

Congressman Hastert Meeting Concerning MSA Design
July 16, 1996

I. What is the nature of selection and adverse risk selection for the market which would be eligible for MSAs under the pilot project?

A. Potential for selection and adverse risk selection

1. Articulate difference between selection and adverse risk selection
2. Clarify which insurance markets are most susceptible to adverse risk selection, i.e., large group market, small group and individual market
3. Elaborate on the benefits of pooling certain higher cost or lower cost subscribers
4. HMO's/Managed Care's impact on risk selection in the private insurance market

B. Potential for adverse risk selection - small employer market

1. Features of the small employer market
 - a. premium costs facing small employers
 - b. State Insurance commission oversight of policies (consumer protection)
 - c. benefits of selection in the small employer market under MSA proposal

C. Potential for adverse risk selection - individual (self-employed) market

1. Features of the individual market
 - a. group versus individual underwriting
 - b. State Insurance commission oversight of policies (consumer protection)

II. How does the structure of the MSA for the pilot project relate to selection and adverse risk selection?

A. Design - flexibility of benefits and dollar limitations

1. Impact on adverse selection potential (ability to control premiums via design)
 - a. Small employer market
 - b. Individual market
2. Key design issues
 - a. Minimum and maximum deductibles
 - b. Level of MSA contributions
 - c. Nature of out-of-pocket limitations

B. Tax treatment - level playing field (differentiate between tax treatment and design flexibility)

1. Impact on incentives (is tax-preferred treatment most important feature?)

C. Combination of Design limitations and Elimination of Tax-Favored Treatment

1. Impact on adverse selection potential
 - a. Small employer market
 - b. Individual market

Congress of the United States
JOINT COMMITTEE ON TAXATION
Washington, DC 20515-6453

BY TELECOPY

MEMORANDUM

TO: Ed Kutler (x5-5646)
Annette Guarisco (x4-4639)
Vicki Hart (x4-4639)
Chip Kahn (x6-1765)
Elizabeth Beavin (x5-0697)
David Nexon (x4-3533)
Dean Rosen (x4-6510)
Lindy Paull (x4-5920)
Doug Fisher (x4-5920)
Jon Talisman (x8-3904)
Chris Jennings (202/456-5542)

FROM: Ken Kies

DATE: July 17, 1996

I am transmitting with this memorandum, the tentative staff proposal on medical savings accounts as discussed today.

If you have any questions, please call me.

July 17, 1996 6:00 p.m.

Tentative Staff Proposal on Medical Savings Accounts

1. Limits on Contributions

Annual contributions to the MSA would be limited to 65 percent of the deductible under the high deductible plan in the case of individual coverage, and 75 percent of the deductible under the high deductible plan in the case of family coverage. For example, if a high deductible plan providing family coverage has a deductible of \$4,000, the MSA contributions would be limited to \$3,000. No other dollar caps would apply.

2. Maximum Deductibles Under High Deductible Plan

In order for an MSA to receive tax-preferred treatment, the maximum deductible under the high deductible plan could not exceed \$2,250 in the case of individual coverage and \$4,500 in the case of family coverage. Consequently, the deductible under the high deductible plan would have to be within \$1,500 to \$2,250 in the case of individual coverage, and \$3,000 to \$4,500 in the case of family coverage. As under the original MSA proposal, these amounts would be indexed for inflation, except indexing would be delayed for one year and the index would be based on the regular consumer price index ("CPI") instead of the medical cost component of CPI.

3. Dollar Limit on Total Out-of-Pocket Expenses

The maximum total out-of-pocket expenses with respect to allowed costs under the high deductible plan could not exceed \$3,000 in the case of individual coverage, and \$5,500 in the case of family coverage. Both amounts would be indexed for inflation like the deductible amounts (i.e., indexing delayed for one year and based on regular CPI). This limitation would be in lieu of the requirement that cost sharing under the high deductible plan after the deductible has been met cannot exceed 30 percent. The maximum total out-of-pocket expenses limitation would include the deductible under the high deductible plan and is designed to give insurers flexibility in designing their high deductible plans. For example, if the deductible under a high deductible plan providing individual coverage is \$2,250, the maximum total co-payments or coinsurance under the plan after

the deductible is satisfied could not exceed \$750. Alternatively, if the deductible under the same plan is \$1,500, the maximum total co-payments or coinsurance after the deductible is satisfied could not exceed \$1,500.

4. **Employer and Employee Contributions Allowed**

Both the employer and the employee would be permitted to make MSA contributions. As with previous MSA proposals, employee contributions would be permitted only if there is no employer contribution to an MSA on behalf of the employee.

5. **Post-65 Distributions**

No penalty tax would apply to distributions from an MSA after age 65 which are not used for medical expenses. Such distributions not used for medical expenses would continue to be subject to regular income tax.

6. **Comparability Rule for Employer Contributions**

To the extent an employer provides high deductible health plan coverage coupled with an MSA to employees and makes employer contributions to the MSAs, the employer would have to make the same contribution on behalf of all employees with comparable coverage. For example, if the employer contributes \$500 to an MSA for one employee with individual coverage under the high deductible plan, the same \$500 contribution would have to be made to an MSA on behalf of all employees with individual coverage under such high deductible plan. If the same employer contributes \$1,000 to one employee with family coverage under the high deductible plan, the same \$1,000 contribution would have to be made to an MSA on behalf of all employees with family coverage under such high deductible plan. As under present law, an employer would not be required to cover all employees under the high deductible plan. Further, if an employer provides high deductible health plan coverage to employees but makes no contributions to MSAs, an employee so covered on his or her own would be permitted to make a deductible contribution to an MSA without regard to whether other employees make such contributions.

No requirements would be imposed with respect to self-employed persons.

DRAFT

July 17, 1996 6:00 p.m.

Tentative Staff Proposal on Medical Savings Accounts

1. Limits on Contributions

Annual contributions to the MSA would be limited to 65 percent of the deductible under the high deductible plan in the case of individual coverage, and 75 percent of the deductible under the high deductible plan in the case of family coverage. No other dollar caps would apply.

2. Maximum Deductibles Under High Deductible Plan and Dollar Limit on Total Out-of-Pocket Expenses

In order for an MSA to receive tax-preferred treatment, the maximum deductible under the high deductible plan could not exceed \$2,250 in the case of individual coverage and the out-of-pocket expenses with respect to allowed costs could not exceed \$3,000 for such claims. In the case of family coverage, the maximum deductible could not exceed \$4,500 and the out-of-pocket expenses with respect to allowed costs could not exceed \$5,500. As under the original MSA proposal, the maximum deductible and out-of-pocket limits would be indexed for inflation, except indexing would be delayed for one year and the index would be based on the regular consumer price index ("CPI") instead of the medical cost component of CPI.

3. Employer and Employee Contributions Allowed

Both the employer and the employee would be permitted to make MSA contributions. As with previous MSA proposals, employee contributions would be permitted only if there is no employer contribution to an MSA on behalf of the employee.

4. Post-65 Distributions

No penalty tax would apply to distributions from an MSA after age 65 which are not used for medical expenses. Such distributions not used for medical expenses would continue to be subject to regular income tax.

5. Comparability Rule for Employer Contributions

To the extent an employer provides high deductible health plan coverage coupled with an MSA to employees and makes employer contributions to the MSAs, the employer would have to make the same contribution on behalf of all employees with comparable coverage. For example, if the employer contributes \$500 to an MSA for one employee with individual coverage under the high deductible plan, the same \$500 contribution would have to be made to an MSA on behalf of all employees with individual coverage under such high deductible plan. If the same employer contributes \$1,000 to one employee with family coverage under the high deductible plan, the same \$1,000 contribution would have to be made to an MSA on behalf of all employees with family coverage under such high deductible plan. As under present law, an employer would not be required to cover all employees under the high deductible plan. Further, if an employer provides high deductible health plan coverage to employees but makes no contributions to MSAs, an employee so covered on his or her own would be permitted to make a deductible contribution to an MSA without regard to whether other employees make such contributions. No special requirements would be imposed with respect to self-employed persons who own a company.

NANCY LONDON KASSEBAUM, KANSAS, CHAIRMAN

JAMES M. JEFFORDS, VERMONT
DAN COATS, INDIANA
JUDD GREGG, NEW HAMPSHIRE
BILL FRIST, TENNESSEE
MIKE DOWNE, OHIO
JOHN ASHCROFT, MISSOURI
SPENCER ABRAHAM, MICHIGAN
SLADE GORTON, WASHINGTON

EDWARD M. KENNEDY, MASSACHUSETTS
CLAIBORNE PELL, RHODE ISLAND
CHRISTOPHER J. DODD, CONNECTICUT
PAUL SIMON, ILLINOIS
TOM HARKIN, IOWA
BARBARA A. MIKULSKI, MARYLAND
PAUL WELLS, MINNESOTA

SUSAN K. MATTAN, STAFF DIRECTOR
NICK LITTLEFIELD, MINORITY STAFF DIRECTOR AND CHIEF COUNSEL

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

TO: CHRIS JENNINGS

FR: Brian P. Moran

DATE & TIME: _____

NUMBER OF PAGES: _____ COVER + 4 Agair

RETURN FAX NUMBER: (202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL
(202) 224-7675.

