

MEDICARE COMPROMISE B

MEDICAL SAVINGS ACCOUNTS (MSAs) AND OTHER PLAN OPTIONS

- Allow MSAs as Medicare choice, to be phased in over a three-year period, with enrollment capped at 10% of beneficiaries. In the first year, capitation payments would be 75% of the AAPCC (instead of 95% as in current risk contracts); legislation would include mechanism for "overpayment adjuster" to lower capitation payments in the following year if payments in a given year turned out to exceed true health costs of beneficiaries by more than 10%. In order to provide data needed for this assessment, beneficiaries choosing MSAs would be required to report on year-end balances in their MSAs. Beneficiaries would be required to spend MSA balances only on health care costs as defined by the Secretary, and there would be a two-year "lock-in" requirement. Joint Congressional/Presidential Commission to study and make recommendations about continuation of program at the end of three-year phase in.
- Allow private fee-for-service plans as Medicare choice provided that (1) limits on balance billing by physicians under current law would continue to apply to all services provided to plan enrollees; (2) plans would have to comply with same quality assurance and beneficiary protection standards that apply to other plans; (3) plans could only be marketed in a county in which, during the preceding year, at least 60% of all practicing physicians (including at least 50% in each of the major specialties) "participated" (i.e., accepted assignment on all claims) in Medicare.

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-for-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

- Secretary would provide, through third party, information to all beneficiaries about plans available in area (similar to Federal Employees Health Benefits Program process). Require enrollment to be conducted by third party (i.e., not by health plans) for one-year transition period, though plans could market directly to beneficiaries after initial information about all plans has been provided (and after the plan's marketing brochures, etc., have been approved by the Secretary).
- After one-year transition period, plans could enroll beneficiaries directly. Health screening prohibited.

SAVINGS PROPOSALS

- Increase overall Medicare savings to \$146 billion.
- Savings of \$146 billion includes proposal for income-related Part B premium. Under this policy, 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.

CHANGES INCLUDED IN MEDICARE COMPROMISE B

MEDICAL SAVINGS ACCOUNTS (MSAs) AND OTHER PLAN OPTIONS

- MSAs--Drop the demonstration terminology, and instead allow them to go nationwide with MSAs, but provide for a 3-year phase-in with a 10% cap. A 3-year phase-in is reasonable (these products won't be available nationwide for about that long, anyway), and the Compromise B proposal has other features that protect Medicare from losing lots of money and beneficiaries, including: (1) limiting participants to 10% of beneficiaries (around 3.5 million people); (2) holding capitated payments in the first year to only 75% of the AAPCC or average fee-for-service payment rate (this would be around \$3600 annually, as opposed to the nearly \$4800 annually that we pay for beneficiaries in risk contracts; the lower rate will help to compensate for the fact that many beneficiaries who currently spend very little will be attracted to MSAs); (3) requiring an "overpayment adjuster" in the legislation so that we can adjust payments in any year following a year in which the data indicates that the capitated payments were more than 10% higher than what the beneficiaries' actual health costs were; (4) requiring a longer lock-in for MSAs (two years as opposed to one); (5) requiring MSA balances to be spent on health expenses as defined by the Secretary and requiring beneficiaries to report to HCFA on year-end balances (so we can determine how much "profit" they are getting (or how much money Medicare is losing)).

All of these factors will make MSAs less attractive at the margins to beneficiaries; although the Conference staff will want to negotiate from here (I am sure they will want to start at a capitation rate higher than 75%, for example), all of these conditions are defensible (the Speaker himself has talked about a mechanism like the "overpayment adjuster"), and we should not do this unless we get most of them.

- Private fee-for-service plans--Compromise B allows these plans to be offered without a demonstration, but it includes features that (1) require physicians to abide by current law balance billing limits and (2) require that a county have a certain minimum participation level by physicians in traditional Medicare before these plans can be offered. Both of these features will minimize the incentives that doctors might have to leave traditional Medicare.

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

- This doesn't change. It is even more important if we allow them to go wall-to-wall with MSAs and private fee-for-service

plans, in order that the attractiveness of these new plans to beneficiaries and providers not drive up the per capita cost of those left in fee-for-service so significantly above the projections that fee-for-service Medicare will continue to breach the caps, be cut, and eventually "wither on the vine."

BALANCE BILLING

- This doesn't change. This is one we need to have if we are to preserve our position about protecting seniors/maintaining Medicare as a "defined benefit" as opposed to a "defined contribution."

PREMIUMS ABOVE MEDICARE CAPITATED PAYMENT

- This doesn't change, either. We've already compromised somewhat in Compromise A, in that we allow unlimited premiums for supplemental benefits so long as there is full disclosure.

MEDIGAP PROTECTION

- This doesn't change. Again, we've already compromised some by bowing to their concern about the effect that community rating of Medigap premiums might have on premiums; we allow Medigap insurers to charge higher premiums (so long as they are the same for everyone with the same demographic characteristics) to those who come back to fee-for-service after being in an MSA or private fee-for-service plan.

ENROLLMENT

- Compromise B specifies a one-year transition period before plans can contact and enroll beneficiaries directly (Compromise A was vague on how long the transition might last, but we discussed something like 3 years with Conference staff). I think they will agree with this. Otherwise, we've essentially folded on this one--this is probably not a problem, because they agree with the provision of FEHBP-like information to all beneficiaries, and if there are marketing abuses--which there surely will be in any event--we will hear about them, and Congress can deal with it.

SAVINGS PROPOSALS

- We've moved up to \$146 billion--I assume this is a net number. If it is, then that means we would need gross savings of around \$153 billion or so, because our additional benefits are costing us around \$7 billion. [Note: I'd accomplish this by taking our \$131 gross (i.e., \$124 net) and adding the income-related premium (\$10 billion, we hope), and then I'd look for another \$5 or so from a combination of ratcheting down slightly on managed care payment rates and the hospital update in the out-years.]

MEDICAL SAVINGS ACCOUNTS: CONCERNS BY HEALTH POLICY EXPERTS

The articles and editorials in the following newspapers and magazines express concerns about the negative impacts of medical savings accounts (MSAs). In addition, analysts from the listed think tanks have conducted studies which reveal the problems with MSAs:

The New York Times

The Washington Post

The Chicago Tribune

The Los Angeles Times

The Boston Globe

The Wall Street Journal

The Indianapolis Star

The New Republic

U.S. News and World Report

Blue Cross & Blue Shield of Ohio

Tax Notes

Center on Budget and Policy Priorities

American College of Physicians

The Brookings Institution

Consumers Union

Selected articles and editorials are attached. For copies of other articles or studies, please feel free to call 456-5560.

The New York Times

"G.O.P Bill Would Profit Insurer With Ties to Party"

by Robert Pear

04/14/96

The Golden Rule Insurance Company, which has close ties to Republican leaders, would profit from the medical savings accounts currently being proposed by Republicans in Congress. Republicans argue that medical savings accounts will expand health care choices for beneficiaries. But many Democrats say that MSAs — which will only help the healthier and wealthier — is a payback to generous lobbying campaigns from companies like Golden Rule Insurance.

Washington Post

"Health Care Turnabout"

Editorial

4/09/96

In the last Congress, Republicans argued that health care reform should be incremental. But now it is Republicans who are loading up the moderate Kassebaum-Kennedy health care bill with controversial amendments, the worst of which is medical savings accounts. MSAs would split and weaken the insurance system. While healthy beneficiaries would choose MSAs, vulnerable beneficiaries would be left in conventional insurance programs and would likely see their health care costs go up.

"Bad Move on Health Care"

Editorial

3/18/96

It used to seem as if Congress was going to pass modest health care reform, now Republicans are threatening to add amendments which could derail Kassebaum-Kennedy and some of which should derail it. Medical savings accounts are one proposed amendment which would weaken and fragment the system. While many people — including physicians who think it might save them from managed care — support MSAs, these savings accounts would create two-tiered health care system and increase the number of uninsured.

"Medical Savings Accounts: Potential and Pitfalls"

by Stuart Auerbach

Proponents argue that medical savings accounts give patients incentives to lower their health care costs. However, MSAs would drain profits from the current system, leaving older and sicker Americans in more expensive conventional health care programs.

Los Angeles Times

"Nix Insurance with a Tax Break; Health Care: High Deductibles Won't Reduce Costly Hospital Stays and Tests, the Most Expensive Segment of Care".

4/7/95

Medical savings accounts would not save health care dollars because most health care money is spent on a few sick people who are beyond cost-reducing incentives. They would, however, encourage doctors to focus on segments of care where financing is still open-ended, mainly long-term care and hospitalization. Even with cost-reducing incentives, however, MSAs could still not compete with managed care because unlike MSAs managed care could control the costs of their high cost patients. Furthermore, the article points out that MSAs would be attractive to the healthy and wealthy but would increase costs for sick and high risk beneficiaries.

Boston Globe

"MSAs a Suicidal Shoal for GOP"

by David Warsh

4/28/96

MSAs will cherry pick the rich and healthy who would opt out of the of their existing insurance plan. Those who are poorer and sicker who would be left in more expensive traditional plans. MSAs are backed by the Golden Rule Insurance Company, which already unapologetically insures only those likely to remain healthy. Medical savings accounts are also supported by some conservative think tanks and by Republican leaders, many of whom believe that this consumer controlled option help differentiate them from President Clinton.

"Medical Savings Mirage"

Editorial

11/18/95

Medical insurance works best if it is spread widely across the population. We want policies which distribute health care costs. MSAs do the exact opposite and therefore should have no place in our budget. MSAs are likely to have a harmful effect on young people who are more likely to use them.

The Wall Street Journal

"The Sick Would Lose, Healthy Would Gain"

Letter to the Editor

Len Nichols, Marilyn Moon, Susan Wall, The Urban Institute

11/03/95

Authors disagree with a WSJ editorial that says the sick would gain from MSAs. They believe that perhaps some sick people who currently have no out-of-pocket maximum would gain, but that healthiest beneficiaries would undoubtedly gain the most from medical savings accounts.

"Politics and Policy: Golden Rule Insurance Takes Lead in Advocating Mass as a Way of Controlling Health Care Costs"

by Phil Kuntz

05/15/95

Golden Rule Insurance Company, the industry leader in marketing MSAs to the private sector, has been touting MSAs to politicians while pouring hundreds of thousands of dollars into their campaigns.

"Politics and Policy: Goodman's Medical Savings Accounts Become a Hot Alternative to Overhauling Health Care"

by Laurie McGinley

04/12/95

MSAs which were viewed in 1994 by many Democrats as a peripheral issue, have become central plank in the GOP plan. Many expect some kind of MSA to pass Congress, which underscores how much the health care debate has shifted.

The Indianapolis Star

"Congress Ready to Adopt His Pet Project"

by Larry MacIntyre and George Stuteville

10/10/95

Pat Rooney, the chairman of Golden Rule Insurance Company may finally reap the political rewards for his and other executive's nearly \$1.5 million contributions to Congress. Congress may pass legislation which allows tax free medical savings accounts, which would benefits companies like Golden Rule Insurance.

The New Republic

"The Gold Standard"

by John Judis

11/06/95

Judis criticizes a Congress which he says is unduly influenced by special interests. One extreme example of this is medical savings accounts tacked on to the Medicare bill by Republicans who were responding to a five year lobbying campaign by the Golden Rule Insurance Company. While Golden Rule Chairman Pat Rooney claimed that medical savings accounts will save \$220 billion in health care costs, there is no evidence that MSAs would save any money. Instead, MSAs would discourage preventive care, benefit the healthy and wealthy, and undermine health care for less well off Americans.

U.S. News and World Report

"There They Go Again: This Year's Battle Over Health Care Reform is a Political Barometer"

by David Bowerlaster and Bruce Auster

04/08/96

MSAs are the most controversial aspect of the Kennedy-Kassebaum bill which critics argue will split the insurance market by attracting healthier and wealthier individuals and leaving sicker and less well off beneficiaries in conventional insurance programs.

Blue Cross and Blue Shield of Ohio

"Medical Savings Accounts: A Quick Fix That Could Destroy the American Health Care System"

by John Burry, Jr.

Medical savings accounts would be a windfall for the healthy and wealthy and would eventually bankrupt the health care system.

Tax Notes

"Medical Shelter Accounts"

by Lee Sheppard

As drafted in the House bill, MSAs would be one large tax shelter. Employers would find MSAs very attractive, since paying into an MSA in lieu of wages would enable them to avoid paying social security tax. The MSA is even a better deal for employees who pay no taxes if they withdraw money for medical expenses and pay income tax and a penalty tax if they withdraw for non-medical purposes, which combined are less than the normal income tax and

social security tax on income. Furthermore, MSAs would be entirely excluded from the taxable estate. It is clear that the rich will use MSAs as another tax-preferred investment account.

Center on Budget and Policy Priorities

"MSA Provision in Health Care Reform Bill Creates Tax Shelter and Casts Doubt on Expansion of Insurance Coverage"

by Iris Lav

This article cites a number of reasons why the inclusion of medical savings accounts in the health care reform bill could make it more difficult and less affordable for employers to offer adequate health insurance to employees most in need of it. Since the purpose of the health care reform bill is to expand insurance coverage, the inclusion of MSAs could undermine the fundamental purpose of this legislation.

"Who Will Use Medical Savings Accounts and Why Will They Use Them?"

by Iris Lav

The Joint Committee on Taxation recently released a study which estimates that large portion of middle- and low-income people would make use of MSAs. This data has been used to answer critics who say that MSAs would only benefit the wealthy. Lav argues that while low and middle income taxpayers may participate in MSAs involuntarily, it could seriously undermine their access to health care. They would likely participate in MSAs because their employers replaced their conventional health insurance plan with MSAs. Those with chronic health problems that require continuing care or consume large amounts of preventive care, may no longer be able to afford their necessary health care costs under a high deductible plan. Furthermore, there is nothing in the current bill which requires employers to make any deposits to MSAs as a condition of offering high-deductible insurance. Without employer contributions, low and moderate income employees would have to finance their high deductibles alone, making it even more likely that they will incur unaffordable health care costs or be unable to afford adequate levels of health care services.

American College of Physicians

"Medical Savings Accounts"

by Jack A. Ginsburg

The American College of Physicians expresses concern that medical savings accounts may not help those who are unemployed or low and middle-income who cannot afford such accounts. Indeed, MSAs may result in reduced health insurance protection and greater out-of-pocket costs for those most in need of health care services. Problems of adverse risk could arise as the healthy choose to establish MSAs causing higher premiums for the less well off who are left in traditional insurance programs.

The Brookings Institution

"Medical Savings Accounts: Facts versus Fiction"

by Joseph White

This article makes three central points: 1) Medical savings accounts will not resolve the current health financing problems; 2) An MSA-based approach will have winners and losers. The winners will be those who are healthier and the losers will be those individuals with greater health problems; and 3) MSAs alone will not expand access to health care. In fact, they could even reduce access for those who need health care the most.

Consumers Union

The Consumers Union cites a number of reasons Congress should reject MSAs including, 1) Risk Selection. MSAs would further divide a system which already caters to the health and wealthy at the expense of poorer and sicker individuals; 2) Low-income individuals, who will not be able to afford high deductibles and out-of-pocket costs will be left in the traditional insurance pool with higher health care costs; 3) MSAs would increase the size of the federal budget 4) there would be no safeguards for consumers who choose MSAs, so even those who could afford them may not be guaranteed health care coverage.

II. Medical Savings Accounts for Medicare Beneficiaries

The New York Times

"Drop Medical Savings Accounts"

Editorial

11/13/95

MSAs would attract healthy and wealthy beneficiaries who could afford high deductibles. However, these retirees would choose tax-free accounts when their healthy and then revert back to traditional Medicare when they get sick. Furthermore, according to CBO, MSAs would drain health care revenues and increase the budget deficit. Congress should reconfigure Medicare on behalf of all retirees not just a select few.

"Medicare Misfire"

Editorial

09/17/95

While Speaker Gingrich claims he wants to reform Medicare, his proposals would undermine health care for the elderly. Tax-free savings accounts would only attract healthy retirees, leaving the chronically ill to sign up with managed care and Government health programs.

Chicago Tribune

"Don't Put Much Faith in the Republican's Hype About Fixing Medicare with Medical Savings Accounts"

by Joan Beck

10/26/95

Medical savings accounts would not, as House Republicans suggest, contribute to savings in health care. MSAs are an untried theory developed by Golden Rule Insurance, a savvy lobbying organization offering lavish political contributions. We need to cut the costs of Medicare, but giving money to those who stay healthy would just raise overall health care costs, since those with high costs would opt for traditional Medicare.

Wall Street Journal

"Unequal Treatment: Medicare Bill Passed by House Would End Egalitarian Approach: Wealthy Stand to Gain, the Poor May Be Hurt"

by Laurie McGinley and Chris Georges

10/20/95

The bills before the House and the Senate could turn Medicare into a multi-tiered system. Medical savings accounts are only mentioned in one section of this article about broad sweeping health care reform. Authors cite critics who say MSAs would only be a viable option for the healthy and wealthy and argue that leaving the sicker weaker beneficiaries in the traditional program would trigger rising health care costs and further cutbacks in coverage.

Health Care Turnabout

IN THE last Congress, it was mainly (though not entirely) the Republicans who argued that health care reform should be an incremental process. They criticized the president for loading up his proposal to pay off political debts and achieve assorted ideological objectives.

Now the shoe—or is it the cast?—is on the other foot. The president and most congressional Democrats are supporting what in the Senate at least remains thus far a relatively modest bipartisan bill. It is the House Republicans who have insisted on decorating their version with some sharp-edged amendments. The Democrats and some moderate Republicans warn that if the ill-advised amendments stick, the bill will likely fail—and so it should. Those in the House and the few in the Senate who would use it as a vehicle for other purposes should back off.

The worst of the amendments involves what are known as medical savings accounts. The goal of the underlying bill is to strengthen the health insurance system by making it easier for people who can afford it to remain insured between jobs. Mainly it would help the part of the population that already has insurance rather than the one-seventh that, largely for reasons of cost, does not. But that's not an unimportant step to take.

The likely effect of medical savings accounts, however, would be to push in the opposite direction, weaken the insurance system and in the end add to the number of uninsured. If the medical savings proposal became law, those who chose would buy so-called catastrophic insurance policies that kick in only after the first \$3,000 or so of annual expenses.

The premiums for those, which would be much lower than for conventional insurance, would receive the same tax treatment as under current law.

An additional amount would then be put in a savings account for the participant. It too would be tax deductible and/or exempt as premiums are now. The recipient would use the build-up to pay medical bills not covered by insurance; under certain circumstances, some would also be available for other purposes. Proponents say the device would give people greater freedom to shop for care and make them better shoppers, much more likely to try to hold down costs, since they would be drawing on their own funds.

But in the process, the savings accounts would also likely split the insurance market. They represent a gamble; the people who would most likely take the gamble would be the healthier and better-off. To some degree, they would be choosing to withdraw from the broader insurance pool to fend for themselves. Left in the pool would be the more vulnerable, who would likely see their insurance costs go up; the increase would make insurance even harder to maintain than now.

