cost of the 1,500 completed interviews (assuming we will need to oversample initially to allow for withdrawals and refusals) will be \$400 for initial interviews and \$200 for follow-up interviews.</p> <p>1,500 X \$600 =</p> | \$900,000       |
| 3.3 Draw sample of enrollees in small firms.                    |  | \$25,000        |
| 3.3 Carry out interviews of small firm enrollees.               | <p>3,000 enrollees/families will receive 2 interviews per year for 4 years.</p> <p>Based on experience with MCBS, we estimate a cost of \$250 per interview.</p> <p>3,000 X 2 times per year X 4 years X \$250 =</p>   | \$6,000,000     |
| 3.4 Draw matched comparison sample of small firms.              |  | \$50,000        |
| 3.5 Carry out surveys of firms in comparison group.             | <p>To achieve 1,500 completed interviews with Comparison group employers, with assume a cost \$800 per completed interview due to difficulties in persuading them to participate, collect baseline data, possibly obtain lists of employees. (If we are not able to identify comparison group employees through IRS or other agencies.)</p> <p>1,500 X \$800 =</p>   | \$1,200,000     |
| 3.6 Identify small firm employees for matched comparison group. |  | \$50,000        |

| REQUIRED TASKS  | ASSUMPTIONS   | ESTIMATED COSTS     |
|---|---|---------------------|
| 3.7 Carry out surveys of small firm employees in comparison group.                  | Assume 3,000 Comparison group employees will be interviewed 2 times per year for 2 years to at a cost of \$275 per completed interview. We assume higher costs for the Comparison group due to more refusals.<br><br>3,000 X 2 times per year X 4 years X \$275 = | \$6,600,000         |
| 3.8 Draw sample of 1,500 self-employed individuals                                  |   | \$25,000            |
| 3.9 Carry out interviews of self-employed individuals                               | Assume one baseline interview and one phone follow-up interview in year 1 at \$600 per employer; 1 additional interview in year 1 at \$250 to collect "employee" data; 2 interviews per year at \$250 per interview during years 2-4.                             | \$3,525,000         |
| 4.0 Draw comparison sample of 1,500 self-employed individuals.                      |   | \$100,000           |
| 4.1 Carry out interviews of self-employed comparison group.                         | Assume one baseline interview and one phone follow-up interview in year 1 at \$800 per employer; 1 additional interview in year 1 at \$275 to collect "employee" data; 2 interviews per year at \$275 per interview during years 2-4.                             | \$4,087,500         |
| 3.8 Receive data from Implementation Contractor, merges files, maintain data bases. | \$100,000 per year for 5 years.   | \$500,000           |
| 3.9 Conduct analyses of data.   |   | \$1,000,000         |
| 3.10 Prepare an interim report of findings and a final report.                      |   | \$200,000           |
| 3.11 Conduct presentations of findings.   |   | \$100,000           |
| <b>Total Evaluation Costs =</b>   |   | <b>\$24,387,500</b> |

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## MEDICARE COMPROMISE

### MEDICAL SAVINGS ACCOUNTS (MSAs) AND OTHER PLAN OPTIONS

- A 2-year national demonstration MSA program with enrollment capped at 3% of Medicare beneficiaries. A joint Congressional/Presidential Commission to study and make recommendations as to whether option should be continued/expanded. Open enrollment; health screening prohibited.
- 4-year demonstration of private fee-for-service plans in 10 states. Current-law rules for balance billing; premiums for basic Medicare benefit package cannot exceed actuarial equivalent of Medicare deductible; coinsurance uniform for all beneficiaries. Open enrollment; health screening prohibited.

### NO "FAILSAFE" OR "LOOKBACK" CAPS ON FEE-FOR-SERVICE

#### BALANCE BILLING

- No balance billing permitted for authorized services received out-of-plan.
- Balance billing permitted for private fee-for-service demonstration (see above), but limited to current-law effective rate for fee-for-service.

#### PREMIUMS ABOVE MEDICARE CAPITATED PAYMENT

- Plans may charge up to their adjusted community rate for basic Medicare benefits, but may not exceed Medicare payment amount.
- No limits on premiums for supplemental benefits if full disclosure made.

#### MEDIGAP PROTECTION

- Require Medigap plans to accept all beneficiaries who elect coverage during annual open enrollment period to protect those who choose one of the new managed care plans but then want to return to traditional fee-for-service Medicare.
- Allow Medigap plans to charge higher premiums to those who elect Medigap after managed care plans, but plans would be required to charge the same average premium charged by that plan to beneficiaries with comparable demographics (e.g., age).