MESSAGE: *Chris, I think this is the best proposal. I will speak to David and Carmen when they get in and let you know if this is or isn't the right proposal.*

FAX NUMBER: 456-5542 Brian

POSSIBLE MSA COMPROMISE

| | |
|---|--|
| Extent of Pilot | 4 years Companies of 50 employees or fewer and self-employed |
| Number of Participants | No limit on number of uninsured Limit of 750,000 500,000 for those now insured |
| Continuation after Test | An affirmative vote to expand No vote to continue existing pilot for individuals enrolled during test period |
| Structure of MSA and high-deductible plan | To be determined, consistent with attached guidelines by the American Academy of Actuaries Medical Savings Account Work Group, RAND, or similar body appointed by the Majority and Minority Leadership of the House and Senate |
| Study | Study and report by impartial body named by Majority and Minority Leadership completed by January 1, 2000 |

July 9, 9:20 am

July 10

The American Academy of Actuaries or RAND shall determine the structure of the high deductible plan and MSA to:

--Provide adequate financial protection and meaningful health coverage for people choosing high deductible plans/MSAs who experience serious illnesses

--Avoid tax windfalls unrelated to medical needs, minimize disproportionate tax benefits for upper income individuals relative to other individuals, and provide equitable tax treatment between MSAs and conventional health insurance plans

--Minimize adverse selection and potential premium increases for firms and individuals maintaining conventional coverage

--Avoid incentives to reduce coverage for lower paid workers to benefit more highly compensated employees or owners

--Maximize disclosure of information to consumers that will promote an informed choice between high deductible/MSA plans and other types of coverage

--Limit, in consultation with the Treasury Department and Joint Tax Committee, per capita tax expenditures to the level assumed in revenue estimates

EXPANATION OF DEMOCRATIC POSITION ON REPUBLICAN PROPOSAL

1. **Extent of pilot.** We have accepted Republican proposal for a broad-based pilot project. The target market for the "test" is the market (small business and self-employed) which is the major potential market for medical savings accounts. According to Joint Tax estimates, three quarters of high deductible/MSA policies would be sold in this market if no restrictions were included in the law.

2. **Number of participants.** Allowing 500,000 policies to be sold in the pilot, with no limit on total participation (because those without current insurance coverage are not subject to the cap) is a major Democratic concession in view of our willingness to drop insistence on a sunset. This level is far in excess of that needed for a genuine test. Establishing a limit of 750,000 plus unlimited coverage for the uninsured would establish a cap that actually exceeds Joint Tax projections (750,000 for all participants). Because the limit is on policies rather than participants, the actual number of people covered would be approximately 750,000 under our proposal.

3. **Continuation after test.** This is a major concession for Democrats, since it effectively means we have dropped our insistence on a sunset. It responds to Republican concerns that people will be deterred from enrolling during the test period because they would be unable to continue if Congress fails to extend the program. It is critical for Democrats that new people not be allowed to enroll after test period ends, unless Congress votes to broaden the program.

4. **Structure of MSA and high deductible plan.** We have accepted the Republican proposal, with modification that the impartial body establishing the structure of MSAs and high deductible plans be given guidance. Proposed guidance would allow body to structure MSAs and deductible plans in any way it thinks best but should address major concerns about program: adequate financial protection for participants, tax equity, adverse selection, and cost to Treasury. We have specified that the body designing the MSA/high deductible would be selected by the Majority and Minority Leadership of the House and Senate, to assure impartiality.

5. **Study.** We have added a requirement for a study and report by an

outside body, selected by the Majority and Minority Leadership, so that the impact of MSAs can be evaluated at the end of the test period.

ADDITIONAL

o Since we have included a compromise proposal on MSAs, we should also include a compromise proposal on mental health equity--Domenici proposal to require that any mental health benefits provided by a plan be included within any lifetime and annual limits established by plans for other services rather than under a separate, lower cap.

o Any agreement on the bill has to include compromises on other parts of the bill where Democrats and Republicans differ. **We need to be given the current draft of the bill immediately for review.**

EXECUTIVE OFFICE OF THE PRESIDENT

11-Jul-1996 08:32am

TO: (See Below)

FROM: Christopher C. Jennings
Domestic Policy Council

SUBJECT: Kassebaum-Kennedy update

We are quietly making progress on reaching closure on an acceptable MSA compromise. If and when we reach consensus on this issue, the pressure will be overwhelming to finalize agreement on all other aspects of the Kassebaum-Kennedy bill.

The MSA compromise discussions/negotiations are being handled almost exclusively by Senators' Daschle, Kennedy, and -- of late -- Senator Breaux. They are talking directly with Senator Lott. We are in the loop, but certainly a step removed -- which, for now, is probably the best thing from our perspective.

The Republicans -- other than Lott -- are getting frustrated that the Dems are not moving as much as they perceive the Republicans are compromising to us; as such, they are writing and calling us to get more actively and visibly involved -- in other words, to jam our Dems a bit. Today, Lott held a press conference to go after Kennedy and criticize him for continuing to object to the appointment of conferees.

Having said the above, it is clear that Lott and Gingrich want a deal and are willing to try to push their right wing members to get something if they can obtain an MSA deal that allows them to save face. Clearly any deal we accept will be a time-limited, constrained (i.e. population capped) demo that cannot be expanded unless Congress votes affirmatively (under regular order procedures) and the President signs a bill to do so. In return for issues we have won, we will probably accept the notion that those who sign up for MSAs during the study period will not have to give them up at the conclusion of the study. (The argument goes that no one or few people will sign up for MSAs during the study if they think they will eventually be required to give them up; Kennedy and Daschle are ok with this as long as they are satisfied with other provisions of the compromise).

We are working with Nancy Ann, Treasury and HHS to assure that our MSA population cap is workable. This is a critical element of our compromise that must pass the credibility test. Nancy Ann and I think it will and we should have an English language version of

our mechanism done in a couple of days.

The other issues around the design/structure of the MSA and the consumer protections for the study period are still unresolved, but both sides are moderating their rhetoric and their demands. (These are issues like where to set the maximum deductible and out-of-pocket cost limits, how much to limit contributions to the MSA account, whether or not employees as well as employers can contribute to the accounts.)

In addition to the MSA issue, we are still supporting the Domenici mental health parity compromise. (This drops all the parity requirements, like copayment, deductible, benefit structure parity requirement, and only retains a parity requirement for lifetime and annual caps.) The Republican Leadership seem determined to not include this at this point; they don't disagree that the provision is now but a shell of its former self, but they hate the "camel's nose under the tent" issue. At this point, virtually all the Dems are supportive and Domenici and Simpson are trying to soften up the Republican leadership. [On both the MSA and the mental health provision, we are trying to stay low, have the Hill attempt to hammer these provisions out, and keep the extent of our knowledge of the discussions to be unknown.]

It is important not to forget that there is a whole bill that these two issues are attached to. Besides insurance reform (the portability and the elimination of pre-existing exclusion provisions, etc.), there is the increase in the self-employed tax deduction to 80%, the long-term care tax clarifications with consumer protections, and a Medicare fraud and abuse provision that Donna (with one exception) loves. These are all extremely popular provisions that we need to take credit for if and when we get a bill.

Having said this, we still have not seen the Republican compromise language on all of the above-mentioned provisions. While we do not believe we will have major problems with their drafting, there are at least three issues that we are nervous about:

1. Insurance Reform. Is their new language acceptable, particularly as it relates to the individual market protections? (We have a concern that people going from the group to individual market may find the Republican compromise relegating them to policies that are provide only for this population -- which would likely lead to accessible, but absolutely unaffordable policies.
2. Advisory Opinions/Fraud and Abuse. The Republican compromise retains the House Advisory Opinion provision, which the Justice Dept and HHS feel strongly will undermine their ability to enforce criminal activities related to health care fraud and abuse. CBO has actually scored it as a \$390 million coster over 6 years. (This provision would direct HHS and Justice to give providers advisory opinions regarding whether their actions constituted fraud or not; the Departments fear that these could well be

missused as tools for defense against a subsequent fraud charge being leveled at a particular provider.) We will be working hard to delete this provision -- apparently the Republicans on the Senate may be sympathetic to our position.

3. Medigap Duplication Issues. So far, the Republicans have not provided sufficient disclosure protections to consumers (in the eyes of the Administration and Mr. Dingell.) These are, as you may recall, the policies that duplicate what Medicare covers and pay the beneficiary a set amount over and above Medicare payment rates. Most analysts think they are of questionable value (at best), but our position is that we simply want to make certain beneficiaries fully understand that they are buying a policy that duplicates Medicare. (I think we can make some progress here, too, with the Senate Finance Committee and the House Commerce Committee -- when this bill finally goes to conference.)

If we get a deal on MSAs, we (Jen, myself, Nancy Ann, HHS, Treasury, Labor and the Justice Department) will be asked to quickly review the statutory language for any additional major problems. (Any publicly stated problems will have to pass an extremely high threshold of importance.) This review will likely coincide with a pro forma conference and a quick attempt to get the bill to the floor and to the President for signature. If we get that far down the road, we should talk about the signing ceremony's timing, design, message and participation. My sense is that people will want to make it a very big deal and that the number of people who want to participate will dwarf how many people probably can.

We will continue to keep you informed as more information becomes available. Sorry this is so long...

cj

Distribution:

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

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

July 11, 1996

To: Nancy-Ann Min
From: Larry Levitt
Re: A few quick thoughts on the MSA language

I have passed the language on to Gary and Len. Here are a few thoughts based on a quick reading:

- The limit on MSA contributions is the lower of \$800 (single)/\$1,600 (family) or one-half of the deductible. The one-half of the deductible part seems overly stringent. I might consider the full deductible (since you've got the dollar limits in there anyway).
- On page 12, it appears to say that there is no 15% tax penalty on withdrawals after age 65. If I understand this correctly, you can withdraw balances after age 65 and it is just treated like regular income. This seems quite generous.
- The minimum deductible for qualified plans (page 13) is \$1,000 for an individual and \$2,000 for a family. This is quite low. Is this what you want? It might minimize adverse selection because a lot of people would join MSAs (depending, of course, on the demonstration limits), including sicker people. However, it might not be so desirable for lots of people to join MSAs.
- For small employers, it is the insurance company that must apply for a registration number for an MSA (page 24 in definition of account sponsor). It seems to me that it should be the entity that issues and acts as the trustee for the MSA.
- I may be reading the language wrong, but it seems like employees have to pay taxes on MSA contributions if no registration number is obtained. This could be perceived as unfair. (There is some language on the bottom of page 30 that might exempt employees, but I don't think so.)

I will read it over some more and talk to Gary as well. Please call if I can help more (415-289-3312).

Take care.

POSSIBLE MSA COMPROMISE

July 10, 1996

A. Structure

1. Cap on Enrollment During Initial Period

The Secretary of Treasury will annually monitor the number of MSA accounts and determine the number of individuals using MSAs. (This requirement is already included in the latest Republican offer.)

** If the number of MSAs exceed Joint Tax (or Treasury) projections during this period, then only employers who are currently offering high-deductible policies in connection with MSAs could continue to offer them.

-- Staff from the Joint Committee on Taxation and Treasury Department would design details as to how enrollment would be monitored and capped.