In a sense this is the very opposite of the insurance principle. It is being pushed by companies that want to sell the catastrophic coverage, plus people drawn to the individual responsibility that the idea entails. But for the population as a whole, it would do more harm than good. The president has rightly suggested that he would be disposed to veto a bill that included these accounts. The Senate should save him the trouble.

G.O.P. Bill Would Profit Insurer With Ties to Party

By ROBERT PEAR

WASHINGTON, April 13 — A health insurance company with close political and financial ties to Republican leaders stands to benefit substantially from a proposal that conservative Republicans want to add to a major health insurance bill scheduled for debate next week on the Senate floor.

The proposal, already approved by the House, would create tax incentives for people to set up medical savings accounts to pay health care expenses. The company, the Golden Rule Insurance Company, sells a special type of health insurance that would have to be purchased by people with such tax-free accounts.

The insurance has high deductibles and relatively low premiums but would pay medical bills exceeding the amount for which the patient was responsible — \$1,500 a year for an individual and \$3,000 for a family, under the House bill. The proposal would allow people to put pretax dollars into the medical savings accounts to pay their deductibles.

The main purpose of the Senate and House bills is to guarantee that people in employer-sponsored health plans would be able to get health insurance after switching or losing their jobs. But some Republican senators, like House Republican leaders, insist that the bill must also encourage medical savings accounts.

Many experts on health care and insurance say such accounts are, at best, a quirky idea that would be worth trying on only a small scale, with proper safeguards for consumers. The Congressional Joint Committee on Taxation estimates that a million households would establish the accounts under the bill approved last month by the House.

The proposal is generating political passion out of proportion to the number of people expected to sign it. Speaker Newt Gingrich and other Republicans say that medical savings accounts would give consumers wider choice of health insurance options, strong new incentives to control health costs and more control over the use of the money earmarked for health care.

But many Democrats denounce the accounts as bad health policy. They say that the proposal is being pushed by Republicans as a reward to Golden Rule and its former chairman, J. Patrick Rooney, a long supporter of Republican causes. His father founded the company, and his family controls it.

The medical savings accounts would work this way. An employer or an employee could put money into the account, and that money would belong to the employee. Any money not used in one year could be carried over and invested, like the money in an individual retirement account. Earnings on such investments would not be taxed, and money withdrawn from a medical savings account would not be subject to income tax if it was used for medical expenses.

At the heart of the debate is an empirical question: are healthy people more likely than sick people to establish medical savings accounts? Most Democrats say yes, while Republicans say no.

The Congressional Budget Office and the American Academy of Actuaries share the concern that younger, healthier people would be more inclined to choose medical savings accounts and the high-deductible in-

Medical savings accounts, approved by the House, come under fire.

urance policies that go with them.

Democrats say that sick people and those with chronic health problems would prefer conventional insurance because the deductibles are much lower: an average of \$250 a year for individuals and \$600 for families. Patients are personally responsible for those amounts, and sick people generally know they will have higher medical expenses, so they will shun the high-deductible policies, the Democrats say. They say healthier people would have more to gain from medical savings accounts because they would have more money left over at the end of a year.

Republicans, by contrast, say the high-deductible policies would also appeal to sick people because the policies could provide unlimited protection against catastrophic medical expenses after the deductibles were met. Insurers now often set annual or lifetime limits on the benefits that will be paid for a subscriber.

But Cathy L. Hurwit, legislative director of Citizen Action, a consumer group with three million members, said, "In theory, the insurance

company would pay all health care costs once you pay your deductible, but nothing in the House bill requires that."

Representative Pete Stark, Democrat of California, said on the House floor last month that the Republican proposal was "a payoff to the Golden Rule Insurance Company" — a characterization disputed by Republican leaders and Golden Rule executives.

Representative Cynthia A. McKinney, Democrat of Georgia, asked on the House floor: "Why medical savings accounts? Just follow the money. The Golden Rule Insurance Company has given more than \$1.4 million to the G.O.P., and, coincidentally, Golden Rule just happens to be the premier company peddling medical savings accounts."

Mr. Rooney offered slightly different numbers. In an interview, he said that he and Golden Rule employees had given \$1.1 million to the Republican National Committee and Republican candidates for Congress since January 1993. Common Cause, the public affairs lobby, said that Mr. Rooney and John M. Whelan, Golden Rule's president, had given more than \$117,000 to Gopac, the political action committee that helped Mr. Gingrich take control of the House.

Golden Rule, which describes itself as one of the biggest suppliers of health insurance to individuals and small groups and says it covers about 1.8 million people, it has shown persistence in trying to promote medical savings accounts.

Mr. Rooney, a maverick in the insurance industry, said: "I support medical savings accounts because I believe they are good for the American people. It's no shock to me that I am being condemned, or my company is being condemned. We are caught up in the conflict between the two parties."

But Mary Nell Lehnhard, senior vice president of the Blue Cross and Blue Shield Association, said, "We're afraid that medical savings accounts will segment the market into people who are very healthy and people who are not healthy." If that happens, she said, "you lose the whole principle of insurance, which is cross-subsidy," with premiums being collected from people who are healthy today to subsidize care for the sick.

"You need a mix of people who are using health care services and people who are not to make it affordable for everyone," Ms. Lehnhard said.

Members of Congress say the overall health insurance bill has an

excellent chance of becoming law, but the outlook for medical savings accounts is less clear. Mr. Gingrich said he would not risk President Clinton veto over the issue, but other conservatives planned to fight for the accounts in a House-Senate conference.

The bill scheduled for debate next week is sponsored by Senators Nancy Landon Kassebaum, Republican of Kansas, and Edward M. Kennedy, Democrat of Massachusetts. Conservative Republicans say they will propose amendments to encourage medical savings accounts. Mrs. Kassebaum, Mr. Kennedy and the White House oppose such amendments, saying they could sink the bill.

The House and Senate bills would restrict practices that insurers use to identify people with medical problems. Mr. Rooney said that Golden Rule sometimes denied coverage to such people or charged them high premiums.

Mr. Whelan, defended those practices in testimony before Congress in 1994: "Fire insurance is not provided after the house catches fire," he said, "nor is auto-theft insurance provided after the car is stolen. To provide health coverage to people for a medical condition which has already occurred may be charitable; it is not the business of insurance."

But Ms. Hurwit of Citizen Action said: "The idea that health insurance is only for the healthy is absurd. Eighty-one million people have some form of health problem that could be labeled a pre-existing condition, everything from asthma to cancer."

Golden Rule has resisted efforts by several states to require the sale of health insurance to all applicants and to limit premium variations.

When New Hampshire was considering such legislation in 1993, State Senator Jeanne Shaheen, a Democrat, issued a news release saying, "Golden Rule represents everything that is wrong with health care in America." She asserted that the company had "resorted to lies and half-truths," telling policyholders that their premiums would soar. In Kentucky, State Representative Ernesto Scorsone, a Democrat, said that Golden Rule had run a campaign of "disinformation, misinformation and outright deception."

Mr. Whelan acknowledged that the company's lobbying had been "forceful and aggressive." But he said that Golden Rule had violated no laws and was merely trying to protect policyholders.

MONDAY, NOVEMBER 6, 1995 A5

Medical Savings Accounts: Potential and Pitfalls

Healthy Americans Could Save and Get Cash, but Older and Sicker Would Suffer, Critics Say

By Stuart Auerbach
Washington Post Staff Writer

When Jack Strayer developed warts on his face from a fungus picked up on a trip to the Yucatan, he decided to have them burned off without anesthesia to save \$120. He also put his gum surgery up for bid to three periodontists.

If Strayer had his way, that's how all Americans would shop for their health care.

The health care plan Strayer uses includes a medical savings account. His employer, the Council for Affordable Health Insurance in Alexandria, purchases a health insurance policy on his behalf with a deductible of \$1,000. In addition, Strayer is given \$1,000 a year to spend on medical care, and whatever he saves, less taxes, goes into his pocket. After he spends the entire \$1,000, his company's health insurance policy kicks in to cover major illness.

The plan offered by Strayer's eight-person organization, an advocate for this new idea in financing health care, is more gold-plated than most, because the health insurance kicks in immediately after \$1,000 is spent. Most medical savings account plans require between \$800 and \$1,800 in out-of-pocket expenses before supplemental insurance starts.

So far, this approach to medical coverage is more talk than action. Only a small number of firms have adopted medical savings account plans. In most instances, the plans are too new to provide meaningful data on how medical savings accounts compare with more traditional health plans. Companies that offer them tend to be smaller firms of white-

collar workers. One of the most visible employers is GOP presidential hopeful Malcolm S. "Steve" Forbes Jr., whose Forbes magazine employs about 500 people. Another is Golden Rule Insurance Co. of Indianapolis, with 1,200 employees. Fewer than 100 city employees in Jersey City use a medical savings account plan.

Nonetheless, such plans have attracted national attention and are being promoted by some physician groups and Republican congressional leaders, who incorporated them in the House legislation to overhaul Medicare, giving senior citizens the opportunity to pick medical savings accounts over traditional insurance programs. The provision may be part of the huge budget reconciliation bill the House and Senate eventually will send to the president. The White House has not yet weighed in on the issue.

The concept has drawn sharp opposition from insurance carriers, some consumer groups and the Blue Cross-Blue Shield organization that provides coverage for hospital and physician services. They argue that it would benefit doctors because it eliminates curbs on what doctors can charge or what services they can provide, and could skim off the healthy and wealthy, leaving the sick and poor for traditional insurance carriers.

Strayer and other supporters brush aside these complaints. They argue that medical savings accounts allow patients to make their own rational decisions on how they buy health care based on its cost. Strayer, who worked in Congress for then-Rep. David A. Stockman, later President Ronald Reagan's budget chief,

believes patients should buy health care the same way they buy cars—by comparing prices that doctors, hospitals and other providers charge. He says that traditional health insurance plans offer no incentives for patients to question doctors about their fees but that patients would do so if lower costs meant cash in their pockets.

The plans attack rising medical costs "by giving consumers a stake in reducing them," J. Patrick Rooney, chairman of Golden Rule, told *Physician's Weekly*. He added that Golden Rule's two-year experience with medical savings accounts has "been a wonderful success" that "controlled costs, increased access to preventive care . . . and promoted wellness."

Edward Husted, chairman of an American Academy of Actuaries task force and a senior vice president of The Hay Group, an actuarial consulting firm in Washington, strongly disagrees with that view. Husted said that Rooney over a period of months has refused to supply data for the actuarial study. Rooney did not return phone calls for this article.

Husted said proponents of medical savings accounts assert "everybody's going to be better off."

"They are not," Husted said. The academy's report, released last month, concludes that if medical savings accounts were adopted for all Americans, the sick and the elderly would be hurt. The report studied legislation sponsored by House Ways and Means Committee Chairman Bill Archer (R-Tex.) promoting medical savings accounts for all Americans.

The young and the healthy will be better off. Those with large health bills will not, and they are 8 percent of the population. It is taking money

from the unhealthy and giving it to the healthy," Husted asserted.

That happens because conventional health insurance plans would be left with costs of caring for the oldest and sickest patients while young, healthy patients would opt for the extra cash that medical savings accounts allow, said Susan Foxworth Skerker, senior director of public policy at Ford Motor Co., which spends \$1.4 billion a year on health benefits. In the insurance field, this is known as cream-skimming or cherry-picking.

"MSAs would be a windfall for the healthy and a bane to the sick. They would provide a cash infusion to two-thirds of all Americans and a big cash drain to the third who use the system the most," John Barry Jr., chairman and chief executive officer of Blue Cross & Blue Shield of Ohio, told *Physician's Weekly*.

What's more, critics of the approach question how much control patients really have in making a rational choice of who provides medical care.

Despite all the political fanfare surrounding the medical savings account idea, Husted doesn't expect a stampede to that option. Most Americans are conservative over how they pick health care coverage and prefer to stick with tried and true programs.

"People with low incomes or high health expenditures are likely to prefer other health care options. However, certain segments of the health insurance market—particularly the self-employed and highly paid—might gravitate toward MSAs because of tax advantages," he said.

LEVEL 3 - 24 OF 24 STORIES

Copyright 1995 The Times Mirror Company
Los Angeles Times

April 7, 1995, Friday, Home Edition

SECTION: Metro; Part B; Page 7; Op-Ed Desk

LENGTH: 748 words

HEADLINE: NIX INSURANCE WITH A TAX BREAK;
HEALTH CARE: HIGH DEDUCTIBLES WON'T REDUCE COSTLY HOSPITAL STAYS AND TESTS, THE MOST EXPENSIVE SEGMENT OF CARE.

BYLINE: By ALAIN C. ENTHOVEN and SARA J. SINGER, Alain C. Enthoven is a professor at Stanford University's Graduate School of Business. Sara J. Singer is his special assistant.

BODY:

At least four members of the California Legislature have copied some federal lawmakers and introduced bills that would create tax-favored medical savings accounts designed to be used in combination with high-deductible or "catastrophic" insurance (for example, the patient pays the first \$3,000 a year) to encourage people to set aside the money needed to pay for care below the deductible. (The new, tax-favored MSAs differ from tax-free accounts available to some people now through their employers because they would be available to everyone, and money not spent at the end of the year would accumulate rather than being forfeited.)

The idea is that if consumers use their own money, they would be more cost-conscious in their use of care. And, if they could have tax-favored MSAs, they would be more likely to accept high deductibles.

But this is the wrong way for the federal government to solve health-care cost, access and quality problems and an even worse solution for California alone.

Exempting MSAs from state taxes probably would be ineffective, because people's behavior is driven mainly by federal tax considerations. And even if favorable state tax treatment persuaded people to adopt MSAs, high-deductible coverage would do little to moderate cost growth in the long run, since most spending is concentrated on a few sick people who are beyond the cost-reducing incentives of the deductible. In 1993, 80% of health-care spending went for the 15% of people with the highest costs, exceeding \$3,050. When someone is diagnosed with a condition he knows will cost more than \$3,000 to treat, more care for his whole family is "free." The incentive to economize is gone.

The important opportunity for savings is not in deterring mothers from taking their children to the pediatrician for the sniffles, but in motivating doctors to provide high-cost care efficiently, and only when it is appropriate. Once hospitalized, patients' spending is unaffected by coinsurance and deductibles, because catastrophic coverage has no impact on doctors' incentives. If everyone had \$3,000-deductible insurance, doctors and hospitals would focus on the



Los Angeles Times, April 7, 1995

segment of care in which financing was still open-ended. Pediatricians would leave primary care and go into neonatology. Costs would increase due to lack of preventive services and early treatment. For example, a recent study of acute appendicitis patients in California found that patients covered under indemnity insurance were 20% more likely than those in prepaid (first-dollar) plans to develop ruptured appendixes.

Another important problem with catastrophic coverage is that the \$3,000-deductible policy would be relatively attractive to the healthy and wealthy. Those who could afford it would be ahead financially so long as they did not need to use their deductible. This would increase costs for the sick and high-risk, left in comprehensive coverage. Making the contributions to an MSA tax-preferred would make catastrophic coverage even more attractive to more people. The bad risks would increasingly bear the cost burden of their care. In a spiral of increasing costs and higher risks, first-dollar coverage would be driven from the market -- a desired outcome, in the view of tax-preferred MSA proponents. But do we want a woman in a five-year struggle with breast cancer to have to spend \$3,000 per year more than someone who has the good fortune to be healthy?

Tax-favored MSAs raise other problems. At a minimum, the additional money going into MSAs would increase state tax losses. Money not spent on Internal Revenue Service-eligible medical expenses could be withdrawn without penalty, so people could accumulate interest on money in MSAs tax-free, paying taxes on the money only when they withdrew it.

Some of the enthusiasm for catastrophic coverage comes from insurers that have not developed managed-care capabilities and depend on indemnity insurance. They think that this approach would give indemnity insurance a better chance to survive against managed care. But catastrophic insurance would not save indemnity insurance. Managed-care organizations would develop competitive products, taking advantage of their superior ability to control the costs of high-cost cases.

The federal government could try an after-tax MSA approach that would be strictly neutral with respect to the type of insurance people choose. But California should not, at least not until the federal government acts first.

LANGUAGE: ENGLISH

LOAD-DATE: April 8, 1995



LEXIS·NEXIS™



LEXIS·NEXIS™



LEXIS·NEXIS™

Boston Globe 4/28/96

ECONOMIC PRINCIPALS

David Warsh

MSAs a suicidal shoal for GOP

WHAT HAVE YOU HEARD about medical savings accounts. MSAs for short? The pitch for them is simplicity itself.

MSAs are said to be like IRAs — tax-sheltered saving accounts, but for medical purposes instead of retirement. You put some money aside to pay the doc for little things, say \$2,000 or \$3,000 a year. If you don't get sick, you roll it over and eventually you pocket it.

For big things, you buy a cheap catastrophic insurance policy with a big deductible, another \$1,000 or so. It takes care of you if you get really sick.

MSAs are said to give you more choice and more control over the doctors you see. If you like, you can pay a little more for a sawbones who will take the time to talk. Or you can wait a day or two to call in hopes of saving some money. No other health reform so powerfully affects consumer behavior. Meanwhile, your doctor gets to practice medicine the old-fashioned way. Only the insurance bureaucracies and the dictatorial health maintenance organizations lose. Everybody else will be better off.

If you believe that's how MSAs would work, I've got a bridge to show you.

MSAs were in the news last week because Sen. Bob Dole is said to want them included in the health care legislation now awaiting reconciliation by a House-Senate conference committee.

Liberal Republicans, led by Sen. Nancy Kassebaum (R-Kansas), deserted Dole on the Senate version of the bill, deleting MSAs. Dole is seeking to restore them in the conference version. President Clinton has promised to veto the measure if it contains MSAs.

Thus the two candidates are on the brink of squaring off, clearly and firmly, pro and con, on the proposition that MSAs would be good for the health care system.

What's the problem? Just this: MSAs would touch off a whole new round of "cherry-picking," of "cream-skimming" (or "adverse selection," as it is formally known) that could seriously damage a health care system which is slowly righting itself on its own.

With MSAs, healthy people would opt out of existing insurance plans, seeking cheaper rates by joining pools of low-risk subscribers. Old and unhealthy people — high risks — would be left behind. Their rates would soar.

A task force of the American Academy of Actuaries studied the House proposal and concluded unambiguously that it would harm the poor and sick. A nonpartisan society of the mathematical elite who calculate the financial effects of complex programs, the actuaries are about as close to a competent, perpendicular judge of the matter as can be found — a supreme court of arithmetic.

Edward Husted, an actuary who headed the task force, said, "The young and the healthy will be better off. Those with large health bills will not, and they are 8 percent of the population. It is taking money from the unhealthy and giving it to the healthy."

Who wants MSAs? Support for them is narrow, but mighty deep. Peek behind the scenes to see who is pushing the idea and the first organization you find is Golden Rule Insurance Co. of Indianapolis.