**ENROLLMENT**

- Require initial contacts with beneficiaries and enrollment to be conducted by third party (i.e., not by health plans) for transition period. Secretary would contract with third party to provide information about all plans in area.
- After transition period, plans could contact and enroll beneficiaries directly. Health screening prohibited.

**SAVINGS PROPOSALS**

- Proposal would charge higher-income beneficiaries a Part B premium up to 75% of program costs, beginning at modified adjusted gross incomes of \$100,000 for singles (phasing up to 75% at \$125,000) and \$125,000 for couples (phasing up to 75% at \$150,000). This proposal could be expected to save in the neighborhood of \$10 billion over 7 years.

## **MEDICAID COMPROMISE**

### **NEW GENERAL FLEXIBILITY PROVISIONS FOR STATES, including:**

- Eliminate federal waiver process for mandatory enrollment in managed care.
- Eliminate federal waiver process for home and community-based care options.
- Repeal the Boren Amendment.
- Repeal the cost-based reimbursement requirement for health centers/clinics.
- Repeal requirements for federal review of managed care contracts exceeding \$100,000.

### **FINANCING**

- Accept and work off the NGA financing formula to achieve CBO scorable savings, (which has no cap and ensures that federal support increases with enrollment), but retain current law with regard to state matching and provider tax rules.

### **ELIGIBILITY**

- Accept NGA definition of eligibility with the exception of two modifications to the kids and disability definitions.
  - Retain current law that phases in kids ages 13-18, but repeal requirement that makes it impossible for states to "roll-back" optional coverage of kids and pregnant women to the mandatory poverty/coverage levels.
  - Retain federal disability designation authority, but restrict it to the definition agreed to in the welfare bill, (which excludes alcoholics, chemical and substance abusers, and some definitions of SSI kids from mandatory coverage).
- Empower states to use any Medicaid savings to provide coverage of anyone under 150 percent of poverty WITHOUT any federal waiver.

## **BENEFITS**

- Accept the NGA benefits definition, but retain appropriate federal standards to ensure that the benefits are meaningful.
  - Retain current law's flexibility in defining benefits' "amount, duration, and scope" as long as it is "reasonable to achieve its purpose," is available statewide, and meets the current law's comparability requirements.
  - Authorize the Secretary to narrow the definition of "treatment" that states must provide for children under the EPSDT benefit.
- Allow states to require nominal copayments for Medicaid HMO coverage.

## **ENFORCEMENT**

- Accept NGA proposal to repeal the Boren amendment and all other provider right of action suits.
- Accept NGA proposal that requires all state administrative appeals to be exhausted prior to any court appeal on eligibility or benefits disputes.
- Preserve individual federal right of action (through the federal courts) for benefit and eligibility disputes.

## **STRUCTURE/SECOND TIER ISSUES**

- Repeal outdated managed care quality standards, i.e., the private/public-75/25 enrollment rule, and substitute outcomes oriented quality rules.
- Retain federal nursing home standards and enforcement, but eliminate duplicative nursing home resident reviews and allow for nurse-aide training to take place in rural nursing homes.
- Retain current federal family financial protections, like spousal impoverishment and protections against liens on family property.
- Preserve current law protections by drafting reforms off of Title XIX.

## Welfare Reform

Assuming as the base the Governors' most recent proposals in March to change HR4, the following modifications are needed:

### AFDC, WORK, & CHILD CARE

#### State Funding/Maintenance of Effort (MOE)

Overall MOE -- Raise level from 75% to at least 80%; higher for States not meeting work requirements

Transferability -- Transfers to child care only; no transfers to Social Services Block Grant

Contingency Fund -- Allow further expansion during recessions

Equal Protections -- Stronger language for fair and equitable treatment and State accountability; mandatory vouchers for children after the five year time limit is reached

Medicaid -- Coverage for welfare families using current AFDC eligibility standards; coverage for those who reach the time limits

Child Care -- Health, safety, and quality standards

Displacement -- Provisions for workfare not to displace jobs

### FOOD STAMPS

Optional Block Grant -- Drop any block grant version from bill and fix provisions that weaken federal standards

Time Limits/Work Requirements on 18-50s -- States must offer work or training slot before terminating benefits. Lengthen time limit from four months to six months