2. No Sunset at end of 4-year period

At the end of the 4-year period, small employers (50 employees and less) could continue to offer MSA policies to their employees and could continue to contribute to these MSAs. At this time, Congress could vote to lift the cap on enrollment and/or make MSAs available to large employers and/or individuals.

If cap has been reached, no need employers cover offer.

B. Consumer Protections

1. Compromise On Maximum Deductibles

| | | |
|-------------|----|---|
| Individuals | - | \$1,500 - \$4,000 (Last GOP Offer) |
| | | \$1,500 - \$2,000 (Kennedy/Daschle Offer) |
| | ** | \$1,500 - \$3,000 (Compromise) |
| Family | - | \$3,000 - \$6,500 (Last GOP Offer) |
| | | \$3,000 - \$4,000 (Kennedy/Daschle Offer) |
| | ** | \$2,000 - \$5,000 (Compromise) |

2. **Compromise On Out-of-Pocket Limits.**

The latest Daschle/Kennedy offer: proposed that no cost-sharing be permitted for out-of-pocket expenses for covered services in excess of \$2,500 for individuals and \$5,000 for families

**** Compromise:** Cost-sharing for covered services could not exceed \$1,000 after the deductible has been met for either individual or family coverage.

Example: An individual with a \$2,000 deductible, would face maximum out-of-pocket costs of \$3,000. A family with a \$4,000 deductible would face maximum out-of-pocket costs of \$5,000.

3. **Lower Cap On Annual MSA Contribution**

Republicans have offered to reduce the maximum annual amount that can be contributed to MSAs by \$300-- from \$2,000 to \$1,700 for individuals, and from \$4,000 to \$3,700 for families.

**** Democrats still propose to further restrict annual contributions.** They initially proposed a formula which would have limited contributions to about \$800, but now indicate some flexibility as to what that amount should be.

4. **No Additional Consumer Protections**

Democrats have agreed to drop all other consumer protection requirements contained in earlier offers, including: (1) nondiscrimination requirements; (2) tax penalties for non-medical withdrawals after age 65; (3) requirement that only employers can contribute to MSAs; and (4) additional limits on contributions to MSAs by self-employed.

July 10, 1996

**MSA DEMONSTRATION: RESEARCH SUGGESTS CONTROLS NEEDED
TO PREVENT ADVERSE EFFECT ON INSURANCE MARKET**

by Iris J. Lav

Overview

July 15 1996

Health insurance reform legislation is stalled largely because of controversy over whether tax-advantaged Medical Savings Accounts should be permitted.¹ A potential compromise would allow a "demonstration" to test and evaluate the effects of MSAs before Congress considers whether to make them permanent. Senator Kassebaum and other Senate Republicans have proposed a broad demonstration that would allow MSAs to be used during the demonstration period by employees of smaller businesses (those with up to 50 employees) and by self-employed persons. ?

There continues to be considerable disagreement about whether it is possible to conduct a safe and effective demonstration project — one that will provide information about the effect of MSAs on workers, employers, and insurers while not creating widespread irreparable harm to any of those participants or to the insurance market as a whole. Although many issues remain outstanding, two types of issues affecting the design of the demonstration are particularly thorny:

- The extent to which the demonstration design should include relatively stringent limits on deductible amounts, coinsurance requirements, and total out-of-pocket expenses for the high-deductible insurance plans used in conjunction with MSAs; and
- The size and scope of the population permitted to use MSAs during the demonstration period.²

¹ Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in the MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the insurance policy. MSAs are included in H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, that the House passed on March 28, 1996. Medical Savings Accounts were not included in the Senate version of the legislation that passed on April 23.

² This paper focuses on design issues that would directly affect the insurance market. A number of other design issues remain outstanding. For example, as the legislation stands, the tax treatment of MSA funds (continued...)

The issues of demonstration design are important because there is a strong potential for widespread use of MSAs to result in a division of the health insurance market — known as “adverse selection” — that could drive up the cost and curtail the availability of conventional insurance. Adverse selection would occur if young, healthy people with low medical costs were to become concentrated in one type of insurance plan, in this case the MSA plans. MSAs would be attractive to such people because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. People with low health care costs could accumulate tax-free investment earnings on those funds and eventually use them as retirement savings or (in some circumstances) for other purposes.

Because the younger, healthier people choosing MSA plans would no longer participate in conventional insurance, conventional, low-deductible insurance would be left covering those who are less healthy and have higher medical costs. As a result, the cost of conventional insurance would increase; the premiums for it would reflect the higher average medical expenses of the pool of people remaining in conventional insurance. According to the American Academy of Actuaries, a disproportionate share of these people would be older employees and pregnant women.

Recent research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much as four-fold, depending on the degree of adverse selection MSAs trigger in the insurance market. At those increased premiums, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and that this decline in the market for conventional insurance would lead some insurers to cease selling it. If this degree of adverse selection in the insurance market were to occur on a broad scale during a demonstration period, the disruptions to the insurance market might not be readily reversible if Congress subsequently decided not to continue the MSA experiment.

The available research suggests that the probability and degree of adverse selection would be related to the two critical issues of demonstration design identified above: the types of high-deductible insurance plans permitted to be used with MSAs and the number of people permitted to participate in the experiment.

- The degree of adverse selection and cost increases for conventional insurance appears to be related to the difference in the risk of out-of-pocket costs consumers would bear under an MSA plan as compared with the risk of such costs under conventional insurance. Healthier workers

² (...continued)

used for non-medical purposes is too lenient to prevent use of MSA accounts as tax sheltered means of accumulating savings for a variety of purposes.

would be more likely than less healthy workers to accept an insurance policy under which they might have to pay a few thousand dollars of health care costs from their own funds if they became very sick, because healthy workers would judge that the probability of their actually having to incur such costs is low. But among less healthy workers, the greater the probability that their out-of-pocket costs under an MSA could significantly exceed such costs under conventional insurance, the more likely they would be to stick with conventional insurance. The research finds that the difference in potential out-of-pocket costs under the two types of insurance does not have to be exceptionally large to trigger this type of division of the health insurance market by health status. When workers covered by high-deductible insurance/MSA plans risk incurring annual out-of-pocket costs that are just \$1,000 more than the potential out-of-pocket costs under conventional plans, the research finds substantial adverse selection.

- Both the House MSA legislation and the Kassebaum compromise could trigger extreme adverse selection. The Kassebaum proposal allows insurance deductibles to be as high as \$5,000 for individuals and \$7,500 for families, while the House bill puts no limits on deductibles. In addition, while conventional insurance typically limits the out-of-pocket costs an individual must pay to \$1,000 or \$2,000 over the course of a year, consumers could be liable for *unlimited* out-of-pocket costs under either the House bill or the Kassebaum compromise. Given the research findings that differences of this magnitude trigger adverse selection, it is critical that the demonstration design put strict limits on both the deductible amounts and the total out-of-pocket costs consumers can incur under the high-deductible insurance policies used with MSAs.
- The effect of adverse selection on the insurance market also depends on the proportion of all insured people who would choose to enroll in the plan that is the most financially advantageous to them, given their expected health status. Since in any given year most people are healthy and few are sick, up to 80 percent of all people could benefit financially in the short run by choosing an MSA plan. While the Kassebaum compromise makes as many as 40 million workers eligible to use MSAs — that is the number of individuals who are self employed or work in a business employing fewer than 50 people — the potential for adverse selection argues for keeping the scope of the experiment far smaller than that until the effects of MSAs on health insurance markets and people who rely on health insurance coverage can be carefully evaluated.

The research cited above on adverse selection, which includes work by RAND, the Urban Institute, and the American Academy of Actuaries, was conducted through computer simulations of the health insurance market. Some MSA proponents believe that intermediating factors, such as the extent to which choices concerning which types of health insurance are purchased are made by employers rather than individuals, will prevent the degree of adverse selection found in the research from occurring in the real world. That may or may not turn out to be correct. But allowing a large-scale test without adequate safeguards and limits on the high-deductible insurance plans used with MSAs is comparable to playing Russian roulette with the health insurance market. Without appropriate limits, substantial and perhaps irreversible harm to insurance markets and to less-healthy segments of the population could result from the process of "demonstrating" and "evaluating" the MSA approach.

* * * * *

Potential Damage to Insurance Market Relates to Design Issues

Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of triggering this type of effect.

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for a wide variety of other purposes.³ On the other hand, older and less healthy people who judge they are likely to incur health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers covered by conventional insurance could incur far higher average health care costs than the larger pool of workers who now are covered by such insurance. To accommodate

³ Under the legislation, a 10 percent penalty applies to withdrawals prior to age 59 ½ for purposes other than medical expenses. Those negotiating a demonstration project reportedly have considered a 15 percent penalty for non-medical withdrawals prior to age 65. Even with the high penalty, however, some taxpayers could gain financially by saving for non-medical purposes through an MSA (which exempts employer deposits from income and FICA taxes and allows interest to compound free of tax) rather than through an investment taxed under normal provisions of current law.

those higher average health care costs, the premiums charged for conventional fee-for-service insurance policies would have to increase dramatically. (See appendix for illustration of how such a division of the insurance market could affect premiums.)

If such a division of the insurance market and the resulting increase in the cost of conventional insurance — the process known as “adverse selection” — were to take place on a widespread basis during an MSA demonstration period, it could become difficult to reverse those conditions at a later date. Experts point out that many employers would not be willing to pay the sharply higher premiums for conventional insurance that adverse selection is likely to trigger. Some employers would no longer offer conventional insurance to employees, and some insurance companies probably would cease selling such insurance. If Congress subsequently decided, based on the results of the demonstration project, that allowing tax-advantaged MSAs is not sound public policy and discontinued them, it is unclear whether or how the market would recover. Participants in the demonstration might no longer have the option to buy conventional insurance coverage at an affordable price.

Goals of Reform Could Be Undermined

Adverse selection — and the resulting increase in premiums and limits on availability of conventional insurance — could substantially undermine the goals of the health insurance reforms contained in the proposed legislation. One purpose of the legislation is to help workers with “preexisting conditions,” which often result in exclusion from coverage when a worker begins a job, changes jobs, or loses coverage under a spouse’s policy. The legislation effectively curtails such exclusions for group insurance policies. But if a worker with a chronic health problem gains only the right to be covered by a high-deductible policy with an MSA — because that is the only option his or her employer offers — the worker may have to expend thousands of dollars out-of-pocket before insurance begins to pay a portion of health care costs. That situation would not fulfill the broader intent of this legislation. But if employers cannot afford to cover their employees with comprehensive insurance because adverse selection has driven up its cost, a high-deductible plan with an MSA may become the only available choice.