With more than 800,000 policyholders, Golden Rule is among the nation's biggest sellers of individual health insurance. MSAs would greatly expand its lucrative market.

When the Wall Street Journal spotlighted the company in 1994, reporter Leslie Scism wrote, "Perhaps no other health insurer can cherry-pick its way to unusually high profits as well as Golden Rule." The company does well in the low-profit industry, "because its hardball legal tactics often carry the day."

Golden Rule is one of the nation's toughest cops of "moral hazard" — the practice of buying insurance only after you know that you're sick. It bluntly asserts that it wants only healthy customers: its application forms are pages long. "Fire insurance is not provided after the house catches fire," the company's president told the Journal. The company sometimes declines to pay for treatment if it can find an unrelated illness that wasn't disclosed.

Many policyholders sue when the company decides they aren't covered for "previously existing conditions," the Journal found, but few collect. Most just slink away at the prospect of still more legal bills.

What about people who have become sick through no fault of their own — yet who lack coverage? Giving them health care "may be charitable, but it is not the business of insurance," says the company's president.

Golden Rule is largely owned and run by 68-year-old J. Patrick Rooney, son of its founder. He's been a lavish funder of Republican congressional campaigns, including

MSAs a suicidal shoal for GOP

■ WARSH

Continued from page A97

GOPAC, the Republican political action committee chaired until last May by Newt Gingrich.

A second rank of proponents includes a handful of conservative think tanks. Chief among them is the Center for Policy Analysis in Dallas, founded in 1983 by economist John Goodman to promote MSAs and bankrolled (to a diminishing extent) by Rooney. Former Delaware Gov. Pete Dupont is an adviser.

Forbes magazine, where maverick presidential candidate Steve Forbes holds forth as publisher, established a modified version of an MSA plan two years ago.

Milton Friedman, the conservative economist, is a prominent supporter. He has argued that the measure would restore to medicine the bucolic standard that prevailed before the Russian Revolution.

A third tier of support for MSAs is the American Medical Association, the old-guard group of physicians that apparently views the MSA as a last-ditch means of preserving a fee-for-service world. The fee-for-service mechanism, in which doctors had incentives to spend heavily on behalf of patients, as long as the patient was insured, has been widely blamed for the crisis of escalating costs that began the binge of "cream-skimming" in the 1970s.

The continuing shift to "managed care" — meaning corporate oversight of doctors' practices by health maintenance organizations and insurance companies — was the chief result of the health care cost crisis. The AMA hopes that medical savings accounts will reverse the trend.

Finally, many Republican political leaders apparently view the MSA as a way of differentiating their

product — of showing they possess a "conservative vision" of how the economy should work that is fundamentally different from that of Clinton.

Dole and House Speaker Gingrich are only the most prominent. House Majority Leader Dick Arney (R-Texas) and Ways and Means Chairman Bill Archer (R-Texas) are others, as are Sen. Phil Gramm (R-Texas) and Rep. Dan Coats (R-Ind.). Massachusetts Gov. William F. Weld is thought to be a fan.

Many conservative health care experts have watched in horror as the leadership of the Republican Party has fastened on the issue of the MSAs. Managed care organizations don't like the savings accounts; neither do the hospitals nor the medical schools. Big businesses, which purchase most of the nation's health care, are generally opposed. So are the unions.

However much they may cherish the days of solo practitioner, most Americans recognize that the era of corporately managed, high-tech medicine is here to stay. They understand that the principle of insurance is different from "free enterprise" or "everyman for himself" — that access to basic health care is a human right that should be insured.

The 1992 presidential election went to the party that best kept its crazies under control. George Bush let Pat Buchanan and the "social issues" ideologues dominate his convention. Clinton kept his left-wing supporters on a short leash and was elected in November. •

The GOP is once again flirting with disaster — this time at the hands of its economic extremists. Incredibly, the man who botched a once-in-a-lifetime opportunity to reform the health care system may be about to get a second chance.

LEVEL 3 - 11 OF 24 STORIES

Copyright 1995 Globe Newspaper Company
The Boston Globe

November 18, 1995, Saturday, City Edition

SECTION: EDITORIAL PAGE; Pg. 10

LENGTH: 536 words

HEADLINE: Medical savings mirage

BODY:

Medical insurance works best if it is spread widely across the population. Healthy people defray the costs of those who are sick in the expectation that they will need help when they become ill. A proposal for so-called Medical Savings Accounts runs counter to this broad-based approach and ought to have no place in the budget legislation now clearing Congress.

Unfortunately, these private accounts, a kind of medical IRA, are a centerpiece of the Republican proposal to transform Medicare. While they would have little impact on Medicare, which is not insurance so much as a government-to-recipient subsidy, they would have pernicious consequences if applied to younger people, who are more likely to avail themselves of the system.

Under the proposal, people would receive a set amount - from the government in the case of Medicare, or from their employers. They would be expected to buy an insurance policy to cover major hospitalizations and other medical catastrophes. The rest of the money would go into a medical savings account, which could be used for routine care. Any amount left at the end of the year would be the account holder's to keep.

The key numbers here are the difference between the figure at which the catastrophic policy kicks in and the amount in the medical savings account. Proponents often use the example of someone with a \$ 1,500 account and an insurance policy for expenses above \$ 5,000. If the account holder required treatment for a chronic condition that did not require hospitalization, he or she might have to spend \$ 3,500 out of pocket.

House Republicans have tagged this plan onto the Medicare section of the huge budget reconciliation bill. The Congressional Budget Office expects that if approved, it might cost \$ 600 million a year. This is comparatively small change in the \$ 160 billion annual Medicare budget. Most elderly people, the CBO reckons, will decide against the plan on the risk that they would have to pay a large out-of-pocket amount.

The real danger lies in a parallel GOP proposal that would use tax breaks to encourage younger people to open these accounts. With such incentives, many healthy people might be tempted to switch from conventional insurance.

Any discussion of medical savings accounts obscures the real crisis in health insurance: the fact that 39.7 million Americans lack protection, a number that



LEXIS·NEXIS



LEXIS·NEXIS



LEXIS·NEXIS

has increased from 31 million in 1987.

In 1984 Singapore revised its health care system to mandate medical savings accounts for its 2.9 million citizens. Every wage earner pays into a series of funds; those who cannot afford the contribution are assured of subsidized care in public hospitals and clinics. Something like this plan might have merit in the United States if every citizen were included and if the government committed itself to subsidize the poor, both healthy and sick.

The Senate excised medical savings accounts from its version of the bill, but the plan was restored in conference committee. That was a mistake. This flawed proposal should have no place in the health care debate until Congress is ready to consider a plan that spreads the cost of one person's illness among 250 million Americans.

LANGUAGE: ENGLISH

LOAD-DATE: November 20, 1995



LEXIS·NEXIS



LEXIS·NEXIS



LEXIS·NEXIS

THE INDIANAPOLIS STAR

Tuesday, October 10, 1995

PAT ROONEY'S GOLDEN TOUCH: *Last of three parts*

Congress ready to adopt his pet project

By Larry MacIntyre
and George Stuteville
STAFF WRITERS

Lobbying Congress is like playing in a high-stakes Las Vegas poker tournament.

It costs a lot to sit at the table, and the opponents are tough. But if you stay in the game — and don't fold — you can win big.

Pat Rooney, chairman of Golden Rule Insurance Co., may be on the verge of winning after three years of lobbying Congress for medical savings accounts — his

■ After years of lobbying and campaign donations, OR seen for some type of medical savings account.

market-based solution for controlling America's health care costs.

To make Golden Rule a serious player in the Congress of the 1990s, Rooney, his company and other executives have anted up nearly \$1.5 million to congressional campaign and political funds since 1989. Those contributions include \$190,000 to House Speaker Newt Gingrich, R-Ga., perhaps the most important deal-

er on Capitol Hill.

And now the Republican-controlled Congress has dealt Rooney two pieces of legislation that contain medical savings accounts.

One bill is almost certain to pass. It would let people of all ages establish tax-deductible medical savings accounts coupled with catastrophic health insurance policies.

The other measure would make

the medical savings account concept a part of reforming Medicare, the government's health insurance plan for the elderly and disabled. Its passage depends on the direction the Medicare debate takes in Congress this month.

In both bills, medical savings accounts are the centerpiece of the Republican plan to reduce the number of Americans without health insurance and control the nation's rising health care costs. With about a third of the House

What are medical savings accounts?

The plan for medical savings accounts that is pending before Congress would work like this:

■ An individual would be allowed to establish a tax- exempt medical savings account provided he or she also took out a high-deductible health insurance policy to cover catastrophic illnesses.

■ An individual could put up to \$2,500 a year into the account, with families allowed up to \$5,000. Contributions from either the individual or the employer would not be taxed.

■ To qualify for the tax break, the insurance deductible would have to be at least \$1,600 for an individual or \$3,600 for a family.

■ Money from the savings account would be used for routine medical expenses, such as doctor visits and prescriptions.

■ Workers could keep whatever money was not used at year's end and roll it into the next year or withdraw it as taxable income with a 10 percent penalty.

■ The health insurance plan would kick in after individual spending — either from the savings account or out of pocket — reached the deductible.

■ Some expenses, such as dental and eyeglasses, would be allowed from the medical savings account but would not necessarily be counted toward the insurance deductible.

See ROONEY Page 4



TRB

FROM WASHINGTON

The gold standard

Central to the House Republicans' Contract with America is the distinction between government geared to "the people" and government geared to "special interests." "We are united here today, over 150 current members of the House and over 200 candidates, united in the belief that the people's House must be wrested from the grip of special interests and handed back to you, the American people," Dick Arney declared in September 1994 when he introduced the contract on the Capitol steps. That's good populist rhetoric, yet this year's Republican House has turned into a bachelorette for special interests. It's the most lobby-driven Congress since the postbellum days when Jay Cooke and the railroad interests had free rein.

There are examples all over the place, in Republican-sponsored legislation governing everything from defense to telecommunications, to securities, to business tax relief. But my favorite for sheer perversity is a provision on Medical Savings Accounts, or MSAs, that the House leadership slipped into the Medicare bill. While House Republicans claim that "the Medicare Preservation Act of 1995" would save the federal program from imminent bankruptcy, this measure would actually raise Medicare costs—by \$2.3 billion over seven years, according to the Congressional Budget Office. It is in the bill for only one reason—a successful five-year lobbying campaign by Indiana's Golden Rule Insurance Company.

Golden Rule is the kind of company that any reasonable national health care reform would have doomed to extinction. This \$600 million corporation built its business by carefully choosing whom it would insure. *Consumer Reports* ranked it "near the bottom" of insurance companies because of its inadequate coverage, frequent rate increases and readiness to cancel policies. As it began to lose business in the '80s to insurance companies that sell managed care plans, it devised a plan for MSAs. Instead of buying a comprehensive insurance policy with a low

deductible, or signing up with an HMO, a firm's employees would purchase a high-deductible catastrophic policy that would, say, only cover costs over \$3,000. But the employer would also establish a medical savings account of \$1,500 to pay for medical expenses. If healthy individuals spent less than \$1,500 during the year, they could pocket the remainder.

Golden Rule touted MSAs as a way of keeping down medical costs by discouraging policy holders from purchasing health care. Doctors liked them because they weren't managed care. And young, healthy employees liked them because they might get money back. Most businesses, however, shied away because MSAs didn't save them any money. And policy experts like Stanford's Alain Enthoven scorned them because they undermined the logic of health insurance: they raised the costs of insurance for the potentially sickly by removing the young and healthy from the actuarial pool. They didn't actually reduce health costs, which are concentrated among the very sick. If anything, they raised them by discouraging people from getting preventive care and early treatment.

Failing in the market, Golden Rule and its chairman, Pat Rooney, did what any wily Republican does: they sought government help to boost their business. Rooney helped start and fund a Dallas think tank, the National Center for Policy Analysis, and a Washington lobby, the Council on Affordable Health Insurance, to promote MSAs as a panacea. Rooney, his executives and Golden Rule's PAC began throwing money at Congress, spending about \$1.4 million in five years. Last year, they contributed more to the Republican National Committee than any other business. They funded not only Newt Gingrich, but also GOPAC and the Progress and Freedom Foundation.

In 1993, Phil Gramm, a recipient of Golden Rule largess, sponsored a bill that would have made MSAs the model for national health insurance. In the House, another Golden Rule beneficiary, Bill Archer, who would later become chairman of the House Ways and Means Committee, introduced a measure to make the funds contributed to an MSA tax-deductible. Neither bill passed in the Democratic Congress, but when the Republicans took over last November Rooney and Golden Rule had reason to celebrate. Archer has put a deduction for MSAs in the tax bill. And the House leadership inserted a provision in the Medicare bill that would allow senior citizens to buy MSAs

Here's how the Medicare MSA would work. Those seniors who don't want the normal low-deductible comprehensive coverage could sign up with an insurance company like Golden Rule for an MSA. The supposedly tottering Medicare fund would give Golden Rule what it determines to be the average cost of insurance—\$5,081 per person in 1996. Golden Rule would then establish a policy with a deductible of \$3,000 and set up a \$1,500 MSA for the policyholder. Senior citizens would be liable for any cost between \$1,500 and \$3,000 and for a percentage of the charges over \$3,000. If they became ill, they would lose money, but, with illness imminent, they could abandon the policy in favor of regular fee for service after only a year.

The Rooney-funded National Center claims that MSAs would save \$220 billion of the \$270 billion the Republicans want to cut in Medicare costs, but the Republican-appointed CBO completely disagrees.

Indeed, the provision has no redeeming fiscal merit. Like MSAs in general, it would discourage preventive care and early treatment with-

out bringing down the cost of high-tech medicine. And it would threaten the Medicare fund by siphoning off healthy seniors. Instead of paying only for what these Medicare recipients actually spend on health care, Medicare would have to pay the full \$5,081—to Golden Rule and its ilk. Those standing to benefit would include healthy and wealthy seniors who could afford to gamble for a year. Golden Rule and similar insurance companies that had been locked out of the lucrative Medicare market and doctors who would escape the strictures of managed care and Medicare fee limits. The poor, the infirm and any American banking on a solvent Medicare system would lose out.

Both the proposal for a tax deduction for MSAs and for an MSA option within Medicare are expected to pass Congress this year, along with similar proposals that stem directly from lobbying efforts by doctors and pharmaceutical companies. On a party-line vote, the House Ways and Means Committee has already defeated Democratic attempts to strike or amend these proposals. If they do pass, and get through, they'll encourage the most inefficient and unsavory elements within the health care industry, setting back even further the cause of health care reform. Worse, passage of these proposals will demonstrate that in this Congress, it is moneyed interests and not the people who count.

JOHN B. JUDIS

NEWS ANALYSIS

Medical Shelter Accounts

Milton Friedman is at it again. It seems that the Hoover Institution economist, who got a Nobel Prize for his observations about inflation, has become an all-purpose endorser for the latest trendy Republican economic nostrum, whatever it may be. This time around it's medical savings accounts (MSAs). But even Friedman cannot bring himself to be more than lukewarm in his endorsement. (*The Wall Street Journal*, Apr. 17, 1996, p. A20.)

After condemning health maintenance organizations as socialist, and blessing the doctor-patient relationship as precious, Friedman recites a short history of how we got into the mess we are in. The mess we are in chiefly consists of delivery of medical insurance through employers and a income tax exclusion for this perquisite that encourages overconsumption and raises prices. But then Friedman concludes that, because the repeal of this popular exemption is politically impossible, the next best alternative is to extend tax exemption to *all* medical spending via MSAs.

How's that again? Employees who now lack the bargaining power to raise their wages would presumably negotiate medical benefits with their employers, and opt for cash instead of expensive first-dollar insurance. With the cash, they would self-insure through MSAs. And then despite MSAs being tax-favored, employees would treat withdrawals as though they were paying from their own pockets, reducing overconsumption. As the drafters of MSAs recognize, low-deductible medical insurance encourages overconsumption, which raises the price of medical services by raising demand.

The economic logic behind MSAs is that consumption of medical services can be reduced by a tax bribe to purchase high-deductible policies. The drafters hope that MSAs will wean Americans from their 50-year-old habit of treating medical services as a free good. It would be far more effective (and a revenue raiser) to limit the present section 106 exclusion to the high-deductible policies described in the MSA bill. (An ironic aspect of the MSA debate is that few, if any, involved have ever been HMO members, or, for that matter, have ever had experience with anything but the best private medicine America has to offer.)

Why should tax practitioners care about MSAs? Because, as drafted in Title III of H.R. 3160, the "Health Coverage Availability and Affordability Act of 1996," MSAs would be one whopper of a tax shelter. (The same provisions

were struck out of the Senate's bill, S. 1028; see *Tax Notes*, Apr. 22, 1996, p. 427, and p. 559 of this issue.) MSAs would encourage businesses that do not now provide medical insurance for their employees to pretend to do so by purchasing cheap high-deductible catastrophic care insurance. This encouragement would take the form of what are basically super-IRAs exempt from every conceivable form of federal tax. Friedman's statement that employers would find MSAs attractive is an understatement. As drafted, MSAs would be more attractive than cash salary.

For most employers, which already provide comprehensive medical insurance, employee complaints would prevent a wholesale conversion to MSAs, just as employee resistance has prevented the quick adoption of other cheaper alternatives. The small revenue loss attached to MSAs — \$1.8 billion over six years — indicates that this law would not be expected to change the behavior of many employers. The revenue estimators believe that MSAs will be offered as an option in existing cafeteria plans, so that most MSA holders will be people earning between \$40,000 and \$75,000 a year. MSAs would *not*, legally or otherwise, replace the section 106 exclusion for employer-provided medical insurance, which is the single largest tax expenditure — projected to cost more than \$70 billion in fiscal 1997. (See *Tax Notes*, Apr. 1, 1996, p. 24 and p. 107.) Friedman and other proponents of MSAs argue that they will at least accomplish something, and something is better than nothing.

How much medical coverage are employers going to buy for their employees for what the government would spend bribing them to do it?

But for those who make this incremental argument, the important question about the proposed new tax expenditure is its cost effectiveness: how much medical coverage are employers going to buy for their employees for what the government would spend bribing them to do it? The tax benefits for the employer would be largely divorced from the medical benefits that would have to be provided for the employees. MSAs might be comparable to the classic cost-inefficient tax expenditure: the low-income housing credit — the bulk of the spending on which goes to enrich real estate developers instead of producing housing.

Super IRAs

Generally, an individual covered only by a qualifying high-deductible medical insurance policy could make tax-deductible (above the line)

the fair market value of the MSA is included in the decedent's gross income on his last income tax return, where it would be taxed at a rate lower than the estate tax rate. This income tax liability could be deducted in computing the decedent's estate tax, making the approximate tax cost of accumulating assets in an MSA 20 percent of the value of the MSA (assuming the decedent is subject to an income tax rate of 40 percent and an estate tax rate of 50 percent). If the MSA passes to a specified beneficiary, then that beneficiary includes the MSA value in his income for the year that includes the decedent's death.