### CHILD NUTRITION

Block Grant -- Consistent with the NGA's most recent draft, no block grants

### IMMIGRANTS

Deeming -- Until citizenship for SSI, AFDC, Medicaid, and Food Stamps, exempt the disabled, and veterans, no exemption for over 75

Bans -- Drop Food Stamps and SSI bans

School Lunches and Discretionary Programs -- Exempt from verification and deeming requirements

### SSI

SSI Age Increase -- Drop provision to tie age of eligibility for SSI elderly to the "normal" social security retirement age

State Supplements -- Drop repeal of State supplement maintenance of effort requirements

### CHILD PROTECTION

Block Grant -- Drop any version from bill

## Concerns with Medical Savings Accounts (MSAs) and with the Specific Proposal Passed by the House

### Summary

- Medical Savings Accounts (MSAs) have great potential to have detrimental effects on the health insurance market, are unlikely to achieve the goals of proponents, have significant potential to be expensive, and are inconsistent with the desire to simplify the tax code. By encouraging healthy individuals to leave traditional insurance pools, MSAs could penalize individuals who are less healthy as well as individuals who cannot risk or afford the MSA option by raising their health insurance premiums. There is no objective evidence that MSAs would be successful in either expanding coverage or significantly containing costs. In addition, as currently structured, MSAs have no requirements that assure that the limited, catastrophic insurance coverage they would provide is meaningful. Moreover, their large deductible would undermine the desirable utilization of potentially cost-effective preventive health care. And, while the Joint Committee on Taxation (JCT) estimates that MSAs would lose \$1.8 billion in revenue over six years (1997-2002), the loss would be much more if participation is more in line with what proponents claim it will be. Finally, because MSAs would complicate the tax code and create new administrative burdens, they are wholly inconsistent with the current desire for tax simplification.

### Concerns

- Adverse selection. By providing a tax incentive for the purchase of catastrophic insurance, as opposed to traditional coverage, MSAs would further encourage healthy individuals to leave the traditional insurance risk pool. The remaining participants in the pool would tend to be sicker than average, and the premiums for those employees would escalate. This segregation of the more healthy from the less healthy -- with a tax break for the healthier -- would not promote sound health policy. Those most in need of coverage would have the least access to it.
  - Less healthy individuals could end up paying more. As a consequence, some could lose insurance coverage.
  - The absence of an effective workable risk adjustment mechanism makes it more likely that there will be serious adverse selection problems.
- Individuals could game the system. While catastrophic coverage could potentially encourage cost containment by requiring higher deductibles, individuals could establish an MSA during their young healthy years, and drop their high-deductible coverage -- switching to a more traditional plan -- during their high-cost years. After doing so, they could still keep their MSA and continue earning tax-free build-up to pay for additional health benefits, long-term care, or retirement on a tax-preferred basis.

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- Allowing individuals to switch plans enables individuals to game the system.
- Allowing individuals to keep their MSA accounts when they opt back into a comprehensive plan rewards gaming.

● **MSAs are untested.** MSAs could have substantial negative effects on the health insurance market and on individuals, especially those with poor health.

- MSAs as defined in the proposal are untested and objective researchers (e.g. the American Academy of Actuaries) are concerned about potential effects. Data from existing MSA plans has not been made available for review.
- Reports that existing MSA plans reduce costs for some employers, even if verified, would not necessarily imply that tax incentives for MSAs would reduce overall health care costs. For example, an employer that currently offers an MSA may be reducing its own costs by shifting costs to another employer that provides health insurance to the worker's spouse.

● **Tax benefit for the healthy and wealthy.** MSAs would enable more individuals to pay out-of-pocket medical expenses on a tax-preferred basis. MSAs would also permit individuals with low medical expenses or substantial financial resources to save \$2,000 a year (or \$4,000 for a family) on a tax-free basis.

- There are no income limits in the proposal. Tax benefits would be much greater for high-income participants than for low-income groups for several reasons. Within any age group, high-income individuals are more likely to participate than low-income individuals. High-income individuals tend to save more than low-income individuals. Finally, high-income individuals are in higher income tax brackets than low-income individuals.
- Individuals who wished to maximize tax-favored savings would be free to pay their medical expenses out of their other funds, and essentially let the MSA serve as an additional IRA without income limits. Healthy individuals may receive windfalls at the expense of less healthy individuals to finance these additional savings accounts.
- For healthy individuals, assets in MSA accounts could accumulate to substantial sums. These amounts could well exceed amounts necessary for health care.
- Because the MSA balance would not be included in the taxable estate, individuals could use MSAs to avoid estate taxes when they die.