The two issues identified above — the risk of out-of-pocket expenses to which MSA users are exposed and the number of people who could use MSAs during the demonstration period — are important determinants of whether a division of insurance coverage between more healthy and less healthy workers would take place and whether such a division would be widespread enough to increase substantially the price and decrease the availability of conventional health insurance.

Research Indicates That Adverse Selection Occurs at Relatively Low Deductible Levels and Out-of-pocket Caps

The levels of deductibles, coinsurance, and risk of out-of-pocket expenses allowed under the MSA legislation pose a high probability of triggering adverse selection in the insurance market, according to research that has simulated the effects of

MSAs. Adverse effects on the market for conventional fee-for-service insurance policies have been found in three separate studies by non-partisan organizations: RAND (which has been widely misinterpreted as reaching the opposite conclusion), the Urban Institute, and the American Academy of Actuaries.⁴

Each of these studies analyzed an insurance market initially offering both high-deductible plans in conjunction with MSAs and conventional low-deductible fee-for-service insurance. In these studies, each consumer was allowed to choose — within certain limits, depending on the study — the plan providing the best financial advantage for his or her health and income status. Premium savings from purchasing high-deductible rather than conventional insurance were assumed to be deposited in the consumer's MSA account. Those deposits, however, are likely to fall short of the annual deductible amounts under those insurance plans. For example, the American Academy of Actuaries showed premium savings of \$1,033 as a result of buying a plan with a \$3,000 deductible and a \$4,000 cap on out-of-pocket expenditures rather than buying a conventional plan with a \$200 deductible and a \$1,000 cap on out-of-pocket expenditures. The risk of out-of-pocket expenditures increased by \$3,000 but \$1,033 would have been deposited in the MSA. Thus users of such MSA plans still would face a substantial risk of paying for medical costs with their own funds.

In comparing the high-deductible MSA plans to conventional insurance, the studies considered three key differences between the two types of insurance. The differences the studies examined were: 1) the deductible amount below which the consumer pays all health care costs; 2) the coinsurance or cost sharing required once the deductible amount has been expended; and 3) the maximum out-of-pocket health care expenses the consumer can incur, above which the insurance pays all expenses.⁵

One of the key findings across all of these studies is that adverse selection will occur even when the insurance policies used with MSAs have relatively low deductible amounts. The selection will occur because less healthy people would face a high probability of paying substantial amounts of medical bills before their insurance coverage begins; most would try to avoid that situation. In the research, adverse

⁴ Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

⁵ For example, a typical conventional insurance policy might require the holder to pay the first \$200 in health care costs (the deductible) and 20 percent (the coinsurance) of costs in excess of the deductible. Most also include a maximum amount of covered medical expenses the policy holder must pay, such as \$1,500 (the cap), above which the insurance pays 100 percent of expenses. This analysis focuses on the deductible amounts and out-of-pocket caps, because those parameters are the more important determinants of the cost to the consumer.

selection was found at deductible amounts of \$1,000 in the Actuaries' study, \$2,000 in the Urban Institute study, and \$2,500 in the RAND study (all amounts apply to single individuals).⁶ By contrast, the MSA legislation that passed the House of Representatives requires a *minimum* deductible of \$1,500, and *no limits* are placed on the maximum deductible amount. The MSA demonstration proposed by Senator Kassebaum also requires the insurance used with MSAs to have a minimum deductible of \$1,500; it limits the deductible amount for single individuals to \$5,000. Thus, it is likely that many insurance plans offered with MSAs would have deductible amounts in the range for which the studies found adverse selection occurs. (See Table 1).

Furthermore, all of the studies assumed consumer protections that are unlikely to occur in the real-world market for MSA plans. The studies assumed that consumers using high-deductible insurance plans in conjunction with MSAs would be protected by caps placed on the maximum amount of out-of-pocket costs they could incur. The out-of-pocket maximums assumed in the studies all were very low relative to conditions likely to prevail in the market; the Actuaries and the Urban Institute assumed a \$2,000 cap on out-of-pocket costs for individuals while RAND assumed a \$2,500 cap. *Yet neither the House legislation nor the Kassebaum proposal requires insurers to put any cap on out-of-pocket costs a consumer could incur under the high-deductible policies.* The Kassebaum plan explicitly says that insurers can require workers to pay 30 percent of all costs above the deductible amount.

Table 1
Comparison of Circumstances of Adverse Selection Findings
to MSA Proposals

| | Deductible for Individuals | Out-of-Pocket Maximum for Individuals |
|--|---------------------------------|--|
| Studies Showing Adverse Selection | | |
| RAND | \$2,500 | \$2,500 |
| Urban Institute | \$2,000 | \$2,000 |
| Actuaries | \$1,000 | \$2,000 |
| MSA Proposals | | |
| HR 3103 | at least \$1,500, no maximum | No limit on out-of-pocket expenses |
| Kassebaum Compromise | \$1,500 to \$5,000 | No limit on out-of-pocket expenses |

⁶ The studies did not all include analysis for family plans, but it is generally accepted that there is little difference in the behavior of markets for individual plans and family plans.

Caps on out-of-pocket costs appear to be particularly important in determining whether adverse selection will occur because the cap is the ultimate determinant of the amount of medical costs a person with serious health problems would have to bear in any year. The higher the cap on the high deductible plan relative to the conventional plan, the less likely it is that a person anticipating potential health problems would be willing to use an MSA plan. The evidence from the research suggests that adverse selection can be triggered by relatively modest differences in out-of-pocket cost risks.

In the three studies, there was only one scenario under which adverse selection did not occur. The RAND study considered one scenario in which the out-of-pocket cost cap for individual participants was set at an identical level of \$1,500 for both the high-deductible plan and the conventional plan. One would not expect to find much difference in the plans chosen by people with differing health statuses under this scenario, because the out-of-pocket risk of using the MSA/high-deductible plan not only was relatively low at \$1,500 a year but also was no different from the \$1,500 risk an individual would assume by using conventional insurance. Not surprisingly, RAND found little or no division of the insurance market in this case.

This RAND scenario has been widely been misreported and misinterpreted as "proving" that adverse selection will not occur. That interpretation is extremely misleading. In another RAND scenario much more representative of conditions likely to prevail in the market under the proposed legislation, a large degree of adverse selection was found.

Table 2
Differences in Caps on Out-of-Pocket Cost Between High-Deductible and Conventional Insurance in Three Studies

| | Conventional Insurance | High-Deductible Insurance Used With MSAs | Difference | Study Found Adverse Selection? |
|------------------|------------------------|--|------------|--------------------------------|
| RAND Scenario I | \$1,500 | \$1,500 | 0 | No |
| RAND Scenario II | \$1,500 | \$2,500 | \$1,000 | Yes |
| Urban Institute | \$1,250 | \$2,000 | \$750 | Yes |
| Actuaries | \$1,000 | \$2,000 | \$1,000 | Yes |

Notes: Differences are shown for individual coverage. The American Academy of Actuaries showed various levels of deductibles and out-of-pocket maximums. This table shows the smallest difference between the high-deductible plan and the conventional plan.

As can be seen in Table 2, which shows the difference in the maximum out-of-pocket costs between the high-deductible and the conventional insurance plans assumed in the various studies, *all* of the studies — including RAND — found adverse selection when the difference in maximum out-of-pocket costs between the two types of insurance was as low as \$750 to \$1,000. Based on this data, it would be reasonable to hypothesize that a division of the insurance market and adverse selection is likely to occur whenever there is a significant difference in the risk of out-of-pocket expenditures between the conventional insurance plan and the high-deductible plan used with the MSA.

For this reason, it also is reasonable to conclude that the proposals put forth by proponents of MSAs would lead to a very high degree of adverse selection. As noted, neither the House bill nor the Kassebaum compromise include *any* limits on out-of-pocket costs.

Research Indicated the Cost of Conventional Insurance Would Increase Sharply

The three studies found substantial degrees of adverse selection despite the relatively modest differences between the deductible amounts and the out-of-pocket caps in the two types of insurance assumed in those studies. If such a degree of adverse selection were to take place, it is likely that some employers, self-employed persons, or individuals could not afford to purchase conventional insurance policies.

The RAND study looked at the relative health care costs of workers who would choose high-deductible coverage with an MSA as compared to those who would choose either conventional coverage or an HMO. As noted above, the study found little difference when the cap on out-of-pocket costs was the same \$1,500 in both types of plan. But for another scenario using an MSA with a \$2,500 deductible plan and a \$2,500 out-of-pocket expenditure cap, considerable division of the insurance market was found. RAND found that MSA users would have average annual per capita health care expenditures of only \$2,840, as compared to \$7,549 for the people remaining in conventional fee-for-service plans and HMOs. And when compared only to people who chose fee-for-service plans — who would have average annual per capita expenditures of \$8,732 — the average medical expenses of MSA users were only one-third as high.

With such differential health care costs among the people in the various plans, the premiums charged for the different types of insurance would have to adjust accordingly and would need to rise sharply for conventional insurance. RAND

concluded that, "Such a large discrepancy makes adverse selection a legitimate concern."⁷

The Urban Institute study found a similar effect on health care costs and health insurance premiums. If open choice between types of plans were available and all people who could gain financially from switching to an MSA did so, the study found that the premium for a conventional policy (for a single person) would have to increase from \$1,701 to \$7,396 to accommodate the higher average health care costs of those remaining in conventional insurance. Under these circumstances, the study suggested, conventional insurance would cease to exist and no longer be available to the less healthy, older people who would be "losers" under MSA plans.⁸

The study conducted by the American Academy of Actuaries found that the premium for a conventional plan for a single individual would rise from \$2,699 to \$4,343 if individuals could select either a conventional plan or a high-deductible plan with an MSA. The actuaries' study found a smaller difference than the Urban Institute or RAND studies because the actuaries did not assume that everyone would choose the plan that yielded the most financial benefit for him or her. For example, the actuaries assumed that three-quarters (rather than all) of the individuals with no significant health care costs would choose the high deductible plan, and that half the individuals with the highest health care expenses would select the high-deductible plan with an MSA.⁹

Although each of the three studies had somewhat different assumptions and methods, each concluded that adverse selection would result in sharply increased premiums for conventional insurance. These studies suggest that the cost of conventional insurance could nearly double and possibly even increase as much as four-fold as a result of adverse selection. The extent of the cost increase would depend on factors such as the difference in the risk of out-of-pocket costs between the high-deductible insurance/MSA and the conventional insurance and the extent to which

⁷ Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA*, June 5, 1996, p. 1670. The conventional plan had a \$250 deductible, a 20 percent coinsurance rate above the deductible, and a cap of \$1,500.