This treatment would encourage rich people to accumulate money in MSAs while paying their medical bills out of other funds. They could still deduct payments of medical expenses out of other funds, because payments or distributions out of MSAs would not be considered in determining a taxpayer's section 213 medical expense deduction.

There is no medical policy argument for excluding MSAs from the estates of holders. People do not need medical self-insurance reserves when they are dead; nor do their surviving spouses need their accumulated reserves free of tax. This estate tax treatment was not inadvertent; it was elaborately thought out. The explanation for this drafting is the phobia that owners of closely held businesses and many Republicans — including the House Ways and Means and Committee chairman — have about transfer taxes. The estate tax break affirmatively encourages rich people *not* to use their MSAs for medical purposes by giving them a roughly 30-point advantage for letting money accumulate in them. This provision undermines the credibility of the whole MSA proposal, though it accounts for a small portion of the revenue loss.

Everybody Out of the Pool

The principal argument against MSAs is not that they would enable the rich to buy more or better medical care. The rich can already do that, and will be able to continue to do so, as they do in any free society. (Even in European countries with comprehensive state-financed medical care, the rich buy better care for themselves in the private market.) The principal argument against MSAs is that the rich will use them as just another tax-preferred investment account and continue to purchase medical care as they do now. And very little of the benefit of MSAs will trickle down to currently uninsured employees of closely held businesses.

House Ways and Means Committee Democrats have objected that MSAs will segment the medical care market by taking the young, healthy, and wealthy out of the insurance pool. As the de-

signers of the ill-fated Clinton medical insurance plan recognized, it is imperative to get these people into the pool if insurance is going to spread the risks. But the reality is that these people are already out of the pool. The medical insurance pool is badly segmented, such that there is little broad risk-sharing going on. (Howls about "two-tier medicine" are inapposite because two tiers would be an improvement over the present situation.) It would be impossible for the enactment of MSAs to affect this segmentation for better or for worse, though the opponents are correct in pointing out that MSAs do not shift risk.

The principal argument against MSAs is that the rich will use them as another tax-preferred investment account.

Here is how the medical insurance market breaks down. The rich and executives covered by luxury plans get whatever they want. The old get very good care through Medicare. Employees of large employers get good coverage, even if they have preexisting conditions, because a large enough group can absorb the risks and because many large employers run their own pools. Employees of smaller employers and others with preexisting conditions buy from the Blues, which are generally the insurers of last resort (and some of which, like New York's Empire Blue Cross, are effectively wards of the state). The young and healthy among this latter group either do not buy insurance at all, or buy it cheaply from cherry-picking companies that reject anyone who has or might make a large claim. (*The New York Times*, Apr. 14, 1996.) The poor get their care through Medicaid and the emergency room.

Finally, even if they worked as their proponents assume, MSAs would not address the ability to afford medical care. MSAs would not lower medical costs; indeed, contribution deductions would be indexed for medical inflation. MSAs would be an extension of the present section 106 tax subsidy, so that they would tend to drive up medical prices even if MSA holders behaved in the ways the proponents hope. Basic economics dictates that every tax subsidy is reflected in a higher price for the thing subsidized. (For discussion of the medical policy and economic issues raised by MSAs, see *Tax Notes*, Apr. 22, 1996, p. 537.) ■

— Lee A. Sheppard

Full Text Citation: H.R. 3160. Doc 96-9343 (221 pages)

cash contributions to an MSA. The legislation sets a floor under the deductible of \$1,500 for an individual policy and \$3,000 for a family policy. The amount of the contribution deduction is the lesser of \$2,000 per individual (\$4,000 per family) or the amount of the annual deductible under the policy. There is no ceiling on the deductible, so a policy with a huge deductible could be very cheap to purchase. (Some policies have deductibles as high as \$10,000 per insured, and gaps in coverage or ceilings on reimbursements beyond that.)

Earnings of the MSA would be free of income tax. No income tax would be imposed on withdrawals spent on an expansive array of medical services. Income tax, but not social security tax, would be imposed on all other withdrawals, with a 10 percent penalty tax on top unless the individual was older than age 59-1/2, dead, or disabled.

If an employer contributed to an MSA on behalf of an employee, the contribution would be excluded from the employee's income. It would also be exempt from the employer and employee shares of the social security tax (combined 15 percent) and unemployment tax. (Employer-provided medical insurance is not subject to these taxes.) Of course, adopting employers would be able to adjust wages to make up for contributions to MSAs that they might make on the employees' behalf. Because all compensation is deductible, the income tax deduction would not be much of a stimulus to employer contributions. But the social security tax saving would lead the employer to prefer an MSA as a form of compensation in lieu of paying the employee in cash and letting him set up the MSA himself.

Perversely, the social security tax saving is so great — five percent of the contribution — that both parties would be ahead if the employer put money in an MSA and the employee immediately withdrew it. By withdrawing for nonmedical purposes, the employee would subject himself to income tax and penalty tax which combined are less than the normal burden of income and social security tax on cash income. Because of the way the social security tax exclusion is drafted, the employer would not have to make up social security tax on an MSA contribution that an employee used for nonmedical purposes.

MSAs resemble IRAs but differ from them in important ways. IRAs provide deferral; amounts withdrawn during retirement are subject to income tax. Amounts withdrawn from MSAs for medical purposes would be completely exempt from tax. And the definition of medical purposes is broad, designed to give the holder unfettered choice in spending. "Choice" is the mantra of

MSA proponents, who recognize Americans' sentimental attachment to doctors. (Hollywood's socially irresponsible deeds include routine depiction of doctors as saints.)

The MSA definition of qualified medical expenses hooks into code section 213(d), the subject of much colorful litigation. Section 213(d) is so broad that the wimp word "health" — or even the more direct "feel good" — might be a more appropriate description of the permitted spending than the scientific-sounding "medical." It was only as recently as 1990 that Congress enacted section 213(d)(9), which denies a medical expense deduction for elective cosmetic surgery. Medical expenses for MSAs would not include medical insurance premiums.

The social security tax saving is so great that both parties would be ahead if the employer put money in an MSA and the employee immediately withdrew it.

A series of penalties prod IRA holders to take withdrawals after they reach age 70, so IRAs do not have excessive accumulations. No withdrawals would ever be required from MSAs, allowing holders to accumulate quite a bit of money in them. It is not required that the holder pay his medical expenses out of his MSA, so an MSA could become just another tax-sheltered investment account. Rich people might want to let their MSAs accumulate funds while paying their medical bills out of other monies.

Death and Taxes

The upper east side of New York City is chock full of doctors catering to the real and imagined illnesses of the rich and their pets. And rich people, though generally healthier than the rest of the population, do have real medical problems. They tend to get melanoma more often than less affluent people. And facelifts have to be redone fairly often, lest the wearer look worse than a "before" picture. But often it seems that the rich simply enjoy the attention and indulgence that pricey medical care provides. They go to the doctor for the same reason they go to spas — to be pampered and have someone listen to their complaints. (*Vogue*, May 1996, p. 240.)

But there is something in H.R. 3160 to stop the rich from consuming medical care with money from their MSAs. MSAs would be excluded from the taxable estate. If the MSA passes to a surviving spouse, then the income tax exclusion for its earnings continues in the hands of the spouse. If the MSA passes as part of the general estate, then



CENTER ON BUDGET AND POLICY PRIORITIES

April 16, 1996

WHO WILL USE MEDICAL SAVINGS ACCOUNTS AND WHY WILL THEY USE THEM?

by Iris J. Lav

Prior analysis of Medical Savings Account proposals has shown that MSAs would primarily benefit those at high income levels because MSAs create opportunities to accumulate tax-sheltered funds for purposes other than medical costs. Higher-income taxpayers would be most likely to take advantage of these tax shelter opportunities because the tax benefits are worth more to taxpayers in higher tax brackets and because such taxpayers can afford to pay substantial out-of-pocket medical costs if they choose to leave the tax-advantaged funds on deposit in the MSAs or if funds accumulated in the MSAs are insufficient to cover their medical bills.¹

Recently, the Joint Committee on Taxation has released data estimating what proportion of people in each income class would make use of Medical Savings Accounts, finding that a large portion of the participants would be middle class.² These data have been used to bolster claims that MSAs would benefit middle class taxpayers as well as the wealthy. But the Joint Tax data are not incompatible with the conclusion that higher-income taxpayers would be the primary beneficiaries of MSAs.

As the text of the Joint Tax analysis makes clear, participation in an MSA may not be voluntary. Taxpayers who participate in MSAs because their employers offer no other option for health care coverage may not benefit from their participation and may become worse off as a result of their employers' switch from offering a conventional insurance policy or a managed care plan to a plan that offers only a high-deductible insurance plan with an MSA.

Joint Tax Highlights Benefits to Companies, Not Employees

The Joint Committee notes that its estimate is based "on the assumption that a larger proportion of small- and medium-sized companies might potentially benefit from the MSA

¹ For a description of how high-income taxpayers would benefit from MSAs, see Iris J. Lav, *MSA Provision in Health Care Reform Bill Creates Tax Shelter and Casts Doubt on Expansion of Insurance Coverage*, Center on Budget and Policy Priorities, March 26, 1996.

² Letter to Chairman Bill Archer, March 27, 1996. The Joint Tax Committee estimates that less than one percent of participants would have incomes below \$30,000, 25.4 percent of MSA participants would have income between \$30,000 and \$50,000, 51.5 percent of the participants would have incomes between \$50,000 and \$75,000, and 22.2 percent would have incomes above \$75,000.

proposal and offer such plans to their employees." To assume that a *company* would benefit generally means that the company would pay less for its employees' insurance coverage. This suggests two further assumptions that likely underlie the Joint Tax analysis.

Small- and medium-sized companies that do not now offer *any* health insurance would not begin to offer high-deductible coverage with MSAs as a result of this legislation. Such an assumption would result in increased rather than decreased costs for the companies and thus would be incompatible with the statement that the companies would benefit. The analysis must instead assume that employers currently offering conventional coverage or managed care plans would begin to offer high-deductible insurance with MSAs.

Furthermore, companies would receive a cost-saving benefit from such a switch only if the total cost of the high-deductible insurance including the MSAs would be less than the cost of the insurance the company currently offers. Thus the small- and medium-sized companies that switch to high-deductible insurance with MSAs likely would not put the entire difference between the conventional insurance premium and the high-deductible insurance premium into their employees' MSAs. Companies would realize cost savings from the switch only if they choose to keep, as a profit-enhancing savings, at least a portion of the difference in premiums between the two types of plans.

Low- and Moderate Income Taxpayers May Participate in MSAs Involuntarily

The Joint Committee on Taxation analysis goes on to say that "Employee wages for small- and medium-sized are weighted toward the lower- and middle-income classes. As a result, the revenue estimate assumes that taxpayers in the lower- and middle-income classes are more likely to be offered a high deductible plan coupled with an MSA as their *primary* health plan." (Emphasis added.) Although the Committee's use of the term "primary" is ambiguous, it suggests some further issues.

Low- and middle-income employees may be reluctant voluntarily to accept high-deductible insurance with MSAs, because they usually do not have the resources to pay large out-of-pocket health care costs. An assumption that substantial numbers of such employees would participate suggests that their employers might offer *only* high-deductible insurance with MSAs and would no longer offer either a conventional fee-for-service policy or a managed care plan. For low- and moderate-income employees who consume significant amounts of preventive care for their young families through a health maintenance organization, for example, or have chronic health problems that require continuing care, the restriction of choice to a high-deductible plan could substantially degrade their ability to afford necessary health care services.

Inadequate MSA Deposits Transfer Large Costs to Moderate-Income Employees

Low- and middle-income employees are likely to face high out-of-pocket costs under the high-deductible insurance plans with MSAs because the MSA contributions made by

their employers are likely to fall short of the annual deductible amounts under those insurance plans. In fact, employers are unlikely to be able to afford to deposit the full deductible amount. Consider the following. A company may currently offer its employees family coverage under a conventional insurance policy and pay an annual premium of \$5,200 for that coverage. If the company switches to offering a high-deductible plan with an MSA, the annual premium for the high-deductible insurance policy would be approximately \$3,900. These costs assume the insurance plans are comparable except that the conventional coverage includes a \$200 deductible while the high-deductible plan has a \$3,000 deductible.³ Because the company's annual premiums savings from switching to the high-deductible insurance plan is only \$1,300 per family (\$5,200 minus \$3,900), the company is highly unlikely to be willing to deposit \$3,000 — the full amount of the deductible — into the employee's MSA. In addition, employers are likely to keep some of the difference as a cost-saving benefit to the company. Thus low- and middle-income employees likely would have significantly less than half of their annual deductible amount — and most likely no more than one-third of the deductible — deposited into MSAs by their employers and thereby available to meet ongoing health care costs.

Moreover, nothing in this bill requires employers to make *any* deposits to MSAs as a condition of offering high-deductible insurance. Once small- and medium-sized employers shift to offering only high-deductible insurance and no longer offer conventional insurance or managed care plans, they would be free to reduce or eliminate contributions to the MSAs at any time. If that occurred, the low- and moderate-income employees of those companies would be left to finance the entire deductible amounts out of their own pockets. Although the low- and moderate-income employees could make deposits on their own to an MSA, they would receive little or no tax advantage from using MSAs — because they either do not pay income taxes or pay taxes at much lower rates than the higher-income taxpayers who would be the primarily beneficiaries of this MSA legislation.

In short, if low- and moderate-income taxpayers use MSAs in substantial proportions, it will likely be because they have little alternative. And the use of the MSAs with high-deductible health insurance plans is likely both to increase their risk of incurring unaffordable health care costs and reduce their ability to afford adequate levels of health care services for themselves and their families.

³ The American Academy of Actuaries estimates the employer cost of the annual premium for a family plan with a \$3,000 deductible would be between \$3,900 and \$4,050, which may be compared to an employer cost for a conventional \$200 deductible plan of \$5,250. That implies a premium cost savings of no more than \$1,320 for the \$3,000 deductible plan.

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
 ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
 ORVILLE DRYFOOS, *Publisher 1961-1963*
 ARTHUR OCHS SULZBERGER, *Publisher 1963-1992*

ARTHUR OCHS SULZBERGER JR., *Publisher*

JOSEPH LELYVELD, *Executive Editor*
 GENE ROBERTS, *Managing Editor*

Assistant Managing Editors

SOMA GOLDEN BEHR DAVID R. JONES
 GERALD M. BOYD CAROLYN LEE
 WARREN HOGE JACK ROSENTHAL
 ALLAN M. SIEGAL

HOWELL RAINES, *Editorial Page Editor*
 PHILIP M. BOFFEY, *Deputy Editorial Page Editor*

RUSSELL T. LEWIS, *President and General Manager*
 JOHN M. O'BRIEN, *Executive V.P., Deputy Gen. Mgr.*
 WILLIAM L. POLLAK, *Executive V.P., Circulation*
 PENELOPE MUSE ABERNATHY, *Senior V.P.,
 Planning and Human Resources*
 RICHARD H. GILMAN, *Senior V.P., Operations*
 JANET L. ROBINSON, *Senior V.P., Advertising*
 RAYMOND E. DOUGLAS, *V.P., Systems and Technology*
 KAREN A. MESSINEO, *V.P., Chief Financial Officer*
 DONNA C. MIELE, *V.P., Human Resources*
 CHARLES E. SHELTON, *V.P., Distribution*
 DAVID A. THURN, *V.P., Production*

Drop the Medical Savings Accounts

A key element of the Republican Medicare reforms, the misguided medical savings accounts, has been knocked out of the comprehensive budget bill on a technicality. But there are plans to revive it. That would be a disservice. The accounts would be costly and benefit only the healthy and wealthy.

Republicans buttress their claim that the accounts would be affordable and attractive to Medicare enrollees by citing a study from a respected actuarial firm. But the study, by Milliman & Robertson, is irrelevant. It analyzes a plan very different from the bills the Senate and House passed.

The overall G.O.P. Medicare reform would cut \$270 billion out of Medicare and give the elderly new enrollment options. Besides traditional coverage, they could use their share of the Government money to join a managed-care plan or set up medical savings accounts. The accounts would combine catastrophic (high-deductible) coverage and a tax-free bank deposit from which to pay routine bills. The idea appeals to doctors because they would be free to charge whatever they liked, thereby avoiding price controls that the G.O.P. would impose on other Medicare options to achieve the \$270 billion cut.

The savings accounts would attract healthy retirees because they would profit from the tax-free buildup of savings. The accounts would also attract wealthy retirees because they could afford the high deductible. The Congressional Budget Office predicted that the option would attract only about 2 percent of retirees and increase the deficit. The

Government would spend more to set up accounts for healthy retirees than to cover them under traditional Medicare.

The Milliman & Robertson study assumed that Congress would nearly triple out-of-pocket expenses for those who stick with traditional Medicare. But the actual bills do not go nearly that far. From that false assumption followed the absurd estimate that 80 percent of the elderly would switch to medical savings accounts. Under the actual provisions the House and Senate passed, the savings accounts would not attract most retirees.

There are other problems with the G.O.P. plan. For example, retirees could game the system by choosing tax-free accounts when they are well and traditional Medicare when they are sick. That problem could be licked by requiring retirees to give five years' notice before switching out of the tax-free accounts. To figure out how to solve the idea's other problems, Congress should set up demonstration projects before it offers the option to everyone.

The Senate parliamentarian temporarily knocked the idea out of the Senate plan because it violated special rules governing the budget bill of which Medicare reform is a part. The Republicans can probably get around that ruling when the bill returns from conference. The wiser course would be for Congress to scrap the savings accounts and reconfigure Medicare so that it harnesses market forces on behalf of all retirees, not just the privileged few.

Page 14

Medicare Misfire

House Speaker Newt Gingrich promised a bold, market-driven reform of Medicare. He has not delivered. The policy he outlined on Friday would shut off effective competition and possibly damage health care for the elderly. Perhaps the Senate leadership plan, to be released this week, will do better.

Medicare is, as Mr. Gingrich never ceases to charge, excessively costly and out of date, having adopted few of the innovative techniques that are used in the private sector to improve quality and lower costs. Mr. Gingrich would solve these problems by, in effect, giving the elderly the option of using a Government voucher to buy private coverage. But the proposal reneges on introducing market competition when it denies health plans the right to rebate part of the voucher to enrollees. Private plans would have no incentive to cut premiums below the amount of the voucher.

Apparently the House refused to allow rebates lest it be attacked for driving the elderly into private managed care for their financial survival. Its voucher, from the sketchy outline provided, seems tied to the cost of the existing Medicare program, and thus offers little hope of reining in costs. Medicare costs will almost surely rise faster than the proposal expects.

Mr. Gingrich would allow private plans to compete for customers by offering them attractive benefits, like coverage of drugs and eyeglasses. But that kind of competition invites plans to tailor benefits to attract healthy retirees who would not be costly to cover, leaving the chronically ill to sign up with the managed care and Government programs. The plan further invites cherry-picking of healthy

retirees by offering the option of choosing a Government-paid catastrophic policy along with a tax-free savings account to cover part of the deductible. These accounts would attract only healthy individuals who would expect to have some of the deductible left over at the end of the year.