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- The 10 percent penalty on nonmedical withdrawals from MSAs would not be high enough to recapture MSA tax preferences in many cases.
- Allowing penalty-free nonmedical withdrawals at age 59 1/2 could encourage individuals to spend their MSA savings on non-health-care consumer goods when their health expenses are likely to be growing and they are not yet eligible for Medicare (at age 65).

- **Social Security and Medicare taxes.** Employers that currently do not provide health insurance could provide extremely minimal health insurance and establish MSAs for their employees. As a result, employers and employees could avoid Social Security and Medicare taxes on employer contributions altogether.

- Although contributions to 401(k) retirement accounts receive tax preferences for income tax purposes, these contributions are included in taxable wages for Social Security and Medicare purposes.
- MSAs could reduce the Social Security and Medicare wage base, especially for low-income workers.

- **Undermines health insurance protection and preventive care.** The proposal could reduce the amount of health insurance protection for individuals, as well as the effectiveness of their care.

- Without out-of-pocket limits and a specified set of benefits for the catastrophic coverage, individuals may not have meaningful insurance protection. These individuals may not be able to pay their health expenses in the event of a major illness, leaving hospitals, Medicaid and other individuals at risk for paying the bill.
- Because employers are likely to contribute less than the increase in the deductible, employees would be at risk for larger out-of-pocket costs in MSAs compared to current plans. According to the American Academy of Actuaries, the amount of out-of-pocket exposure can be high, especially if employees are given choice.
- MSAs may discourage effective preventive care. The high deductible coverage associated with MSAs may lead to delayed care and under-utilization of routine and preventive health care services.

- **Undermines targeted health spending.** Under the proposal, individuals would be free to withdraw MSA funds tax-free to pay for less critical health care items that are not covered by their catastrophic insurance.

- MSAs would discourage cost containment by enabling more employees, self-employed individuals and others to pay for these types of out-of-

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pocket expenses with tax-preferred dollars. As a result, MSAs favor high-deductible plans over low-deductible plans in these circumstances.

-- Using MSA funds for less critical care would deplete the funds set aside for health care. If individuals later experienced more serious health care problems, they would lack funds to pay the high deductible for more critical care.

-- Although MSA funds could not be used to pay for catastrophic premiums on a tax-preferred basis, MSA funds could be used on a tax-preferred basis to pay for long-term care insurance premiums. As a result, premiums receive unequal treatment even though a policy goal of the bill is to treat long-term care in an equal manner to medical care.

● **Questionable effect on cost containment.** Although a high deductible could potentially encourage consumers to be more cost conscious, high deductibles and MSAs could increase costs in other ways.

-- MSAs divert participation from managed care. Capitated plans and other managed care arrangements hold the promise of coordinated, quality-tested care and cost efficiency not provided through MSAs.

-- Allowing MSA funds to be used on a tax-preferred basis to cover medical expenses of family members, who are not covered by the high-deductible plan and who could be covered by a low-deductible plan, reduces cost consciousness and could result in increased medical expenses for these individuals.

-- Allowing the MSA owner to be covered by other specialized coverage plans that are not subject to the high deductible would reduce the effect of a high deductible on cost containment.

● **Inconsistent with tax simplification and difficult to administer.** MSAs would constitute a major step away from tax simplification. The addition of this new arrangement under the tax code would add complexity for taxpayers and the IRS, and could lead to a risk of significant noncompliance.

● **Inconsistent with the thrust of the bill.** MSAs are inconsistent with the basic policy of the larger bill, which is directed toward broadening risk pools.

May 22, 1996

pt 1) Rand study 74-82 - free care cost more than expected.

Report → (Most people would not have free care)

Based on what Rand discovered,

14. (2) We can expect families to shop wisely for health care when their own dollars are at stake. That wise shopping -- a judicious use -- should have the effect of limiting resources in health care ~~costs~~.

RAMP Response -- NOT TRUE

pt 3) AHC-CIO Response to emul' coverage of MAB.

more likely to see states than to do this now obviously b/c they have one now -- the question is capacity of industry & subsidizing that w/ no evidence will reduce costs.

(Compared reform to private industry) to help private insurance industry.

check

pt 4) "Your employer pays \$2000 into an account in your name" - No employer is required to pay for obli's w/

to deductible. In fact, this would require employers

to pay more than they are now and \$2000 plus

the cost of purchasing a CATA benefit would be

more than what most any employer is paying

CATA Benefit is not deductible