⁸ These results were found for an MSA used with an insurance plan that imposed a \$2,000 deductible for single policyholders and provided full coverage for all health care costs once the deductible is met. Such a plan was compared in the Urban Institute study to a conventional plan with a \$250 deductible, 20 percent coinsurance, and a \$1,250 cap on out-of-pocket costs.

⁹ The actuaries' study suggests that the results it found are possible for plans with deductibles as low as \$1,000 combined with out-of-pocket maximums of \$2,000, compared to a conventional plan with a \$200 deductible and a \$1,000 out-of-pocket maximum. For both types of plans, cost sharing is assumed to be 20 percent up to the maximum.

people of varying health statuses choose the plan likely to provide the most financial benefit to them.

In short, the research finds a high probability that adverse selection will occur at the levels of deductibles and out-of-pocket costs permitted under the House bill or the Kassebaum compromise. It finds that this adverse selection will result in substantial premium increases for conventional insurance — increases large enough to make such insurance unaffordable and unavailable for many Americans. As the American Academy of Actuaries has noted, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."¹⁰ These findings raise the question of whether an appropriate MSA demonstration can be designed.

Implications for MSA Demonstration Design

Can a "safe" MSA demonstration be designed that both tests whether the adverse selection found in the computer model-based research will occur in the real world and also limits potentially non-reversible damage to the conventional insurance market? That is not an easy task.

One way to limit damage is to limit the scale of the experiment. If a relatively small number of companies are allowed to participate in the demonstration (perhaps several thousand), a large amount of corroborative information could be gathered and evaluated. This would allow a study of the impact of MSA policy without engendering widespread market changes. For example, information could be gathered about the health status of workers in companies that choose MSA plans as compared to workers in companies that do not choose MSAs, as well as the effect of these choices on employees. If the participating companies were concentrated in a few states, the effect of the decision of some businesses to offer MSAs would be felt throughout the market and could be measured.¹¹ At the same time, the limitations on the number of companies that could offer MSAs would assure that the effects of adverse selection are not severe enough to damage irreparably the small-group market for conventional insurance while the experiment is being conducted.

¹⁰ American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995, p. 23.

¹¹ It is generally thought that small business would offer only one type of insurance to their employees; for that reason, it is unlikely that the effects of adverse selection would be found within a single small business.

Another way to limit damage is to require the high-deductible insurance/MSA plans to include caps on out-of-pocket expenditures that are only modestly higher than the caps typical for conventional insurance in the area. The results of the RAND study suggest that high deductibles and caps can lead to sharply delineated divisions in the health insurance market and to commensurate increases in the cost of conventional insurance, while more modest limits can dampen that effect. In addition, placing moderate limits on deductibles and out-of-pocket expenditures will afford some measure of protection during the experimental period for less healthy workers who are forced to accept a high-deductible MSA plan, either because their employer has made the change or because insurance companies are offering only MSA plans to self-employed persons in their area.

It is also important to limit the potential for MSAs to be used as a lucrative tax shelter by some people who anticipate low health care expenditures. The MSA proposals impose penalties for withdrawal of funds for purposes other than paying medical costs, but neither the 10 percent penalty in the House bill nor the 15 percent penalty proposed in the Kassebaum compromise are sufficient to prevent this type of abuse. The penalties are particularly ineffective for funds held for a significant number of years. The longer the funds are held, the more valuable the deferral of taxes and the tax-free compounding of earnings on deposits becomes. In addition, the penalties are rendered nearly meaningless if depositors earn high rates of return on funds in MSAs. Rates of return high enough to overwhelm the effect of a 10 percent or 15 percent penalty could be earned if funds are invested in a vehicle such as a mutual fund reflecting a broad index of the stock market (on average the stock market has risen approximately ten percent annually over the past decade) or if general interest rates in the economy rise substantially in the future. If the purpose of MSA funds is to pay for medical expenses, the penalties for non-medical uses should be set at levels that insure funds are preserved for that purpose.

Similarly, the MSA proposals allow withdrawals of MSA funds without penalty for any purpose after the holder has reached a certain age — 59½ in the House bill and 65 in the Kassebaum proposal. A healthy taxpayer using an MSA, who would have far more after-tax savings than if the same amount of earnings had been saved in most other ways permitted under current law, could spend those funds on an extended vacation or any other way he or she would choose once the taxpayer reached the designated age. Yet, that same person might require long-term care within the next several years and might fall back on Medicaid to pay for that care. In other words, the person could expend one tax subsidy on personal consumption and then require another tax subsidy for health care costs. To prevent this kind of abuse, penalties for non-medical use of MSA funds should apply throughout the life of the holder rather than ceasing at a particular age. The funds accumulated in the MSA could continue to be used for covering out-of-pocket costs for health services in the latter years of life, when health care costs (including out-of-pocket costs) tend to be higher.

Appendix

If healthier people choose high-deductible insurance with MSAs in the hope of keeping their unspent deposits, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise.

Consider an example in which there are five people with health insurance provided by one company.¹² Together, the five people have \$15,000 a year in medical expenses. The insurance company charges the group of five a premium of \$14,000 a year for insurance, out of which it reimburses the group for approximately \$11,000 in medical expenses. Note that in this example the result is the same whether the medical expenses of the five people are distributed as in column A or column B below. So long as the five people remain in a group, the employer would pay an average of \$2,800 on behalf of each employee.

| Hypothetical Distributions of Medical Expenses | | |
|--|--------------|--------------|
| | Example A | Example B |
| Person 1 | \$3,000 | \$600 |
| Person 2 | 3,000 | 600 |
| Person 3 | 3,000 | 1,000 |
| Person 4 | 3,000 | 6,400 |
| Person 5 | <u>3,000</u> | <u>6,400</u> |
| Total Medical Expenses | \$15,000 | \$15,000 |

Now assume that the medical expenses are distributed as in column B and that Persons 1 through 3 chose a high-deductible plan with an MSA. The employer pays a lower average premium for each of them and also deposits \$2,000 in an MSA for each of them. Of the \$6,000 deposited in the MSAs, only \$2,200 (the sum of the expenses for Persons 1 through 3) would be used for medical expenses. The remaining \$3,800

¹² The following example is not based on actuarial analysis. The numbers used are for illustration only.

would become savings for Persons 1 through 3. (Some of that amount might or might not be used to pay medical costs in a subsequent year.)

Persons 4 and 5 did not choose a high-deductible plan because a high-deductible plan would result in higher out-of-pocket costs for them. But when the employer tries to purchase conventional insurance for a group consisting of just these two individuals who have average medical costs of \$6,400 a year, the premiums exceed \$6,000 per person. The employer cannot continue to offer comprehensive insurance at that price.

This simple example illustrates how MSAs disrupt the principle of insurance. MSAs make it advantageous for healthy people to leave the insurance pool, which in turn removes from the pool a substantial amount of funds currently available to help subsidize people whose medical costs exceed the premiums they pay. If MSA users remain healthier than average, they can use the excess funds in their MSAs for their retirement, or for education, vacations, or car purchases; these excess funds will *not stay in the health care system*. The result is that the price of a basic comprehensive health insurance plan will be much higher than it would be if a normal cross-section of people of varying health statuses participated in a comprehensive insurance plan.

While this example considers the effect of dividing the insurance pool within a single employer, these effects also could occur across employers or in the insurance market for self-employed people or individuals. Consider two insurance companies that insure small businesses. If one insurance company offers only high-deductible policies with MSAs, the premiums charged for those policies could be relatively low, reflecting both the fact that those covered by such policies would tend to be healthier than average and the fact that insurance does not kick in until the deductible is reached. If the second insurance company offers only conventional insurance, its business is likely to come from small enterprises having reasons to continue conventional insurance coverage. For example, the enterprises may employ many middle-aged to older workers or workers in their child-bearing years. But the conventional insurer in this example would be forced to charge higher premiums for such insurance than it might charge if its mix of clients was more representative. Under current laws in more than half the states, insurers are required at least partially to average — “community rate” — the differences in employee health statuses across the small businesses they insure.

In addition, experts point out that the risks of all insured groups are partially pooled internally by insurance companies even when the law does not require such pooling; insurance companies tend to compute a basic rate for, say, all small businesses and then make marginal adjustments to arrive at the premiums charged specific businesses. Under the proposed MSA legislation, these opportunities for broadly averaging health costs across businesses are likely to diminish sharply. Insurance

companies that do not specialize in providing high-deductible policies with MSAs are likely to face upward pressure on premiums and may not be able to continue offering conventional policies at prices employers can afford.

| Employment | Workers less than 65 years of age | 1993 |
|--------------------------|-----------------------------------|--|
| Firm Size | Workers (in millions) | Employer coverage Other Private Insurance |
| 0 - 24 | 21 | 3.3 |
| 25 - 49 | 8 | 0.4 |
| 50 - 74 | 4 | 0.4 |
| 75 - 99 | 3 | 0.4 |
| 100 - 499 | 15 | 10 |
| 500 - 999 | 5 | 0.4 |
| 1,000 + | 39 | 20 |
| Total private employment | 94.4 | 80 |
| Total public employment | 19.8 | 11 |
| Self-employed | 12.8 | 3 |
| Total Employment | 127.0 | 57.5 |

(Note: could include supplemental or ltc policies)

MSA partic.

LT 100,000 no amt
50 ≤ 750,000 - 300,000 wage
MSA high skilled
≥ 1,500
≥ 3,000
42 mil
etc.