The plan Mr. Gingrich released owes more to his concern about saving \$270 billion to balance the budget than it does to his concern about reforming Medicare. Even so, the specific measures appear unlikely to generate anything close to the required savings. The only safeguard is a provision that would have the Government automatically cut fees for doctors and hospitals participating in the Government program if costs rose faster than budgeted. But therein lies a big problem. The cuts will almost certainly need to be huge, because doctors have historically offset price cuts by pushing additional tests and procedures on their patients. Big cuts could drive many doctors to flee the program, dragging their patients with them into private care. If that is Mr. Gingrich's goal, it needs to be spelled out and justified.

Whether the Republican leaders can offset these problems will depend in part on details that they have not yet released. For example, they might adjust the voucher amount paid to a private plan according to the health status of its enrollees — introducing enormous complexity reminiscent of the Clinton Administration's aborted plan. Or they might regulate the value of the voucher to keep the cost of private plans from rising precipitously. But the information released so far provides no such mechanisms. The House plan is more an attack on Medicare than a reform.

FOCUS - 17 OF 21 STORIES

Copyright 1995 Chicago Tribune Company
Chicago Tribune

October 26, 1995 Thursday, NORTH SPORTS FINAL EDITION

SECTION: COMMENTARY; Pg. 29; ZONE: N

LENGTH: 902 words

HEADLINE: AMAZING TRICKS;
DON'T PUT MUCH FAITH IN THE REPUBLICANS' HYPE ABOUT FIXING MEDICARE WITH MEDICAL SAVINGS ACCOUNTS

BYLINE: Joan Beck.

BODY:

"There's no use trying," she said. "One can't believe impossible things."

"I daresay you haven't had much practice," said the Queen. "When I was your age, I always did it for half-an-hour-a-day. Why, sometimes I've believed as many as six impossible things before breakfast."

Lewis Carroll in "Alice's Adventures in Wonderland".

Republicans in the House may not have fallen down a rabbit hole. But they are asking the elderly to believe impossible things about the Medicare "reform" plan passed by the House last week. Seniors--and those who have an interest in their well-being--will go along at their own risk.

Congress still hasn't passed final Medicare legislation. President Clinton has promised to veto it. The regulations that would govern its operation haven't been written. But it would take a lot of faith in government and practice in believing impossible things to be confident that proposed changes would really save the \$270 billion Republicans want to chop out of increases in Medicare spending by 2002 without harming the elderly.

It takes a lot of faith, for example, to believe that the Medical Savings Accounts in the House legislation would actually contribute to those savings--as much as \$220 billion of the \$270 billion goal, according to proponents.

The idea of Medical Savings Accounts is largely an untried theory, especially when people over age 65 are involved. It was developed primarily by Golden Rule Insurance, an Indiana company which wanted to generate new business and which skillfully pushed the plan by means of a think tank it helped to fund, by savvy lobbying and by strategic and lavish political contributions.

A major supporter of MSAs is House Speaker Newt Gingrich, who often praises the idea in talks and in his book, "To Renew America." He, his COPAC campaign committee and other Republican legislators are reported to have received contributions from the insurance company lobbyists.

Medical Savings Accounts are being praised as a way to "privatize" health



LEXIS·NEXIS™



LEXIS·NEXIS™



LEXIS·NEXIS™

care again, to provide individual incentives to keep costs down and to give seniors fearful of the constraints of managed care a way to "manage their own health care." The way it would work is generally like this:

Each Medicare recipient who chooses a MSA would get a voucher good for about the average amount Medicare spends on each beneficiary--estimated to be a little more than \$5,000 in 1996. With the voucher he would buy a high-deductible, catastrophic health insurance policy that would pay most of his health care expenses over \$3,000.

The rest of the money--\$1,500 by one example--would go into an account to be used to pay small medical bills. Once that sum was spent, recipients would have to pay any other expenses themselves until they reached the \$3,000 level where the insurance policy would kick in. If recipients hadn't used all of the money in their account by the end of the year, they could withdraw it and use it as they choose, provided they pay taxes on it. Or they could roll it over into the following year to cover future medical expenses.

Supporters say MSAs will motivate patients to help keep health care costs down because they are essentially paying their own bills until they reach the high deductible and because they can choose their own doctors.

Critics point out that giving money to Medicare recipients who stay healthy just adds to the total cost of the system--\$2.3 billion over seven years according to an estimate by the Congressional Budget Office. The elderly who face high bills or who have long-term medical expenses would probably opt for traditional Medicare, opponents say, and their higher-than-average expenses would no longer be balanced by seniors who stay well and cost the system very little.

You need practice believing in impossible things to assume that pushing seniors into managed-care organizations, as the House bill would do by raising the costs of traditional care, will save Medicare money and assure the elderly of adequate care. HMOs are skilled at signing up the healthiest groups of people and avoiding the high-cost ill. They often give doctors incentives to minimize treatment. And they cost Medicare about as much as other options for the elderly, according to limited studies.

It takes faith to believe that changes in Medicare won't do harm to hospitals and to medical training programs for physicians. And that patients won't suffer as fewer specialists are trained or are allowed to see Medicare patients. And that all the seniors who would like to stay in the current Medicare program will be able to afford the price increases that seem inevitable in the next seven years. And that the elderly--who range from savvy CEOs and presidential candidates to the comatose and those with Alzheimer's disease--can shift through the options and find a way to get good care at reasonable cost.

It even takes faith to believe that all the Republicans who voted for the Medicare legislation in the House and who are trying to drum up national support for it really understand what's in the bill--or have even read it.

Most of us do see a necessity for helping Medicare hold down its steeply rising costs. But we will need a lot more practice and evidence--before we believe Gingrich and his colleagues have solved the problem. We may never get



around to breakfast.

GRAPHIC: GRAPHICGRAPHIC: Illustration by Tom Herzberg.
LANGUAGE: ENGLISH

LOAD-DATE: October 26, 1995



LEXIS·NEXIS



LEXIS·NEXIS



LEXIS·NEXIS

DRAFT May 14, 1996

**Medical Savings Accounts:
A Review of Issues and Research**

Prepared for:

**The Office of The Assistant Secretary for Planning and
Evaluation,
U.S. Department of Health and Human Services**

Prepared by:

Lewin-VHI, Inc.

May 1996

DRAFT May 14, 1996

BACKGROUND AND INTRODUCTION

Medical savings accounts (MSAs) provide a mechanism through which out-of-pocket medical expenses can be paid on a pre-tax basis. A variety of research organizations have promoted MSAs for a number of years, often advocating their use in conjunction with a high-deductible (or "catastrophic") insurance policy.

Recently, MSAs have gained prominence as an element of health reform proposals being considered by Congress. The balanced budget proposal enacted by Congress and vetoed by the President last year included MSAs along with catastrophic insurance as an option for Medicare beneficiaries as well as for people under age 65.

Insurance market reforms passed recently by the House (H.R. 3103) also provide for the creation of MSAs in the non-Medicare market. The House MSA proposal will be considered by a House-Senate conference committee, along with insurance reforms passed by the Senate — which do not include an MSA provision. H.R. 3103 would provide for employer or individual contributions to an MSA in conjunction with the purchase of an insurance policy that has a deductible of at least \$1,500 for an individual and \$3,000 for a family. An MSA contribution would be pre-tax (i.e., not included in taxable income, like an Individual Retirement Account) up to the amount of the deductible or \$2,000 (\$4,000 for a family), whichever is less. The Joint Committee on Taxation estimates that the MSA provision in H.R. 3103 would reduce federal tax revenue by a total of \$1.8 billion over the period 1996 to 2002.¹

This paper is intended to inform the current debate by reviewing recent research related to MSAs in the non-Medicare market.² Our purpose in this paper is to summarize the existing work that has been done on MSAs; we have made no judgment about the methods used in these studies or the validity of their findings. We have sought to present a cross-section of different methodologies and points of view, but have not attempted to review everything that has been written about MSAs. We first describe the common characteristics of MSAs. We then discuss the possible effects of MSA initiatives similar to H.R. 3103 on the health system and summarize any prominent recent research or analysis where appropriate.

CHARACTERISTICS OF MEDICAL SAVINGS ACCOUNTS

Medical savings accounts are generally designed with the goal of putting high-deductible coverage on an equal footing from a tax standpoint with more comprehensive employer-sponsored coverage (i.e., coverage with less patient cost sharing).

DRAFT May 14, 1996

Currently, health care expenses paid by employers on behalf of employees — either through premiums paid to an insurer or through direct payment of expenses through a self-funded health plan — are tax deductible as a business expense for the employer and exempted from taxable income for employees. If the employer offers a high-deductible health policy (e.g., with a deductible of \$1,500), the premium would be paid on a pre-tax basis, but the employee would have to pay for any out-of-pocket expenses and uncovered services with after tax income. As a result, the tax system tends to favor coverage with lower patient cost sharing over more catastrophic coverage.

Under current law, employees can, in fact, pay for out-of-pocket costs and uncovered services with pre-tax income by contributing to a flexible spending arrangement (FSA). However, the value of flexible spending arrangements is limited by the fact that any unused balances at the end of every year are returned to the employer. In 1992, 21% of employees eligible to contribute to a health care FSA did so.³

Unlike FSAs, MSAs generally permit unused balances to carry forward to the following year rather than being returned to the employer. In addition, MSAs are usually designed to be "portable," meaning that an employee could retain it when changing jobs.

Eligibility for participation in an MSA is often predicated on an individual's purchase of a high-deductible insurance policy. In that case, the MSA would be used by an individual to cover his or her out-of-pocket costs under the deductible, as well as to purchase services not covered by the insurance policy. Typically, the amount of pre-tax contribution that can be made to an MSA is limited by the amount of the deductible in an individual's insurance policy. Under some approaches, either an employer or an employee can contribute on a tax-preferred basis to the employee's MSA. Under other approaches, an employee may not make a contribution to the MSA if the employer has already done so.

Generally, MSA funds can only be used for medical expenses; a tax penalty is assessed on withdrawals for non-medical purposes. The Internal Revenue Service definition of medical expenses is commonly used to determine appropriate uses of MSA funds. Some proposals (including H.R. 3103) permit funds to be withdrawn for non-medical uses without penalty after the account holder reaches a certain age (e.g., 59½).

Some MSA approaches permit the interest income generated by an MSA to accrue tax free, while others tax that income.

DRAFT May 14, 1996

DISCUSSION OF THE LIKELY EFFECTS OF MSAs

In this section, we discuss the likely effects of an MSA-type proposal similar in structure to H.R. 3103. The primary effects include:

- Lowering health care costs by reducing service use through higher levels of cost sharing.
- The potential for risk selection and segmentation of the insurance market.
- Potential financial gains or losses for employees and individuals.
- The compatibility of MSAs and managed care.

For each issue, we discuss conceptually what the effect would be and how it might influence the efficacy of MSAs. We then summarize any recent research or analysis that helps to quantify the effect.

Attached as Appendix A is a table summarizing the key conclusions of a selection of major MSA analyses.

Lowering Health Care Costs by Reducing Service Use

The ability of MSAs to lower overall health care costs hinges, in large part, on the degree to which people respond to higher deductibles (along with the presence of an MSA) by reducing their use of services. The idea is that the presence of insurance induces people to use more services than they would if they had no insurance, because they are not paying the full cost for the services. In the extreme, fully comprehensive insurance with no deductibles or copayments means that people who are insured face no financial cost for seeking care, and might therefore seek significantly more care than they would if they had no insurance or less comprehensive coverage.

Quantifying the effect of different levels of patient cost sharing on the use of services is difficult, because it is hard to separate the effect of the cost sharing from the consequences of risk selection. Risk selection would occur if people who are sicker tend to choose coverage with lower deductibles and people who are healthier choose coverage with higher deductibles. If risk selection is present, then the fact that people enrolled in higher deductible plans use fewer services than people enrolled in lower deductible plans is ambiguous. It could be the case that the higher deductible discourages service use, or it could alternatively be the

DRAFT May 14, 1996

case that the people in the higher deductible plan are simply healthier and use fewer services (or the truth could lie somewhere in between).

Because of this difficulty, analysts generally rely on the RAND Health Insurance Experiment to estimate the effects of patient cost sharing on service use. Although the RAND study is somewhat dated (it was conducted during the 1970s), it avoided the problem of risk selection by assigning participants to different levels of cost sharing rather than allowing them to choose the coverage themselves. The experiment looked at the effect of various levels of coinsurance, which ranged from no coinsurance to a plan with 95 coinsurance. The coinsurance rate was charged to expenditures below a maximum dollar expenditure (which was related to family income, but no more than \$1,000 per year). The experiment found that health spending rose steadily as the level of coinsurance fell; persons with no coinsurance had 60 percent greater expenses than persons with 95 coinsurance.⁴

The estimates of reduced service utilization used by various MSA analysts include:

- **Cato Institute/National Center for Policy Analysis.** Researchers affiliated with the Cato Institute and the National Center for Policy Analysis (NCPA) often cite the result from the RAND study that families with no deductible used 58% more health resources than families paying 95% of their health care expenses out of their own pockets (up to a \$1,000 maximum).⁵ If this result were indicative of how service use would decline as people switch from current levels of coverage to high-deductible coverage and MSAs, then health care costs would decline significantly under an MSA approach. NCPA researchers estimate that universal catastrophic insurance combined with MSAs could reduce total U.S. health care spending by as much as one-fourth.⁶
- **American Academy of Actuaries.** In their analysis of MSAs, the American Academy of Actuaries (AAA) used utilization factors developed by the Health Care Financing Administration (HCFA).⁷ The Actuaries use two sample plans for the purposes of their analysis. The "standard plan" (meant to approximate the coverage many people have today) has a \$200 deductible for an individual, a required 20% copayment on expenses in excess of the deductible, and a maximum individual out-of-pocket payment of \$1,000. The "high-deductible plan" that would be offered in conjunction with an MSA has a \$1,500 deductible for an individual, the same 20% copayment, and an out-of-pocket limit of \$2,500. Among the AAA's primary conclusions are:

DRAFT May 14, 1996

- The AAA estimates that health expenditures (including administrative costs) for individuals would average \$3,040 under the standard plan and \$2,638 under the high-deductible plan. In other words, health expenses would decline by about 13% if everyone switched from the standard plan to a high-deductible plan.
- The presence an MSA in conjunction with a high-deductible plan would mitigate some of the reduced utilization caused by higher patient cost sharing, since some people may view the MSA as more of an insurance policy than a savings account. The AAA's estimates indicate that with the presence of an MSA, health expenditures under a high-deductible plan would be between 2% and 12% lower expenditures under a standard plan (rather than 13% without an MSA).
- **Brookings Institution.** A researcher from The Brookings Institution suggests that the changes in utilization cited by the Cato Institute and NCPA analysts are overstated because "most Americans have nothing resembling the kind of unlimited insurance" they describe.⁸ He argues that most people today already have coverage with some level of deductible or copayments, and that managed care approaches have already lowered use rates since the period during which the RAND experiment was conducted.
- **Other Analysts.** Researchers from the Urban Institute use utilization factors similar to those used by the American Academy of Actuaries.⁹ A researcher with the Congressional Budget Office estimates a reduction in health expenditures of between 5% and 8% based on a change from standard coverage to a high-deductible policy. If the high-deductible policy is paired with an MSA, he estimates the reductions in spending would be only 2% to 4%.¹⁰

In addition to discouraging service use, higher patient cost sharing might also cause patients to shop more aggressively for better values (e.g., lower physician fees), thus lowering overall health care costs. Some analysts question this conclusion. They note that most health care spending is attributed to people who would have already exceeded their out-of-pocket limit in a high-deductible plan, and therefore would have little incentive to shop around for lower prices. According to one estimate, over 80% of health spending by people with employer-sponsored coverage is attributed to people who use more than \$2,000 in services in a year.¹¹

One researcher responds to this argument by suggesting that a sizable proportion of spending falls below a high deductible (e.g., one-third to one-half). He argues that people would have an incentive to shop for better values until they meet their deductible, and that the lower prices resulting from this market pressure would carry-over to the rest of the health care system.¹²

Potential For Risk Selection And Segmentation Of The Insurance Market

An issue frequently raised about MSAs relates to their potential effects on the availability and cost of other insurance products in the health insurance market. By design, MSAs expose participants to the risk of higher out-of-pocket spending than more traditional plan designs — such as typical indemnity plans or managed care alternatives — in exchange for a lower premium. This type of arrangement tends to be more attractive to healthier individuals, who have fewer concerns that they might incur high health care costs.¹³ If MSAs tend to attract relatively healthier enrollees in the marketplace, the premiums for other types of insurance plan designs may increase because the average health status of the enrollees covered by such plans will be reduced.¹⁴

Concerns about MSAs attracting a healthier than average mix of enrollees are important because this type of risk selection can have a destabilizing effect on insurance markets. Risk selection in favor of or against certain plan designs can result in severe differences in the health status characteristics of enrollees across different insurance plans, which will have substantial effects on the premiums for such plans. To the extent that the premiums of plans reflect their enrollment mix rather than their efficiency, market competition among different type of plans will be distorted.

The potential for risk selection exists primarily within employer plans that offer multiple health plans and within those segments of the insurance market where significant pooling of risk across individuals or employers exists, such as the individual and small group health insurance markets in states that have adopted insurance reforms. In states that have not adopted reforms, there is far less pooling in these markets and risk selection would be less of a concern.

Recent analysis of risk selection issues under MSAs includes:

- **Urban Institute.** Researchers at the Urban Institute¹⁵ developed a simulation to test the potential risk selection effects associated with MSAs. Using data from the National Medical Expenditures Survey, they simulated the effects on premiums of offering a choice of two insurance arrangements to employed persons: a comprehensive insurance arrangement¹⁶ and an MSA with a catastrophic insurance plan.¹⁷ They

DRAFT May 14, 1996

found that if only one-quarter of the people who would be better off (in terms of out-of-pocket spending) under MSAs enrolled in MSA plans — i.e., that some risk selection occurred — the premium for comprehensive coverage would increase by 63% relative to a scenario where there was no adverse risk selection. The higher the enrollment in MSA plans among those who would be better off, the larger the increase in the premium for comprehensive coverage.