750,000
300,000 - SE

Data sources: Commerce Department
 EBRI

Employer survey - Firm size
B.E.A.
ep/yr

bls - wage

94.4
19.8

114.2

Ken

From July
61.5
12.1

79.6

MEMORANDUM

TO: Interested Parties
FR: Chris J.
RE: Joint Tax Assumptions in the MSA Model
DT: July 8, 1996

David Nexon met with Joint Tax today to discuss the underlying assumptions in their Medical Savings Account (MSA) model. Here are some quick notes/findings of interest:

- The eligible population numbers (that are lower than ours) are based on Commerce Dept. numbers for firms eligible and BLS numbers for populations eligible. (Does this make sense to Labor and HHS?)
- For 50 and under population now under consideration by the Republicans, JCT assumes that 750,000 would choose MSAs. They assume that it will take only two years to get to that 750,000 number and then, presumably, the number would level off at 750,000.
- JCT assumes that there are 12.8 million self-employed individuals in the nation and that 3.1 million of this population cover themselves (i.e., get only a 25% deduction).
- JCT projects that of the 750,000 who opt for MSAs, fully 300,000 would be self-employed.
- JCT also projects that of the 750,000 people who opt for MSAs, 300,000 would currently have high deductible health policies. (NOTE: This is a different 300,000 from the self-employed number; having said this, most of those who have high deductible plans are assumed to be the self-employed.)
- Of those who opt for MSA, less than 100,000 (no specific number) are assumed to be uninsured.
- Of the 450,000 employment group policies (750,000 minus 300,000 self-employed who cover themselves), 60% of the policies are assumed to have employer contributions to the account and 40% are assumed to have the employee contribute to the account.

Thought you might find this information to be useful.

Medical Savings Account Study

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

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

1. Key Research Questions

- o How do employers respond?
 - the number and characteristics of employers offering MSAs;
 - employer decisions regarding the number, nature, and scope of insurance options available to employees, as well as and contribution levels
- o Which employees participate?
 - Do MSAs disproportionately attract particular employees (e.g. those with higher/lower income or those in good vs. poor health)?
- o How would the market be affected?
 - Which insurers market MSA-linked catastrophic coverage, and what level(s) of cost sharing do they promote?
 - How would MSAs affect the supply and cost of other insurance choices?
 - How would health care costs be affected?
- o How is tax revenue affected?
 - Based on employer and employee participation and contribution rates, what is the tax revenue effect of MSA legislation?

- o How are out-of-pocket costs affected?
 - How do MSAs affect enrollees' out-of-pocket spending?
- o Interaction between Managed Care and MSAs:
 - To what extent do employers and employees opt to combine MSAs with managed care products vs. Fee-for-service products?
- o Effect on Utilization and Health Status:
 - How do MSAs affect health care utilization decisions, including us of primary and preventive health services, and individual health status?

2. Study Structure

- o Sample of Firms: nationally representative sample drawn from firms electing to offer MSAs; comparison firms drawn to match MSA firms from sample frame used by Census Bureau.
- o Total cap on number of MSA accounts: To be determined
- o Length of Demonstration: 4 years(1/98 - 1/02)
- o Report Dates: Interim Report January 2000, Final Report September 2001
- o Frequency of Data Collection: annual
- o Administrative Data Sources: Insurer Reports
- o Survey Data: Employers (MSA offerors and Comparisons), Employees (MSA selectors, MSA non-selectors, and comparisons)

3. Administration

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

4. Methods

A. Data Collection

- o Data on employer behavior (e.g., take-up rates, employer contributions), insurance premiums, and the insurance options offered by the firm would be collected directly from the firm.
 - o Data on employee behavior and demographics would be collected from a survey of employees. Data on utilization of medical care and out-of-pocket costs would be collected from insurer claims data as well as the employee survey.
 - o Tax effects would be estimated based on relevant information from the insurer reports and the employer and employee surveys.
- B. Length of Demonstration The Demonstration would last four years and baseline and annual follow-up data would be collected from both firms and individuals.
- E. Estimated Cost of Study \$20 million (see attached breakdown).

Rough Estimate of MSA study costs

| | | |
|----|---------------------|------------|
| 1. | Data collection | |
| | • Families | 6m |
| | • Firms | 4m |
| | • Insurance records | 2m |
| 3. | Analysis | 8m |
| | TOTAL | 20m |

PROPOSED SECTION ON MEDICAL SAVINGS ACCOUNTS STUDY

SEC. __. MEDICAL SAVINGS ACCOUNTS STUDY.

(A) In order to assess the effectiveness of Medical Savings Accounts in

conjunction with high deductible health insurance in the self-employed and small group (up to firm size 100) market, the Secretary is authorized to carry out a study analyzing employer and employee participation, tax effects, out-of-pocket costs, and other relevant information, for firms and employees offered a medical savings account option compared to an appropriate control group. Such study shall, to the maximum extent possible---

(1) collect such data annually for up to 4 years;

(2) yield results that can be generalized to the nation as a whole;

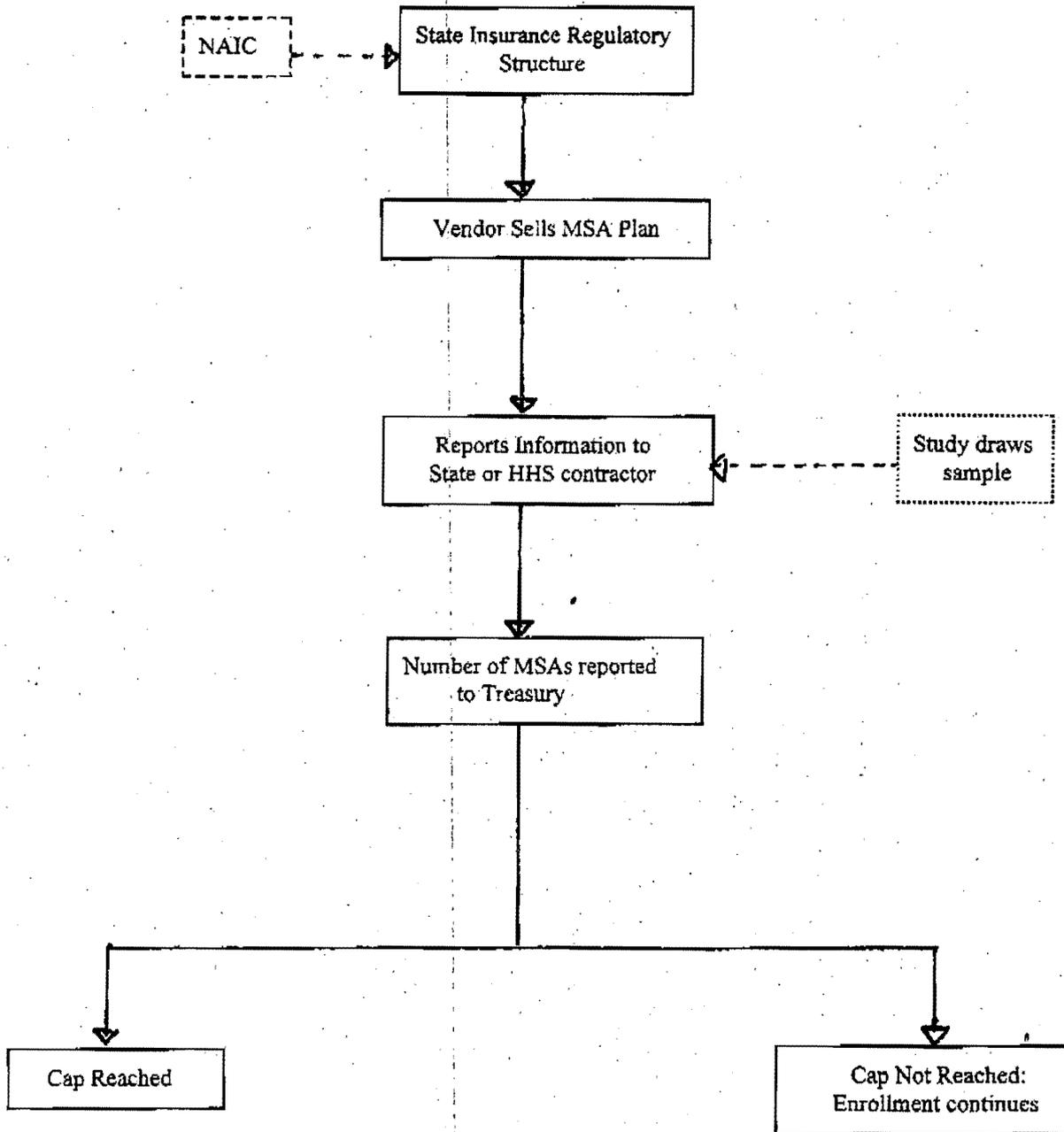
The results of such study shall be compiled and presented within 2 years after the 4-year study period.

(a) AUTHORIZED OF APPROPRIATIONS.--For the purpose of carrying out this section there are authorized to be appropriated a total of \$20,000,000 for fiscal year 1997 and the succeeding six fiscal years.

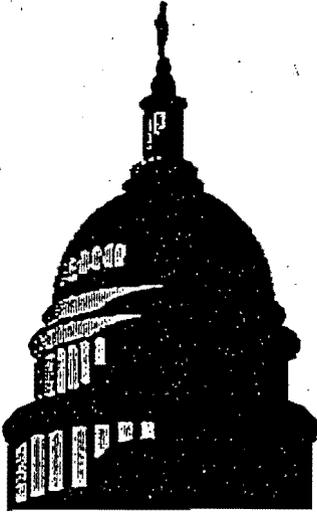
MSA Reporting System

1. States perform their normal regulatory functions, consistent with the insurance reform requirements of the Health Insurance Reform Act. This would include approval of qualified catastrophic health insurance plans (CHI) (see #2), and appropriate marketing, disclosure and reporting functions. The NAIC could develop model regulations for the states, but this is not required.
2. Treasury will estimate the cap on policies to be sold and will issue rules for what constitutes a qualified medical savings account, consistent with the Health Insurance Reform Act. Qualified CHIs can only be sold in conjunction with a qualified MSA.
3. Insurers sell qualified CHIs during an open enrollment period. There is no limit on the number of policies which can be sold during this time. Insurers and other vendors can establish the MSA accounts.
4. A count of qualified policies sold is maintained on an ongoing basis. The insurer reports sales (can be batch reporting) to either the state (if the state so elects) or HHS (or its contractor). The report would contain basic information on the CHI policy and MSA account numbers, the employer and employees covered.
5. HHS or its contractors would approve the sale if it occurs during the enrollment period and the employer has 50 or fewer employees or if the sale is to a self-employed person. The insurer would be given an approval number, similar to how credit card transactions are handled electronically.
6. Steps 4 and 5 above constitute the data from which the demonstration study would draw the study sample. A sample would be drawn from the approved sales and more detailed surveys would be conducted.
7. The contractor reports to HHS, which in turn forwards the data to Treasury. (If the states have elected to participate, they would report to the HHS contractor.)
8. At six month intervals, the number of policies sold is compared to the cap.
 - If the cap is reached, then Treasury publishes a formal notice stating that the cap has been reached and that no new employers may open MSAs for their employees after a specified date (e.g., 60 days later). Employers who have established MSAs within the enrollment period and who have at least 50% of eligible employees enrolled in MSAs may continue to open accounts for new hires or other employees who now want to have an MSA. (The "50%" would be based on self-reporting by the employer, subject to auditing and penalties for violations.)
 - If the cap is not reached, then enrollment continues.

MSA REPORTING SYSTEM



DVP



NAIC Washington Counsel
444 N. Capitol Street, NW
Washington, DC 20001

Facsimile Cover Sheet

To:

Chris Jennings

Organization:

White House

Phone:

456-5560

Fax:

456-7431

From:

Nicole Jerny

Organization:

NAIC

Phone:

202/624-7798

Fax:

202/624-8579

Date:

7/2/96

Document:

Pages including this
cover page:

Comments:

*I have placed notes or brackets by
now or confirmed info. - I'll call to discuss*

DRAFT**Quick Response to Inquiry re: state regulation of Medical Savings Accounts**

For the states of Arizona - Missouri, a * indicates that eligible medical expenses are defined as those defined in Section 213 (d) of Internal Revenue Code. Will make calls to learn of other restrictions that may apply to benefit packages.

Arizona*

- Total Deposits made to the account from either the account holder or employer are limited to \$2,000/account holder and \$1,000 per dependent up to 2 dependents
- No specification re: benefit packages but presumably state law applicable to high deductible insurance policies applies
- Statute states that upon agreement between employer and employee an employer may contribute to employee's MSA exclusively or in addition to medical coverage

Colorado*

- Maximum contribution \$3,000. (Employer and employee contribution combined-Total-no variation based on dependent/family status) } *
- "Qualified higher deductible plan" is defined as policy that provides for payment of covered benefits that exceed the deductible (which shall not exceed \$3,000) that is purchased by employer for the benefit of employee who makes deposits into medical savings account.
- Employer or employee may establish MSA
- Conversation with regulator indicated that this law has not had much effect since state tax is 5% of federal tax liability } *

Idaho*

- Maximum contribution (employer and employee combined) \$2,000
- No specifications on benefit package for insurance policy used with MSA
- Employer may offer to establish MSAs for employees or may contribute to employee's existing MSA

Illinois*

- Maximum contribution of \$3,000 per taxpayer (\$6,000 only in case of two account holders filing joint return), adjusted annually for CPI
- "Qualified higher deductible health plan" means a health coverage policy or contract that provides for payments for covered benefits that exceed the "higher deductible" and that is purchased by employer for employee for whom employer makes deposits into a msa ("higher deductible" defined as \$1,000 and \$3,000, to be adjusted by CPI)
- Group high deductible policies must comply with group health insurance requirements
- MSA program includes an employer purchase of a "qualified higher deductible plan" or employer contribution into MSA.

Indiana*

- Deductibles must be between \$1,000 and \$5,000-figures to be adjusted
- "Qualified higher deductible health plan" means a health policy that provides for payment of eligible medical expenses (defined in tax code) after "higher deductible" (Defined as \$1-5,000) is exceeded
- Contributions must not exceed \$5,000 (per accountholder). *3* appears spouses*
- MSA programs to be established by employer and employee may contribute but may not contribute an amount larger than necessary to make balance in account equal to the deductible
- Coverage documents must be approved as for other health policies

could each have account - does not address indiv/family max

Michigan*

- Maximum contribution \$3,000, minimum deductible for higher deductible plan \$1,000 and max. deductible is \$3,000, (As of '94) to be adjusted annually according to general price level
- "Qualified higher deductible health plan" means health coverage policy that pays for covered benefits in excess of deductible and that is purchased for benefit of MSA account holder
- Employer or resident of state may establish MSA

Mississippi*

- Deductibles between \$1,250 and \$2,500 for individuals, between \$1,750 and \$3,500 for health coverage provided to individual and dependents
- "Qualified higher deductible plan" is health policy that provides for payment of covered expenses in excess of the higher deductible
- MSA can be established by employer or resident
- MSA program includes employer purchase of qualified higher deductible plan and employer or individual payment into a msa an amount equal to at least 66^{2/3}% of premium reduction realized by purchase of higher deductible plan

Missouri

- Benefit package must include a contribution level that will be equal to cost of standard small group plan
- Regulation specifies that 50% of the employer's contribution level shall be used by insurer or self-funded plan to purchase a major medical policy.
- Employer contributions to individual MSA are tax exempt
- Dept. of insurance in consultation with Dept. of Health to define "bona fide medical and health care expenses"

Montana

- ◆ Maximum contribution \$3,000.
- ◆ Account can be established either by the employer, the employee, or an individual state resident.
- ◆ Eligible medical expenses means an expense paid by the employee or account holder for medical care defined by 26 USC § 213 (d) for the employee or account holder or a dependent of the employee or account holder.

Nevada (need to call state for additional information)

- ◆ Account established by employer.

New Mexico

- ◆ Account established by the employer in which the employer provides a qualified higher deductible plan, contributes to a MSA, and appoints an account administrator to administer the plan.
- ◆ For 1995, the maximum deductible shall not be less than \$1,000 and not be more than \$3,000. The department may adjust annually the maximum employer contribution to reflect the last known increase in the medical care component of the consumer price index. For 1995, the employer's contribution shall not exceed \$3,000. > max per family
- ◆ Qualified higher deductible plan is a health coverage policy, certificate or contract that provides for payments for covered health benefits that exceed the policy, certificate or contract deductible that is purchased by an employer for the benefit of an employee. - Subject to mandated other health ins. laws
- ◆ Eligible medical expense means an expense paid by the employee for medical care described in section 213(d) of the Internal Revenue Code of 1986 that is deductible for federal income tax purposes.

Ohio (new law--summary based on summary documents)

- Maximum tax-deductible contribution/account holder-\$3,000 (spouses can deduct \$3,000 each if each hold an account)
- No max. deductible or limit on out-of-pocket liability on catastrophic accounts
- Benefits regulated as other health policies-If MSA holder applies to enroll in more comprehensive plan with a lower deductible, insurer can apply same waiting periods and underwriting requirements as insurer applies generally to all applicants unless account holder enrolls during a designated open enrollment period--Other than this exception to portability requirements, other requirements of small group laws apply

Oklahoma

- ◆ Individuals or employers can contribute to a medical savings account. An individual or employer can purchase a qualified higher deductible health benefit plan approved by the state offered by an entity regulated by the state for the benefit of an individual or employer and dependents. An individual can deposit into a MSA or the employer can make a contribution on behalf of the employee all or part of the premium differential realized by the employer based on the purchase of a qualified higher deductible plan. An employer that did not previously provide a health plan or health coverage policy, can contribute all or part of the deductible of a qualified higher deductible plan.
- ◆ The amount of deposit for the first taxable year shall not exceed \$2,000 for the account holder and spouse and \$1,000 for each dependent child of the account holder. The maximum allowable amount of deposit for subsequent years shall be increased annually by a percentage equal to the previous year's increase in the national consumer price index.
- ◆ An eligible medical expense is an expense paid by the taxpayer for medical care described in section 213(d) of the Internal Revenue Code.

Utah

- ◆ Account can be established by employer or individual. The program can be established by an employer in which the employer purchases a qualified higher deductible plan and contributes to the MSA. Or alternatively, the account holder can purchase a qualified higher deductible plan and contribute to the MSA.
- ◆ A contribution into an account made by an employer on behalf of an employee, or made by an individual account holder may not exceed the greater of \$2,000 in that tax year, or an amount equal to the sum of all eligible medical expenses paid by the employee or account holder in that tax year. In this latter circumstance, eligible

no higher allowed for family - per account holder

medical expenses are expenses in that tax year that an insurance carrier has applied to the employee or account holder's deductible.

- ◆ Qualified higher deductible plan means a health coverage policy, certificate, or contract, that provides for payments for covered benefits that exceed the higher deductible and that is purchased by an employer for the benefit of an employee for whom the employer makes deposits into a MSA or by an account holder.
- ◆ Eligible medical expense means any expense paid by the taxpayer for medical care described in section 213 (d) of the Internal Revenue Code.

*subject to Saver's
 credit
 laws -
 see that
 benefits &
 premiums
 are in
 reachable
 realm*

Virginia

Statute authorized development and establishment of a plan upon Congressional authorization (includes MSAs for medical assistance and workers' compensation programs).

West Virginia

- ◆ Any individual resident of the state can establish a medical savings account.
- ◆ Medical expenses means the amounts paid for services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, which expenses may be included in calculating the federal deduction for medical and dental expenses for federal income tax purposes; for insurance premiums for combined plans issues pursuant to this section, but excluding expenses for cosmetic surgery as defined in section 213 of the Internal Revenue Code of 1986, as amended.
- ◆ Insurance Commissioner directed to promulgate regs re: annual contribution minimum and maximums. Any individual resident of the state or employer can establish a medical savings account
- ◆ Medical expenses means the amounts paid for services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, which expenses may be included in calculating the federal deduction for medical and dental expenses for federal income tax purposes; for insurance premiums for combined plans issues pursuant to this section, but excluding expenses for cosmetic surgery as defined in section 213 of the Internal Revenue Code of 1986, as amended.
- ◆ Insurance Commissioner directed to promulgate regs regarding the annual minimum and maximum contributions among other items.