- **Cato Institute.** A CATO Institute researcher argues that the risk selection problem is overstated.¹⁸ He reviewed the experience of a number of large employers that now offer MSAs with high deductible insurance plans to their employees and concluded that risk selection has not been a serious problem. He also argues that since low-deductible health insurance policies are "driving up the cost of health care," it would "not necessarily be a bad thing" if the cost of such policies rose as a result of adverse selection. He further suggests that risk selection occurs because of insurance market reforms that restrict insurers from charging premiums based on health status or denying coverage to people with pre-existing health conditions. If insurers were not restricted in this way, then an individual who developed an expensive health condition would not necessarily be able to switch from high-deductible to low-deductible coverage.
- **Brookings Institution.** An analysis by a researcher at the Brookings Institution questions the anecdotal evidence offered about the effects MSAs have had in the market. He points out that other plan changes were made when MSAs were implemented, and that the American Academy of Actuaries was unable to obtain actual claims information from any of these arrangements in order to perform a thorough, quantitative analysis.¹⁹

Premium Levels for High-Deductible Coverage and the Financial Implications for Employees

A number of analysts of MSAs assume that employers would be willing to deposit into an employee's MSA all (or at least most) of any premium savings generated by moving from a standard plan to a high-deductible plan. Given this assumption, the financial implications for employees are affected greatly by how much premiums decrease when switching from low-deductible to high-deductible coverage. This decrease influences how much premium savings would be available to contribute towards an MSA, and in turn influences the level of an employee's financial exposure to out-of-pocket costs. In other words,

DRAFT May 14, 1996

a key issue is: When switching coverage, how much does an individual's deductible rise relative to how much his or her premium falls?

Scenarios presented by MSA analysts lead to very different conclusions about the financial implications for employees and individuals:

- **Cato Institute/National Center for Policy Analysis (NCPA).** These researchers present a variety of scenarios similar to the following: An employer now pays about \$4,800 for a typical family insurance policy. The employer could, instead, purchase a policy with a \$3,000 deductible for about \$1,800 and put the \$3,000 in premium savings into a MSA.²⁰

The implications of this scenario are that *all* employees (regardless of their health status) would be better off than under the status quo. An employee who used more than \$3,000 in health services would not have any out-of-pocket obligation — the MSA would cover the full \$3,000 deductible. An employee who used less than \$3,000 in health services would also have no out-of-pocket obligation, and could use the remaining MSA balance for services not covered by the insurance policy, either now or in the future.

One NCPA research report presents premiums for a range of health insurance policies offered in the marketplace, observing that "by increasing the deductible from \$250 to \$2,500, the average family would save as much in premiums as the coverage it foregoes."²¹

- **American Academy of Actuaries.** The AAA's analysis reaches a very different conclusion, suggesting that the premium savings from switching out of a low-deductible plan into a high-deductible plan would be significantly less than the increase in the deductible faced by an individual.

As described above, the AAA's results depend on the extent to which people view an MSA as an insurance policy or a savings account. Based on their "medium effect" case, the Actuaries present the following results:²²

- Combined employer and employee premium savings resulting from switching out of a low-deductible plan and into a high-deductible plan would be \$623 for an individual, which could be contributed to the individual's MSA. This amount is significantly lower than the maximum out-of-pocket obligation of \$2,500 under the high-deductible plan, leaving an individual with potential out-of-pocket expenses of

DRAFT May 14, 1996

\$1,877 (the difference between the maximum out-of-pocket obligation and the MSA contribution).

- Since the MSA contribution is lower than an individual's maximum out-of-pocket obligation, people who use a large amount of health care services would be worse off under the high-deductible/MSA combination (i.e., they would face significant out-of-pocket costs under a high-deductible insurance policy once their MSA accounts were depleted). People who use few services would be better off, because they would build up balances in their MSAs. The AAA estimate that 74% of employees would be better off financially in a single year, while 26% of employees would be worse off.
- **Urban Institute.** Researchers from the Urban Institute produced results similar to those presented by the American Academy of Actuaries:²³
 - An individual enrolled in the high-deductible plan would have \$591 available for an MSA (the combined employer and employee premium savings from switching out of a low-deductible plan). The high-deductible plan used for the Urban Institute's analysis had a \$2,000 deductible with no copayments (i.e., the insurer covers 100% of costs once the deductible is met). Therefore, an individual is left with potential out-of-pocket costs of \$1,409 (the difference between the deductible and the amount available for an MSA).
 - After a one year period, 80% of individuals would be better off financially and 20% worse off. After the cumulative effects of a three year period, 73% of individuals would be better off and 27% worse off.
- **Congressional Research Service (CRS).** Estimates prepared for CRS by The Hay Group show results similar to those from the Actuaries and the Urban Institute. These estimate show a \$627 premium difference between a standard policy (\$200 deductible and 20% copayment) and a high-deductible policy (\$2,500 deductible).²⁴

Compatibility of MSAs and Managed Care

Another issue frequently raised about MSAs is their compatibility with managed care.²⁵ The MSA approach to reducing costs — increasing individual autonomy and cost consciousness — is very different from the approach employed by managed care, which involves relatively little cost sharing but the active management of each enrollee's health care use.²⁶

DRAFT May 14, 1996

Several analysts have considered whether and how MSAs could be integrated with managed care approaches.

- **American Academy of Actuaries.** The AAA conclude that it would be "very difficult" to integrate HMO coverage and MSAs, and that integrating MSAs and other types of managed care plans would be possible but could present "serious problems."²⁷ Several potential approaches to integration are considered, including using MSAs to control the use of outpatient and physician office services or incorporating MSAs as part of an exclusive provider organization (EPO) or preferred provider organization (PPO) product. The AAA suggests that the large deductible associated with an MSA approach would make capitation impossible unless some part of the MSA funds could be used as part of the capitation to providers..
- **National Center for Policy Analysis.** Researchers at the NCPA state that HMO enrollees would have the same opportunities to use MSAs as individuals enrolling in conventional fee-for-service plans. They point out that many HMOs are incorporating deductibles, which will provide incentives for HMO members to have MSAs.²⁸

SUMMARY

MSAs are a relatively new and highly controversial concept, and there is little evidence about their potential effects on the health care system. Although programs similar to MSAs are being used by a number of employers (including several large employers), no systematic analyses of these arrangements has been conducted and published for public review, either by MSA advocates or critics.

MSA advocates (e.g., researchers affiliated with the Cato Institute and the National Center for Policy Analysis), have presented arguments suggesting that MSAs would reduce health spending substantially, permitting large contributions into MSAs that would substantially offset the higher deductible people would face. Under this scenario, virtually all individuals would be better off under an MSA/high-deductible insurance plan than under the status quo.

In the absence of empirical evidence, a number of analysts — including the American Academy of Actuaries and researchers from the Urban Institute — have simulated the effects of MSAs. The results from these studies are, in many cases, at odds with the arguments made by MSA advocates. They predict significantly smaller decreases in health spending (which means that less is available to fund MSAs), in part due to the argument that higher patient cost sharing and managed care approaches have already lowered health care costs. In

DRAFT May 14, 1996

addition, these studies suggest that MSAs could exacerbate risk selection problems, further segregating the healthy from the sick in the insurance market, and that many individuals would be worse off under MSAs (particularly those with expensive health conditions).

DRAFT May 14, 1996

NOTES

¹ Joint Committee on Taxation, "Estimated Budget Effects of Items Contained in an Amendment in the Nature of a Substitute to H.R. 3103 to be offered by Chairman Archer on Tuesday, March 19, 1996" (March 18, 1996). The Joint Committee on Taxation (JCT) prepares revenue estimates of the tax-related provisions of legislation. Their analysis has not been included in our review because there is no public document describing the details of their assumptions and results. A description of JCT's methodology for analyzing MSAs can be found in: Joint Committee on Taxation, "Description and Analysis of H.R. 1818 ("The Family Medical Savings and Investment Act of 1995"), JCX-28-95, (June 26, 1995).

² A number of papers also have looked at the effects that MSAs would have if introduced as an option for Medicare beneficiaries, including: Jack Rogers and Jim Mays, "Medical Savings Accounts for Medicare Beneficiaries," (August 1995); National Center for Policy Analysis, "Saving the Medicare System with Medical Savings Accounts," (September 1995); Milliman & Robertson, "Vouchers as an Option on Medicare, Projected Savings," (September 1995); Heritage Foundation, "Reforming Medicare: What Congress can Learn from the Health Plans of America's Corporations," the Heritage Foundation Background, (October 1995); and Lewin-VHI Inc, "Changes in Medicare Program Spending Under Alternative Medical Savings Account Models" (September 1995). These papers have not been included in the discussion because the characteristics of the Medicare market are different from the voluntary health insurance market for non-Medicare individuals (e.g., the Medicare program is highly structured, offers universal coverage to a uniform benefits package, is primarily delivered in a fee-for-service manner, and is characterized by individual rather than employer choice).

³ Paul Fronstin, "Medical Savings Accounts: Issues to Consider," EBRI Notes, v. 16, n. 7 (July 1995).

⁴ Joseph P. Newhouse, et al, "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, v. 305, n. 25, (December 17, 1981).

⁵ For example, see: Peter J. Ferrara, "More than a Theory: Medical Savings Accounts at Work," *Cato Institute Policy Analysis*, n. 220 (March 14, 1995); Michael Tanner, "Medical Savings Accounts: Answering the Critics," *Cato Institute Policy Analysis*, n. 228 (May 25, 1995); Brink Lindsey, "Patient Power: The Cato Institute's Plan for Health Care Reform," *Cato Institute Briefing Paper*, n. 19 (October 4, 1993); and John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," *National Center for Policy Analysis Policy Report No. 168* (January 1992).

⁶ Goodman and Musgrave, page 27.

⁷ The American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," *Public Policy Monograph* (May 1995).

⁸ Joseph White, "Medical Savings Accounts: Fact Versus Fiction," *Brookings Occasional Paper*.

⁹ Len M. Nichols, Marilyn Moon, and Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," *The Urban Institute* (April 1996).

¹⁰ Larry Ozanne, "Effects of Catastrophic Insurance and Medical Savings Accounts on Medical Spending," unpublished paper (March 21, 1996). The author is a senior analyst with the Congressional Budget Office (CBO), though the views expressed in the paper do not necessarily represent the views of CBO.

¹¹ Len M. Nichols, Marilyn Moon, and Susan Wall, "Medical Savings Accounts: A Policy Analysis," *The Urban Institute* (March 1996).

¹² Tanner, page 9.

¹³ American Academy of Actuaries, page 5.

¹⁴ EBRI Notes, page 3.

¹⁵ Nichols, Moon, and Wall (April 1996).

DRAFT May 14, 1996

¹⁶ The comprehensive plan had a \$250 deductible and 20 percent coinsurance with a \$1,250 annual limit on out-of-pocket spending.

¹⁷ The catastrophic insurance plan provided comprehensive coverage after a \$2,000 deductible.

¹⁸ Tanner, pages 16 and 17.

¹⁹ White, page 15

²⁰ This example is from Ferrara. Similar examples can be found in Tanner and Lindsey.

²¹ Goodman and Musgrave, page 13.

²² American Academy of Actuaries.

²³ Nichols, Moon, and Wall (April 1996).

²⁴ Bob Lyke, "CRS Report for Congress: Medical Savings Accounts," Library of Congress (July 21, 1994).

²⁵ See for example, EBRI Notes, page 4; American Academy of Actuaries, page 12.

²⁶ See Nichols, Moon, and Wall (April 1996), page 22.

²⁷ American Academy of Actuaries, pages 12 and 13. For example, the Actuaries point out that federal law would not permit a federally-qualified HMO to incorporate an all-purpose deductible.

²⁸ Goodman and Musgrave, page 32.

DRAFT May 14, 1996

REFERENCES

- American Academy of Actuaries, "Medical Savings Accounts : Cost Implications and Design Issues," Public Policy Monograph, American Academy of Actuaries (May 1995).
- Burry Jr., John, "Medical Savings Accounts: Bad Medicine for the U.S. Healthcare System," Blue Cross/Blue Shield of Ohio (1994).
- Burry Jr., John, "The Future of Health Care: Don't Let Medical Savings Accounts Derail the American Healthcare Revolution," Blue Cross/Blue Shield of Ohio (May, 1995).
- Ferrara, Peter J., "More than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis, n. 220 (March 14, 1995).
- Fronstin, Paul, "Medical Savings Accounts: Issues to Consider," EBRI Notes, v. 16, n. 7 (July 1995).
- Goodman, John C., Musgrave, Gerald L., "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis Policy Report n. 168 (January 1992).
- Joint Committee on Taxation, "Estimated Budget Effects of Items Contained in an Amendment in the Nature of a Substitute to H.R. 3103 to be offered by Chairman Archer on Tuesday, March 19, 1996" (March 18, 1996).
- Lindsey, Brink, "Patient Power, The Cato Institute's Plan for Health Care Reform," Cato Briefing Papers, The Cato Institute (October 4, 1993).
- Lyke, Bob, "CRS Report for Congress: Medical Savings Accounts," Library of Congress (July 21, 1994).
- Moon, Marilyn, Nichols, Len M., and Wall, Susan, "Medical Savings Accounts : A Policy Analysis," The Urban Institute Working Paper #06571-001 (March, 1996).
- Newhouse, Joseph P., et al, "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine, v. 305, n. 25, (December 17, 1981).

DRAFT May 14, 1996

Nichols, Len M., Moon, Marilyn, and Wall, Susan, "Tax Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," The Urban Institute (April, 1996).

Ozanne, Larry, "Effects of Catastrophic Insurance and Medical Savings Accounts on Medical Spending," unpublished paper (March 21, 1996).

Pauly, Mark V., "An Analysis of Medical Savings Accounts : Do Two Wrongs Make a Right?" The AEI Press (1994).

Pauly, Mark V. and Goodman, John C., "Using Tax Credits for Efficient and Equitable Medical Savings Accounts and Health Insurance," American Enterprise Institute (March 1, 1995).

Pauly, Mark V. and Goodman, John C., "Tax Credits for Health Insurance and Medical Savings Accounts," Health Affairs (Spring 1995).

Tanner, Michael J., "Medical Savings Accounts: Answering the Critics," Cato Institute Policy Analysis 228, Cato Institute (May 25, 1995).

Thorpe, Kenneth E., "Medical Savings Accounts: Design and Policy Issues," Health Affairs, v. 14, n. 3 (Fall 1995).

White, Joseph, "Medical Savings Accounts: Fact Versus Fiction," Brookings Occasional Paper, The Brookings Institute (1995).

APPENDIX A COMPARISON OF MEDICAL SAVINGS ACCOUNT ANALYSES

ISSUES	SELECTED ANALYSES			
	Cato Institute/ National Center for Policy Analysis (NCPA)	American Academy of Actuaries (AAA)	Urban Institute	Brookings Institution
Cost Savings Through Reduced Use of Services	<p>These analysts cite the assumption that families with an insurance policy that has no deductible use 58% more services than families with a high-deductible.</p>	<ul style="list-style-type: none"> • Health spending for individuals with a high-deductible plan would be about 13% lower than spending under a low-deductible plan normally found in the current market. • When a high-deductible plan is paired with an MSA, health spending would be between 2% and 12% lower than spending under a low-deductible plan. • Spending on services not covered by insurance — which could be paid for on a pre-tax basis out of an MSA — would rise. 	<p>Uses the same assumptions as the American Academy of Actuaries.</p>	<p>Savings estimates cited by Cato and NCPA analysts are over-stated because:</p> <ul style="list-style-type: none"> • Few people today have coverage with no deductible. • Managed care approaches have already lowered service use, so high-deductible plans and MSAs would save less than earlier studies might indicate.

202 401 7321 #18

5-14-96 12:03PM

SEN BY:

ISSUES	SELECTED ANALYSES			
	Cato Institute/ National Center for Policy Analysis (NCPA)	American Academy of Actuaries (AAA)	Urban Institute	Brookings Institution
Risk Selection	<ul style="list-style-type: none"> Argue that risk selection is not a major problem, based in part on the experience of several employers that offer MSAs and high-deductible plans. Since low-deductible health insurance policies are "driving up the cost of health care," it would "not necessarily be a bad thing" if the cost of such policies rose as a result of adverse selection. 	<p>If individuals are free to choose a standard plan (i.e., similar to a fee-for-service plan in the current market) or a high-deductible plan, then the premium in the standard plan could rise by 61%.</p>	<p>If one-quarter of the people who would be better off financially under an MSA enrolled in a high-deductible plan with an MSA, the premium for standard coverage (i.e., with a low deductible) would increase by 63%. If more of these people enrolled in an MSA, the percentage increase in the standard premium would be even higher.</p>	<p>Questions the anecdotal evidence that high-deductible plans and MSAs have not led to risk selection when used by certain employers. He observes that the American Academy of Actuaries was unable to obtain actual claims information from any of the employers or insurers that have used MSAs.</p>

SELECTED ANALYSES				
ISSUES	Cato Institute / National Center for Policy Analysis (NCPA)	American Academy of Actuaries (AAA)	Urban Institute	Brookings Institution
Financial Implications for Employees and Individuals	<ul style="list-style-type: none"> Present a variety of scenarios that indicate that all employees would be better off under an MSA and high-deductible plan than under current insurance arrangements. One scenario cited: An employer now pays \$4,800 for a typical family insurance policy. The employer could, instead, purchase a policy with a \$3,000 deductible for a premium of \$1,800 and put the \$3,000 in savings into an MSA. Under this scenario, no employee would have to pay anything out-of-pocket and could accrue savings in an MSA account if he or she uses less than \$3,000 in services in a year. 	<ul style="list-style-type: none"> Switching from a low-deductible plan to a high-deductible plan would not reduce the premium enough to fund an MSA that covers all of an employee's out-of-pocket costs. The maximum employee obligation under a high-deductible plan would be \$2,500, while the premium savings available to contribute towards an MSA would amount to only \$623. In any given year, 74% of employees would be better off financially under an MSA than under a standard insurance plan, while 26% of employees would be worse off. 	<ul style="list-style-type: none"> Similar to the AAA analysis. The maximum employee obligation under a high-deductible plan would be \$2,000, while the premium savings available to contribute towards an MSA would amount to only \$591. After a one year period, 80% of individuals would be better off financially under an MSA approach, while 20% would be worse off. After a three year period, 73% of individuals would be better off and 27% worse off. 	<p>Suggests that premium reductions cited by Cato Institute and NCPA analysts are over-stated, in part due to risk selection. That is, premiums charged for high-deductible plans reflect the fact that healthy individuals are more likely to choose such plans.</p>

ISSUES	SELECTED ANALYSES			
Compatibility with Managed Care	Cato Institute/ National Center for Policy Analysis (NCPA)	American Academy of Actuaries (AAA)	Urban Institute	Brookings Institution
	<ul style="list-style-type: none"> HMO enrollees would have the same opportunities to use MSAs as individuals enrolling in conventional fee-for-service plans. Many HMOs are already incorporating deductibles, which will provide an opportunity for HMO members to use MSAs. 	<p>It would be "very difficult" to integrate HMO coverage and MSAs. Integrating MSAs and other types of managed care plans would be possible but could present "serious problems."</p>	<p>Not applicable.</p>	<p>Not applicable.</p>

Medical Savings Accounts (MSA) Proposal

4-Year Experiment. Before consideration of the merits of expanding MSAs to the entire nation, a 4-year experiment would be initiated, concluding with a report submission by a nationally-recognized, independent third-party. The report would address the feasibility and advisability of extending MSAs more broadly. It would focus on:

- The number and demographic characteristics of MSA users.
- The impact of MSAs on cost containment for users and the entire market.
- The cost of MSAs (in terms of revenue loss to the Treasury).
- The correlation, if any, of MSAs to positive/negative health insurance coverage rates.
- The effect of MSAs on the insurance market, including risk selection issues and their potential impact on premiums of non-MSA users.
- The impact of MSAs on the use of preventive care services and on the health care delivery system in general.
- NOTE: As a condition of health plans ability to participate in the experiment, they would agree to providing all necessary data to adequately evaluate MSAs.

Three Design Options for the Experiment:

1. Expanded geographic-based experiment

2. Firms with ≤ 50

Limit participation to # of workers/revenue loss projected for MSAs

3. Firms with > 50

Limit participation to # of workers/revenue loss projected for MSAs

MSA Structure:

- All structural policies in latest Republican MSA proposal (6-10-96) are assumed unless inconsistent with the amendments outlined below.
- Contributions to MSAs for employees can be made only by employers.
- The definition of catastrophic (high deductible) health plans is modified to:
 - (1) Cap the maximum deductible at \$1,500 for individuals and \$3,000 for families and
 - (2) Institute a total annual out-of-pocket stop-loss at \$2,500 (including the deductible) for individuals and \$5,000 for families (including the deductible) with no additional artificial dollar limits on covered benefits.
- The allowable build-up of savings in the MSA account is limited to three times the maximum deductible.
- Insurers and firms offering MSAs are required to also a traditional insurance policy. Differences in premiums across the two plans must reflect only the objective differences in benefit levels and cannot reflect the health status of the individuals who choose (or are expected to choose) the plans.

- The maximum employer contribution to the MSA account in a year cannot exceed the lower of the MSA deductible OR the savings from difference in costs between a traditional benefit plan and the high deductible MSA plan.
- Tax-free withdrawals are limited to health care expenses that count towards the deductible under the high deductible plan.
- Tax treatment for the self-employed is structured to be consistent with health deductions for traditional plans -- (so as to not bias selection in favor of MSAs.)

Consumer Protection Assurances:

- Assure that the model MSA regulatory act by the National Association of Insurance Commissioners (NAIC) (outlined in the Republican proposal) provides for adequate consumer and market protections for MSAs, including provisions to deal with risk selection concerns. MSAs must be a full insured plan subject to the small group insurance reforms provided in the state in which the product is sold, and must be in compliance with the insurance reforms included in the Kassebaum-Kennedy bill.

Affirmative Vote to Expand MSAs Nationwide.

- After receipt of recommendations and analysis from the independent national organization, the Congress will take a vote on whether or not to continue or extend MSAs to the rest of (or any part) of the nation's population. An affirmative vote will be required to expand the use of MSAs.

MSA File

Medical Savings Accounts (MSAs)

- **House Bill.** The House bill would establish trusts or custodial accounts called "medical savings accounts" (MSAs). The bill would:
 - permit an individual who has catastrophic health care insurance (with a deductible of at least \$1,500, or \$3,000 for family coverage) to make tax-deductible contributions to an MSA up to the lesser of the deductible or \$2,000 for individuals (or \$4,000 for a family); or
 - provide, subject to the same limitations, an exclusion from employees' income (and social security wages) for employer contributions to MSAs.

Earnings on amounts in an MSA would accumulate tax-free. Distributions from MSAs could be used, without being taxed, to pay for medical care (including deductibles under the catastrophic coverage, noncovered services, and long-term care services), but could not be used to purchase insurance (other than qualified long-term care insurance, COBRA-type continuation coverage, or coverage while unemployed). Amounts not used in a year could be carried forward into the next year. Distributions used for nonmedical purposes would be subject to income tax, plus a 10% penalty tax if paid prior to age 59 1/2, death or disability. The balance remaining in the MSA at death would be excluded from estate tax.

- **Adverse selection.** By providing a tax incentive for the purchase of catastrophic insurance, as opposed to comprehensive coverage, MSAs would further encourage healthy individuals to leave the insurance risk pool. The remaining participants in the pool would tend to be sicker than average, and the costs 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.
- **Tax shelter for the healthy.** MSAs would 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. 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. Moreover, because the MSA balance would not be included in the taxable estate, individuals could use MSAs to avoid estate taxes when they die.
- **Use of MSAs by high-paid versus low-paid.** According to an October 1995 monograph of the American Academy of Actuaries:

The *employee demographics* will determine whether a high-deductible/MSA approach is feasible. If most of the jobs are low-paying -- say, between \$10,000 and \$20,000 -- there would likely be very little interest in any plan with a deductible as high as \$1,800, because low-paid employees may not have enough money to self-insure the high deductible. Even less interest would ensue if employees were required to contribute to the MSA, instead of employers, because low-paid employees usually have very little discretionary funds.

On the other hand, if there were substantial numbers of employees with salary of, say, \$50,000 or more, the chance to put money into a tax-advantaged fund could be very attractive. Such employees are better able to self-insure the high deductible and have more in the way of discretionary funds to contribute to the MSA....

- **Undermine 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, such as vision care and orthodontic expenses. This would deplete the funds set aside on their behalf for health care. If they later experienced more serious health care problems, they would lack funds to pay the high deductible for more critical care.
- **MSAs may discourage cost-saving preventive care.** The high deductible coverage associated with MSAs may lead to delayed care and under-utilization of routine and preventive health care services.
- **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.
- **Employer contributions overstated.** Proponents of MSAs have overstated the amount employers could contribute to employees' MSAs without increasing employer cost. The reduction in premiums when employees switch from comprehensive to catastrophic coverage (the source of employer contributions to MSAs) will typically be less than the increase in the deductible. Therefore, employees with MSAs would be at risk for larger out-of-pocket costs than under current plans, because employers are likely to contribute less than the increase in the deductible. (In an impartial analysis by the American Academy of Actuaries, the mid-range estimate of these reductions in premiums was \$1,562 per family for an employer that switched from a plan with a \$200 deductible to a plan with a \$3,000 deductible for all its employees. An employer contribution to an MSA of this full \$1,562 amount would not meet the employees' full \$3,000 deductible if the individual had high health expenses.) And because of adverse selection, if employers offered employees a choice between the plans, employers could not hold their costs constant without reducing their MSA contributions to a level which may be well below the \$1,562 amount described above.
- **Questionable effect on cost containment.** While catastrophic coverage can 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 comprehensive 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. Moreover, MSAs would also discourage cost containment by enabling more employees, self-employed individuals and others to pay for out-of-pocket expenses with tax-preferred dollars. And even if MSAs encourage some individuals to reduce health expenditures, low participation in MSAs would result in very little overall 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. For example, individuals would have to keep their own records on what Section 213 expenses they had incurred that were not reimbursed by insurance to determine whether they constitute qualified medical expenses that could be paid with MSA withdrawals. The IRS would need to verify the amount of these unreimbursed expenses, and, for tax-deductibility, would need to verify, on a month by month basis, that the taxpayer is covered only by a high-deductible health plan.
- **Needs further study.** It is important to make sure that we understand fully the consequences of this proposal for the tax system and health care. To that end, it should be analyzed in the context of the overall health care plan of which it is a part. In this case, it seems inconsistent with the basic thrust of the larger bill, which is directed toward broadening the risk pool.
- **Revenue loss.** JCT estimates that the MSA proposal would reduce revenues by \$1.8 billion over 7 years.

HEALTH INSURANCE REFORM COMPROMISE

Principals' Issues

Tier I: Resolved Issues

- A. An MSA experiment of a fixed duration (3-5 years), evaluated by an independent, nationally-recognized body, that requires an affirmative vote (under regular order procedures) to extend or expand.
- B. Populations eligible to participate in the experiment:
 - 1. The self-employed and
 - 2. Businesses with 100 and less employees.
(Utilization of MSAs by businesses and the self-employed is limited to projection of users by the Treasury Department).

Tier II: Unresolved Issues

- A. Mental Health Parity

Staff Issues

Tier I: Resolved Issues

(Accept latest -- 6-10-96 -- Republican MSA tax policy and insurance changes, which assume that MSAs are an insured product that comply with state insurance laws and the insurance reform provisions in H.R.3103, UNLESS inconsistent with amendments outlined below.)

- A. Catastrophic benefit package designed to be consistent with RAND study recommendations to avoid risk selection. Maximum deductibles (and total out-of-pocket costs) for individuals and families are set consistent with RAND recommendations (i.e., \$2,000/\$4,000) and the minimum deductible is set at one half the maximum deductible (i.e., \$1,000 for individuals and \$2,000 for families).
- B. Contributions to MSAs can be made only by employers and the amount of the contribution is limited to the lower of the plan's deductible OR the difference in the cost of the premium between the catastrophic benefit plan and the traditional plan. (Experts say that it is about one-half the set deductible.)
- * No requirement for a cap on build-up during the experiment; no requirement that insurers and plans must offer choice of traditional/MSA plans; no requirement that MSA account spending be solely limited to benefits covered by the catastrophic benefit plan; and no requirement that a risk adjustment mechanism must be in place to sell MSAs.

Tier II: Unresolved Issues

- A. Definition of the self-employed and ways to address the potential problems associated with "favored tax status."**
- B. How is the MSA utilization cap mechanism monitored and enforced?**
- C. Who is designated as the independent, nationally-recognized evaluator of the study? How is it referenced in the statute? What are the various issues this body is charged to study?**
- D. Review of provisions of the bill to assure there are no major problems. Issues of particular concern include:**
 - Medigap duplication issues**
 - Medicare fraud and abuse issues**
 - Insurance reform provisions**
 - Other issues, such as long-term care tax clarifications and other revenue raisers/losers.**

456-5392

(4)

Problems With Medical Savings Accounts

1. LAVISH TAX BREAKS FOR THE RICH

- * The \$1.7 billion revenue loss will go almost exclusively to the highest income and healthiest Americans.
- * Joint Tax Committee Analysis concludes that less than 1% of those who will purchase MSAs under this amendment will make less than \$30,000 a year. Virtually no one will purchase these plans who make less than \$20,000 a year.
- * The well-to-do will be able to use MSA as a second IRA, except that this IRA will have no income limits and will accrue disproportionately to the extremely wealthy. People choosing this option with large assets can use their own money to pay their medical bills and protect their tax deferred MSA savings.
- * A little known provision that helps only people with assets of over \$600,000 excludes MSA balances from estate taxes. Even the most generous IRA expansion proposed by Republicans and Democrats does not provide for this exclusion.
- * Health care analysts are virtually unanimous in their opposition to MSAs:
 - The American Academy of Actuaries says that MSAs are "Taxing money from the unhealthy and giving it to the healthy."
 - The Center on Budget Policy Priorities says, "MSAs create new tax shelter opportunities. Use of an MSA would be highly advantageous to substantial numbers of high income taxpayers."

2. HAND-OUT TO GOLDEN RULE INSURANCE COMPANY

- * To select MSAs, an individual is required to select a catastrophic insurance plan, and Golden Rule is one of the largest marketers of catastrophic plans in the country. MSAs would simply allow Golden Rule to greatly enlarge their market.
- * This company gave \$1.6 million in political contributions to Republicans over the last 5 years.
- * They are near the bottom of insurance company rankings done by consumer groups, such as Consumers Union, because they provide inadequate coverage, frequent rating increases, very aggressive underwriting, and readiness to contest claims and cancel policies.

3. UNRAVELS HEALTH INSURANCE AND INCREASES PREMIUMS FOR WORKING AMERICANS

- * Because healthy and wealthy individuals are most likely to purchase MSAs, those who remain behind in the traditional insurance plans will likely face higher premiums because the insurance pool has been weakened.
- * The premium increases could be high enough to force lower income working people to drop their coverage.

- * Insurance pool for ordinary Americans, without MSAs, will suffer both from healthy people pulling out to obtain MSAs and also from individuals with MSAs who become sick going back into the traditional insurance pools.

4. PART OF THE REPUBLICAN PLAN TO "WITHER AWAY" MEDICARE

- * This Golden Rule plan is the tool that Republicans want to use to have Medicare "wither on the vine." It is advocated by Speaker Gingrich -- who coined this phrase and by Leader Dole who proudly talks about his vote against the original enactment of the Medicare program.
- * Clearly Medicare MSAs have an even greater potential to undermine the financial stability of the Medicare program to both beneficiaries and the taxpayers who support it by exposing the program to an option that rewards cherry picking healthy beneficiaries -- not competition over cost and quality. Medicare MSAs were included in the Republican reconciliation bill vetoed by President Clinton in December, 1995
- * Today's amendment is just the first step back toward the Republicans and Golden Rule's ultimate goal of putting in MSAs into the Medicare program. They were rejected doing Medicare MSAs when the President vetoed their excessive Medicare cuts; now -- through today's amendment -- they are setting the stage for pushing Medicare MSAs as the next logical step.

5. DISCOURAGES PREVENTIVE CARE

- * MSAs may discourage cost-saving preventive care, such as annual check-ups, immunizations and other wellness efforts. The high deductible coverage associated with MSAs may lead to delayed care and under-utilization of routine and preventive health care services.
- * 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 providing through MSAs.
- * MSAs will not promote cost containment in the long-run. By allowing people to have MSAs when they are healthy but switch to more traditional coverage when they become ill, the MSAs simply become a vehicle for sheltering income, not a means of promoting more cost-conscious consumers.

American Academy of Actuaries Estimate of Savings

	<u>Individual Plan</u> \$1,500/\$2,500	<u>Family Plan</u> \$3,000/\$4,000
1. Employer savings for MSA plus high deductible plan	\$508	\$1,250
2. Employer savings as a percentage of deductible	33.9%	42%
3. Employer & employee savings	\$635	\$1,568
4. total savings as a percentage of deductible	42.3%	52%
5. Reduction in premium from baseline for higher deductible plan with no MSA	\$703	\$1,719
6. Premium reduction as a percentage of higher deductible	47%	57.3%
7. Savings in premium for individual plan with \$2,000 deductible and no MSA	\$828	
8. Above savings as a percentage of the deductible for MSA option	55.2%	
• 33.3% increase in deductible but only 8.3% increase in savings		
9. Savings in premium for individual plan with \$3,000 deductible and no MSA	\$1,033	
10. Above savings as a percentage of the deductible for MSA option	68.9%	
• 100% increase in deductible but only 21.9% increase in savings		
11. Savings in premium for family plan with a \$6,000 deductible and no MSA		\$2,906
12. Above savings as a percentage of the deductible for MSA option		96.9%

Note: These savings assume as a baseline an individual plan (\$200/1000) and a family plan (\$400/4000) with no MSA

Public Policy **1** *Monograph*

**MEDICAL
SAVINGS
ACCOUNTS**

**COST IMPLICATIONS
AND
DESIGN ISSUES**



AMERICAN ACADEMY *of* ACTUARIES

Table II-3
Cost Effect of Change to \$1,500 Deductible Plan for Individuals

Plan	\$200 Deductible, \$1,000 Maximum Out-of-Pocket ^a	Before Induction ^b	\$1,500 Deductible, \$2,500 Maximum Out-of-Pocket		
			Low Induction ^c	After Induction HCFA Induction ^c	High Induction ^c
1. Premium	\$2,699	\$2,178	\$2,030	\$1,996	\$1,920
2. Out-of-Pocket	341	794	\$697	642	\$522
3. Total Health Expenditures ((1) + (2))	\$3,040	\$2,972	\$2,727	\$2,638	\$2,442

Source: American Academy of Actuaries

^aCost of illustrative standard plan using American Academy of Actuaries distribution.

^bCost of illustrative high-deductible plan before induction.

^cCost of illustrative high-deductible plan considering the range of induction factors.

Table II-3 shows the premium and out-of-pocket expenses that would result if the average insured person were moved into the high-deductible plan, assuming that the person had no other choices for coverage. Before taking induction into consideration, the premium would decrease from \$2,699 to \$2,178, because of the application of the higher copayments. The insured's out-of-pocket expenses would increase from \$341 to \$794. The total health expenditures would decline slightly, because no administrative expenses would be associated with the insured's out-of-pocket payments. The effect of induction is shown using each of the three sets of factors from Table II-2A.

Tables II-4A and II-4B show, for individuals and families, respectively, the premiums for various high-deductible plans. The premiums were determined by the following process:

1. The increase in copayments from the assumed current individual plan was determined for each health care expense in the work group's dataset.

2. The increase in copayments from the assumed current family plan was determined for each health care expense in a family distribution, based on the NMES model.

3. The reduction in health care expense resulting from the induction effect was determined by applying the HCFA assumptions and method to the increase in copayments.

4. The copayments of the high-deductible plan were then applied to the revised health care expenses, to determine the aggregate health care costs reimbursed by insurance.

5. The aggregate insured health care costs were increased by 15% to account for administrative expenses.

Table II-4A
Cost of Different Copayment Designs—Individual Plan

Deductible/ Maximum Out-of-Pocket	Premium	Reduction from Baseline Premium
Baseline		
\$200/\$1,000	\$2,699	-0-
\$1,000/\$2,000	2,176	523
\$1,500/\$2,500	1,996	703
\$2,000/\$3,000	1,871	828
\$3,000/\$4,000	1,666	1,033
\$4,000/\$5,000	1,501	1,198
\$5,000/\$6,000	1,369	1,330

Source: American Academy of Actuaries

Note: Relative cost of plans after consideration of induction, before consideration of the MSA.

Table II-4B
Cost of Different Copayment Designs—Family Plan

Deductible/ Maximum Out-Of-Pocket	Premium	Reduction from Baseline Premium
Baseline		
\$400/ \$2,000	\$6,567	-0-
\$1,000/ \$2,000	6,170	397
\$2,000/ \$3,000	5,411	1,156
\$3,000/ \$4,000	4,848	1,719
\$4,000/ \$5,000	4,385	2,182
\$5,000/ \$6,000	3,989	2,578
\$6,000/ \$7,000	3,661	2,906

Source: American Academy of Actuaries

Note: Relative cost of plans after consideration of induction, before consideration of the MSA.

COMBINING HIGH-DEDUCTIBLE PLANS WITH MSAS

Section II discussed the induction effect. Here, we will attempt to quantify that effect, on (1) the expenditures of the average employee, and (2) the average total claim cost and administrative expenses. Also, we briefly analyze the various winners and losers that would result from a shift from the low-deductible plan to the MSA/high-deductible plan arrangement. Finally, we discuss the potential effect of the arrangement on employers, including some of the factors that would influence risk and selection.

THE AVERAGE EMPLOYEE

The case considered here is a switch from the low-deductible plan to a combination of a high-deductible plan with an MSA. This illustration assumes that the employer will freeze his contributions (line 5 of Tables IV-1 and IV-2) and thus reflects all savings back to the employee who contributes a relatively small part of the total plan cost. In evaluating this possibility, it is necessary to consider whether this is a realistic assumption for the employer.

Table IV-1
Employee Savings—Individual Plan

Deductible/ Maximum Out-Of-Pocket	\$200/\$1,000		\$1,500/\$2,500		
	Proportion of MSA Considered as Savings	Not Applicable	10% Low Effect	50% Medium Effect	90% High Effect
Employer Costs*					
1. Premium					
1a. For Administrative Expense	282	220	215	209	
1b. For Claims	1,877	1,471	1,436	1,398	
2. Subtotal [(1a) + (1b)]	\$2,159	\$1,691	\$1,651	\$1,607	
3. MSA Contribution					
3a. For Administrative Expense	0	9	10	11	
3b. For MSA Claim Fund	0	459	498	541	
4. Subtotal [(3a) + (3b)]	\$0	\$468	\$508	\$552	
5. Total [(2) + (4)] (80% of \$2,699)	\$2,159	\$2,159	\$2,159	\$2,159	
Employee Costs*					
6. Premium					
6a. For Administrative Expense	70	55	54	52	
6b. For Claims	470	368	359	350	
7. Subtotal [(6a) + (6b)]	\$540	\$423	\$413	\$402	
8. MSA Contribution					
8a. For Administrative Expense	0	2	2	3	
8b. For MSA Claim Fund	0	115	125	135	
9. Subtotal [(8a) + (8b)]	\$0	\$117	\$127	\$138	
10. Total [(7) + (9)] (20% of \$2,699)	\$540	\$540	\$540	\$540	
11. Out-of-pocket medical expenses	\$342	\$851	\$772	\$672	
12. MSA Contribution [(3b) + (8b)]	0	\$574	\$623	\$676	
13. Net employee cost [(10) + (11) - (12)]	\$882	\$817	\$689	\$536	
14. Employee Savings (\$) \$882 - (13)]	N/A	\$65	\$193	\$346	
15. Employee Savings (%) [(14) / \$882]	N/A	7%	22%	39%	

Source: American Academy of Actuaries

*Assumes that the employer will predict the savings from copayment change and pay that amount to an MSA. Total employer costs (line 5) are held constant.

*The total of premium share plus out-of-pocket medical expenses less the MSA contribution. Line 13 is net annual employee cost. Lines 14 and 15 show reduction in net employee cost.

Table IV-2
Employee Savings—Family Plan

Deductible/ Maximum Out-Of-Pocket	\$200/\$1,000		\$3,000/\$4,000		
	Proportion of MSA Considered as Savings	Not Applicable	10% Low Effect	50% Medium Effect	90% High Effect
Employer Costs*					
1. Premium					
1a. For Administrative Expense	\$685	\$529	\$519	\$509	
1b. For Claims	\$4,569	\$3,525	\$3,460	\$3,392	
2. Subtotal [(1a) + (1b)]	\$5,254	\$4,054	\$3,979	\$3,901	
3. MSA Contribution					
3a. For Administrative Expense	0	24	25	27	
3b. For MSA Claim Fund	0	1,176	1,250	1,326	
4. Subtotal [(3a) + (3b)]	\$0	\$1,200	\$1,275	\$1,353	
5. Total [(2) + (4)] (80% of \$7,869)	\$5,254	\$5,254	\$5,254	\$5,254	
Employee Costs*					
6. Premium					
6a. For Administrative Expense	171	132	130	127	
6b. For Claims	1,142	882	865	848	
7. Subtotal [(6a) + (6b)]	\$1,313	\$1,014	\$995	\$975	
8. MSA Contribution					
8a. For Administrative Expense	0	6	6	7	
8b. For MSA Claim Fund	0	293	312	331	
9. Subtotal [(8a) + (8b)]	\$0	\$299	\$318	\$338	
10. Total [(7) + (9)] (20% of \$7,869)	\$1,313	\$1,313	\$1,313	\$1,313	
11. Out-of-pocket medical expenses	\$973	\$2,173	\$2,004	\$1,798	
12. MSA Contribution [(3b) + (8b)]	N/A	\$1,469	\$1,562	\$1,657	
13. Net employee cost [(10) + (11) - (12)]	\$2,286	\$2,017	\$1,755	\$1,454	
14. Employee Savings (\$) [\$2,644 - (13)]	N/A	\$269	\$531	\$832	
15. Employee Savings (%) [(14) / \$2,286]	N/A	12%	23%	36%	

Source: American Academy of Actuaries

*Assumes that the employer will predict the savings from copayment change and pay that amount to an MSA. Total employer costs (line 5) are held constant.

*The total of premium share plus out-of-pocket medical expenses less the MSA contribution. Line 13 is net annual employee cost. Lines 14 and 15 show reduction in net employee cost.

06571-002

April 1996

**TAX-PREFERRED MEDICAL
SAVINGS ACCOUNTS AND
CATASTROPHIC HEALTH INSURANCE
PLANS: A NUMERICAL ANALYSIS
OF WINNERS AND LOSERS**

**Len M. Nichols
Marilyn Moon
Susan Wall**

**The Urban Institute
2100 M Street, NW
Washington, DC 20037**

The authors are grateful to the Robert Wood Johnson Foundation for financial support of this research, to John Holahan, Steve Zuckerman, and Edwin Husted for helpful comments on earlier drafts, and to Michael Ting for programming and computational assistance. The opinions expressed herein are those of the authors alone and are not those of the Urban Institute or its trustees.

spendable value of left-over MSA balances, were taken into account.¹⁸ We calculated the financial effects on winners and losers for one year and over three years. We also investigated whether the socio-demographic characteristics of winners were different from those of losers.

Table 1 reports the premium and MSA contribution estimates used in our simulations.

Table 1. Premium and MSA Estimates

Health Insurance Plan type	Actuarial Premium	Employer Insurance Contribution	Employee Insurance Contribution	MSA contribution by employer
Comprehensive	\$1,701	\$1,361	\$340	n/a
Catastrophic	\$1,110	\$1,110	0	\$251

Source: Urban Institute analysis of NMES data, 1994 dollars.

We estimated the comprehensive single premium at \$1,701 and the catastrophic premium at \$1,110. We assumed that the employer would pay, on average, 80 percent of the premium in the comprehensive case and would be willing to spend the same amount on each worker in the MSA/catastrophic arrangement. Thus, the employer would spend \$1,361 regardless: either as 80 percent of the comprehensive premium or as 100 percent of the catastrophic premium plus a deposit of the remainder, \$251, into the worker's MSA. This means that shifting to the MSA/catastrophic arrangement immediately returns \$340 to the worker in saved out-of-pocket

*Note: Assumes catastrophic plan is \$2000 / \$2,000
Assumes comprehensive plan is \$250 / \$1,250*

¹⁸We could not measure the implicit value of financial protection in either the comprehensive or MSA/catastrophic arrangement, for while real, this amount is subjective. Because we could not take this value into account, we have somewhat overstated the number of winners -- for some the financial gains from switching to the MSA/catastrophic plan will be smaller than the value they place on greater financial protection. In real life, these workers might not switch from the hypothetical comprehensive arrangement to the postulated MSA/catastrophic plan, even though from a sheer financial point of view they could "win" by doing so.

**PREMIUM INCREASES IN CONVENTIONAL PLANS AS THE RESULT OF
FAVORABLE SELECTION TO MSAs AND ADVERSE SELECTION FROM
CONVENTIONAL PLANS**

American Academy of Actuaries estimates that the conventional plan premium will increase from \$2,699 to \$4,343, an increase of 61%.

Urban Institute estimates that even low incidence of adverse selection will increase conventional plan premiums from \$1,701 to \$2,766, an increase of 63%.

PRACTICAL CONSIDERATIONS

This discussion shows how a plan that wasn't designed with sufficient forethought could end up losing much of the savings attributable to the induction effect of a high-deductible plan. This is the dampening effect we referred to earlier. While it is possible that a sponsor of a tightly controlled plan can introduce design constraints that preserve much of the induction savings, it might be much harder to accomplish that goal in a loosely-regulated national plan. Absent restrictions, employees would be free to select from plans with a range of copayments and co-ordination features. Employers and insurers could (and many would) design their plans so as to take advantage of the selection process. Restrictions could narrow the freedom of employers, insurers, and employees to select against the program, but such restrictions would narrow the range of choices individuals could make. Also, enforcement of increased restrictions would add to the administrative expense of the program.

In the least regulated system, Congress would simply enact the tax framework necessary for MSAs, and permit employers, states, and individuals to change their health insurance within that framework. Employers and insurers could replace the current plans with high-deductible plans—but that would not be a requirement. Employers would also be free to maintain their current level of expenditures for health care or reduce, or increase, those payments.

Individuals would be free to select from among the range of insurance products available. For example, when a choice was available, the healthier individuals would tend to select the high-deductible, low-cost plan, while the less healthy would

tend to choose a low-copayment plan. In many families, one member would select a low-copayment plan, while another family member who works for another employer would select a high-deductible plan, or choose not to be covered. Or, if available, all family members would select high-deductible plans from their respective employers and rely on the coordination-of-benefits provisions to pay most or all of covered charges.

As a consequence, the high-copayment plans would cover the healthiest individuals, and the lower-copayment plans would cover the less healthy individuals. That selection process would, in turn, result in increases in premiums for the low-copayment plans and decreases in premiums for the high-deductible plans.

EFFECTS OF SELECTION

Table II-5 shows the potential premium levels that would result from the selection process if individuals were free to select either the current or the high-deductible plan. The calculation assumes that three-fourths of the individuals with no significant health care expenses would select the high-deductible plan. It was also assumed that half the individuals with the highest health care expenses would select the high-deductible plan and that half would select the current plan. For individuals other than those with insignificant health care costs and those with high health care costs, the percentage selecting the high-deductible plan was graded between 75% and 50%. The selection would be greater for the higher deductible plans and lower for the relatively low deductible plans. Table II-5 only shows the same selection at each point.

Table II-5
Effect of Selection

Deductible/ Maximum Out-of-Pocket in High-Deductible Plan	Premium Before Selection		Premium After Selection	
	\$200 Deductible Plan	High Deductible Plan	\$200 Deductible Plan	High Deductible Plan
\$1,000/\$2,000	\$ 2,699	\$ 2,176	\$ 4,343	\$ 1,585
\$1,500/\$2,500	\$ 2,699	\$ 1,996	\$ 4,343	\$ 1,430
\$2,000/\$3,000	\$ 2,699	\$ 1,871	\$ 4,343	\$ 1,330
\$3,000/\$4,000	\$ 2,699	\$ 1,666	\$ 4,343	\$ 1,171
\$4,000/\$5,000	\$ 2,699	\$ 1,501	\$ 4,343	\$ 1,048
\$5,000/\$6,000	\$ 2,699	\$ 1,369	\$ 4,343	\$ 950

Source: American Academy of Actuaries

Note: Analysis based on the change in cost of plans if both are offered to a standard population.

American Academy of
Actuaries

Table 4. Effect on Comprehensive Premium of Employer Offering an MSA Alternative

Percent Choosing MSA	Comprehensive Premium	Employee contribution toward comprehensive premium if the employer contributes the same amount to all workers	Employee contribution toward comprehensive premium if the employer reduces the MSA contribution to zero and diverts these funds to shield workers in comprehensive plans
0%	\$1701	\$340	n/a
25% of winners (20% of total)	\$2766	\$1405	\$1342
50% of winners (40% of total)	\$3444	\$2083	\$1916
75% of winners (60% of total)	\$4628	\$3267	\$2891
all winners (80% of total)	\$7396	\$6035	\$5031

Source: Urban Institute analysis of NMES data, 1994 data.

MEDICARE: Preliminary Administration vs. Breaux/Chafee Comparison

Savings:

\$124 billion vs. \$154 billion

Primary difference is from additional beneficiary savings

*** (CBO has not yet scored Breaux/Chafee)**

Structural Reforms: Seems very similar (or acceptable compromises) to Administration

- Provides for variety of new plan choice options, including Preferred Provider Organization (PPOs) and Provider Sponsored Organizations (PSOs)
- No arbitrary budget failsafe mechanism
- No repeal of balance billing protections for private fee-for-service plan
- Does not allow higher premiums to be charged for basic benefits in managed care
- No full-scale MSA option; substitutes a MSA demonstration

Provider Proposals: Similar to Administration savers package. Major differences:

- Medicare 10% Disproportionate Share Hospital (DSH) cut. (We have no cut).
- Drops some of our savers from long-term care and nursing home reimbursement
- Physician cut slightly lower

Beneficiary Proposals: Most of Savings Difference (estimated about \$40 billion more)

- Consistent with Administration premium protections, including QMBs, up to 200 percent of poverty
- After 200 percent of poverty, begins a phase-out of Medicare premium subsidy. (E.G., couples above \$20,000 will pay a premium equal to 31.5 percent of Part B program costs, phasing in to 100 percent at around \$150,000 per couple.)
- Increase initial Medicare eligibility age to 67 (to conform with Social Security phase-in).

Today's vote against Medical Savings Accounts (MSAs) is a victory for the mainstream, a victory for bipartisanship, and -- most importantly -- a victory for the American public. It responds to the President's State of the Union call on the Congress to pass a long overdue package of much needed health insurance reforms. By defeating MSAs, the Senate took an important first step toward achieving this goal.

The Senate showed today that Democrats and Republicans can work together to pass health reform initiatives that reflect the priorities that the vast majority of Americans support. And that they can do so without insisting on controversial amendments that could hurt the health care delivery system and that have no broad-based support.

It is our hope that the upcoming conference will follow the Senate and report out a bill that can retain the bipartisan support that the Kassebaum-Kennedy bill currently has. We look forward to working with the conferees in the upcoming days and weeks to producing a bill that we all can proudly support.

KASSEBAUM/KENNEDY INSURANCE REFORM UPDATE--MSA DECISION TREE

Update on Hill Vis A Vis K/K Bill and MSAs

- Update on the other "M's":
 - MEWAs
 - Medical malpractice
 - Mental health parity
 - Medicare fraud and abuse (advisory opinions)
 - Miscellaneous (we have not seen ANY language on all other provisions)
- Republicans latest MSA offer
- Democrats response
- Republican Strategy/Conferee Appointments

Demonstration: What are the options for the broad structural design of demo?

- Traditional MSA study
- MSA to targeted populations, but available to any such population in the nation

Demonstration Structure: Who is initially studied and who evaluates demo?

- If a traditional demo, do we conduct a study on all possible users
- Firms that have ≤ 50 employees (including self-employed?) (See break-out of #'s)
- Firms that have >50 employees (See break-out of #'s)
- Evaluator Options: (Not Committee Chairmen) Administration under contract, AAA, NAIC, GAO etc.

MSA Structure: How is it designed to strengthen MSA tax/policy structure?

- Deductible issue
- Income limits
- Caps on savings build-up
- Risk adjuster requirements on states

MSA Expansion: How is it structured to expand (if desirable) to other populations?

- Affirmative vote yes to expand
- Affirmative vote to repeal automatic expansion
- Who and when do we phase-in? (Link to study?)

Additional MSA issues

- Linkage to Medicare MSAs

MEWA FILE

APPLICATION OF NORMAL CHURCH PLAN COMPLIANCE RULE

Amend section 202(b) by adding at the end thereof the following:

“Nothing in this section shall apply to church plans, except such plans shall comply with the reform standards established under this Act, and if such plan fails to meet any requirements imposed on such plan by this Act, the plan shall make corrections to meet such standards as provided in section 3(33)(D) of the Employee Retirement Income Security Act of 1974 as if the standards in this Act are requirements of such paragraph.”

CLARIFY EMPLOYER AND EMPLOYEE DEFINITION

Amend definition of employee and employer (sections 2(2) and 2(3)) by adding before the period in both places:

“except in the case of a church plan such term shall have the meaning given such term under section 3(33)(C) of the Employee Retirement Income Security Act of 1974.”

SPECIAL CHURCH PLAN BENEFITS RULE

Amend section 103(d) by adding at the end thereof the following:

“The Secretary shall exempt a church plan, as defined under paragraph (33) of section 3 of the Employee Retirement Income Security Act of 1974, from any provision of this Act, if the plan’s terms to prevent adverse selection conflict with such provision, or if the plan certifies to the Secretary that compliance would cause the plan to be actuarially unsound.”

DEFINITION OF CHURCH BENEFIT PLANS AS NOT AN INSURER

Amend Section 201 by adding the following new subsection:

“(d) Special Rule for Church Plans.—Neither a church plan (within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974) nor any trust established under such plan shall be deemed to be an insurance company or other insurer, or to be engaged in the business of insurance for purposes of, or be subject to, any law of any state purporting to regulate insurance companies, insurance contracts, annuity contracts, multiple employer welfare arrangements, providers of third party administrative services, or other similar arrangements, providers or organizations. A church plan shall be deemed to be a single-employer plan for purposes of this section and for the purposes of ERISA.”



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Associate Administrator
for Policy
Washington, D.C. 20201

MAR 23 1995

Theresa Alberghini
Chair
Vermont Health Care Authority
89 Main Street
Drawer 20
Montpelier, VT 05620

FYE
Debbie

Diana - FYE
[Signature]

Dear Ms. Alberghini;

I wanted to respond to questions that have been raised regarding the inclusion of Medical Savings Accounts (MSA) as a component of a section 1115 statewide Medicaid demonstration. We have received your state's demonstration application, which does not currently include an MSA proposal, and have been discussing the Medicaid managed care expansion and coverage features with state staff. We would have concerns if MSAs were to be proposed for the Medicaid population under such a demonstration.

In reviewing such a request, the Health Care Financing Administration would raise the following issues, assuming the proposal is similar to MSA proposals being discussed nationally:

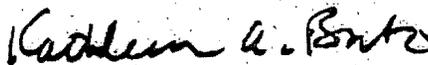
- o We are not sure how the proposal would further the goals of the Medicaid program, for both the Medicaid population and individuals newly eligible under the demonstration.
- o One important issue is the possible "cashing-out" of the Medicaid entitlement, which could change the fundamental nature of the Medicaid program away from a program that provides health services.
- o Several issues arise regarding how MSAs would work with a low income population -- would individuals have to choose catastrophic coverage only, along with an MSA; who would pay for the high cost sharing typically used under such proposals?
- o A basic principle for us is to make sure that Medicaid beneficiaries are not potentially worse off under a demonstration than they otherwise would be under the regular Medicaid program in terms of the scope of services covered and their out-of-pocket costs. An MSA proposal could lead to reduced Medicaid benefits for current eligibles.

Page 2 -- Theresa Albrghini

- o The demonstration would need to be budget neutral over a 5-year period.
- o We would carefully examine the costs for which federal matching funds were requested and how the federal dollars would be used.
- o What impact would MSAs have on adverse selection into non-MSA choices and on the per capita costs of health plans serving the remaining population?

HCFA continues to encourage state innovation in the section 1115 demonstration process. Any proposal that would include MSAs needs to be put forward by the state, along with an analysis of how it would affect elements of the current Medicaid program and addressing the issues discussed in this letter. In any event, we are moving expeditiously to consider the demonstration application Vermont has submitted.

Sincerely,



Kathleen A. Buto

cc:

Kent Stoneman, Director of Medicaid Division, Department of
Social Welfare

Veronica Celani, Health Policy Director, Agency of Human Services

Sherrie Fried, Office of Research and Demonstrations, HCFA