NANCY LONDON KASSEBAUM, KANSAS, CHAIRMAN

JAMES M. JEFFORDS, VERMONT
DAN COATS, INDIANA
JUDO GREGG, NEW HAMPSHIRE
BILL FRIST, TENNESSEE
MIKE DOWNE, OHIO
JOHN ASHCROFT, MISSOURI
SPENCER ABRAMAN, MICHIGAN
SLADE GORTON, WASHINGTON

EDWARD M. KENNEDY, MASSACHUSETTS
CLAIBORNE PELL, RHODE ISLAND
CHRISTOPHER J. DODD, CONNECTICUT
PAUL SIMON, ILLINOIS
TOM HARKON, IOWA
BARBARA A. MIKULSKI, MARYLAND
PAUL WELLSTONE, MINNESOTA

SUSAN K. HATTAN, STAFF DIRECTOR
NICK LITTLEFIELD, MINORITY STAFF DIRECTOR AND CHIEF COUNSEL

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

TO:

Chris Jennings

FR:

David Nexon

DATE & TIME:

NUMBER OF PAGES:

COVER +

3

RETURN FAX NUMBER:

(202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL
(202) 224-7675.

MESSAGE:

FAX NUMBER:

456-5542

THE IMPACT OF THE DEMOCRATIC OFFER ON THE ATTRACTIVENESS OF MSAs

1. The allowable deductibles (\$2,000 per individual and \$4,000 per family) and stop-loss (\$2,500/\$5,000) under the Democratic offer are far above the typical conventional plan. The typical small business plan has a deductible of \$200 (1/10th of that allowed under the Democratic offer) and a stop-loss of \$1,000 (40% of the Democratic offer).¹
2. Most individuals have medical costs each year that are below the Democratic deductible level. Seventy eight percent of all adults have medical costs of less than \$2,000 in a given year.²
3. The Democratic deductible and stop-loss level results in major savings in premiums. Raising the deductible further does not produce a proportionate additional reduction. According the American Academy of Actuaries, the family plan premium under the Democratic MSA deductible and stop-loss would be \$4,385--a savings of \$2,182 (33%) compared to the conventional plan. By the time the Democratic deductible level is reached, the law of diminishing returns sets in on further increases in the deductible. Going to a \$6,000 deductible, a 50% increase in the deductible, increased savings by only one-third (\$724).³
4. The Democratic deductible is at the level that the market has already established as the norm for high deductible, MSA-type plans. According to experts at the American Academy of Actuaries, in general, MSA/high deductible plans today do not impose any additional cost-sharing after the deductible is reached. Moreover, individual deductibles are generally in the \$1,500-\$2,000 range, rarely higher. Family plans are typically \$2,000 to \$3,000.
4. Changes in the stop-loss, the most important consumer protection feature, make only a very minor difference in premium savings, according to experts on the American Academy of Actuaries MSA task force. An increase in the stop-loss of \$1,000 saves only about 3.7% in premium costs.

¹ BLS. This is also the level that the American Academy of Actuaries uses to model the typical conventional plan (Medical Savings Accounts: Cost Implications and Design Issues).

²American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, p. 6.

³American Academy of Actuaries, p. 8.

Analysis of Workers Eligible for MSAs During 1997-99 Start Up Period Under H.R. 3103 Compromise

| | Number of Workers | Percent of Total Workforce |
|---|--------------------|----------------------------|
| Employees in firms with 50 or fewer employees and self-employed | 41.8 million | 32.9% |
| All others | 85.2 million | 67.1% |
| TOTAL | 127 million | 100% |

Analysis of Potential Users of MSAs During Start-Up Period Under H.R. 3103 Compromise That Currently Have Health Insurance.

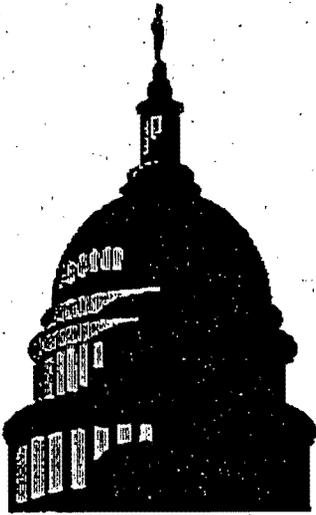
Coverage → 15% of Eligibles

| | Number of Workers With Health Insurance | Percent of Workforce With Health Insurance |
|--|---|--|
| Eligible for MSAs in 1997 – Employees in firms with 50 or fewer employees with employer-provided insurance and self-employed | 6.1 million | 7.66% |
| Not eligible for MSAs until 2000 | 73.5 million | 92.3% |
| TOTAL | 79.6 million | 100% |

Survey of Selected MSA Plans: Summary of Cato Institute Policy Analysis no. 220

| Amount of Deductible | Percent of Plans |
|-----------------------------|-------------------------|
| More than \$2,000 | 17% |
| \$2,000 or less | 83% |
| \$1,500 or less | 25% |

Source: Cato Institute Policy Analysis no. 220: More Than a Theory: Medical Savings Accounts at Work



NAIC Washington Counsel
444 N. Capitol Street, NW
Washington, DC 20001

Facsimile Cover Sheet

To:

Chris Jennings

Organization:

White House

Phone:

456-5560

Fax:

456-7431

From:

Maute Spang

Organization:

NAIC

Phone:

202/624-7790

Fax:

202/624-8579

Date:

6/28/96

Document:

Pages including this
cover page:

Comments:

*Here's a start - from our MSA paper -
will call as I learn more*

NAIC
MEDICAL SAVINGS ACCOUNTS*

| STATE | CITATION | PROVISIONS |
|----------|-------------------------------|--|
| Arizona | § 43-1028, 43-1331 | Trust established as an individual MSA shall not add the amount of interest income received on obligations of the state. Employer may contribute to the employee's individual MSA exclusively or in addition to medical coverage. For each taxable year, deposits may not exceed \$2,000 for account holders and \$1,000 for each dependent up to 2 dependents. Funds used solely for medical expenses are not taxable. Funds can be withdrawn without penalty on the last business day of a calendar year but are subject to income tax. Withdrawals for non-medical expenses are considered taxable income and incur a penalty equal to 10 percent of the withdrawal amount. |
| Colorado | §§ 39-22-504.5 to 39-22-504.7 | Employer or employee may establish MSA. Maximum contribution \$3,000. All contributions are on a pre-tax basis. Funds exempt from income tax if used to pay eligible medical expenses. |
| Idaho | §§ 63-3022J | MSAs may be established and contributed to by individuals or employers. Maximum annual contribution \$2,000. Annual contributions and interest earned are deducted from taxable income. Funds used for purposes other than for eligible medical expenses considered taxable income. Account holder shall pay income tax and a penalty equal to 10% of money withdrawn if funds used for purposes other than eligible medical expenses. When account holder reaches 59 1/2 years of age, withdrawals may be made for any reason without penalty. |

| STATE | CITATION | PROVISIONS |
|-----------|--|---|
| Illinois | 820 ILCS 152/1 to 820 ILCS 152/20, 820 ILCS 152/30, ILCS 152/85 | MSA is an account established to pay eligible medical expenses of an employee and dependents. MSA programs include all of the following: purchase by an employer of a higher deductible health plan; contribution into a medical care savings account. Maximum amounts are adjustable based on consumer price index; principal contributed to and interest earned on MSA and money reimbursed to an employee for eligible medical expenses are exempt from taxation under IL Income Tax Act; money withdrawn for other purposes considered income and is taxable. |
| Indiana | IC 6-8-11, IC 6-3-2-18 | Employers may establish MSA for employees and dependents of employees. Employer must purchase a qualified higher deductible health plan, make a contribution that equals all of part of the difference between the cost of the higher deductible health plan and the employer's previously incurred health coverage costs, and designate an account administrator. Maximum amounts are adjustable based on the consumer price index or other federal indicator of general price levels. Funds withdrawn for purposes other than payment of eligible medical expenses shall be subject to taxation. Effective January 1, 1996. |
| Louisiana | HB 1259 (1995) | Health Care Commission to forward recommendation to Insurance Commissioner regarding MSAs. |

| STATE | CITATION | PROVISIONS |
|-------------|-----------------------|--|
| Michigan | §§ 550.981 to 550.988 | Employer or resident of state may establish MSA. MSA is one of the following: program established by an employer that previously provided a health coverage policy that includes all of the following: purchase of a higher deductible health plan; maximum contribution \$3,000; amounts adjusted annually based consumer price index; if funds withdrawn for purpose other than payment of eligible medical expenses, administrator shall withhold 10% of amount withdrawn as penalty. |
| Mississippi | §§ 71-9-1 to 71-9-9 | MSA can be established by employer or resident. MSA program includes all of the following: purchase by an employer or resident of a qualified higher deductible health plan; payment into the MSA at least 66 2/35 of the premium reduction realized by the purchase of a qualified health plan; and an account administrator. Principal and earned interest shall be excluded from tax; money withdrawn and not used to pay eligible expenses shall be taxable income. |
| Missouri | § 143.999 | Employer contributions to Individual Medical Account for health care expenses shall be exempt from income tax. Annually employer shall determine contribution level to be expended for coverage which shall be in lieu of any standard indemnity or health insurance provided. Percentage of employer's contribution shall be used by the insurer, HMO etc. to provide benefits. Remainder will be used to fund an IMA to pay for health care expenses not covered by the policy. Funds in account spent on health care are exempt from MO state income tax. |

| STATE | CITATION | PROVISIONS |
|------------|---------------------------------|---|
| Montana | HB 560 (1995) | Employer may establish MSA for an employee or employee's dependent. Resident of state may establish an MSA. Contribution and interest are tax exempt. Amounts withdrawn from account not tax exempt and subject to 10% penalty of withdrawn amount if used for other than payment of eligible medical expenses. Max. annual contribution \$3,000, but no limit on amount maintained in account. |
| Nevada | AB 592 (1995) | If an employer elects to provide health care benefits through an MSA, the program must be administered by an approved entity. Funds can be withdrawn to pay eligible medical expenses not otherwise paid by a third party, to reimburse employee for eligible medical expenses or by the employee on the last business day of the year. |
| New Jersey | AB 635 (1994) | The feasibility of permitting the use of MSA plans under the state's small employer health benefit program shall be studied by the program's board of directors. |
| New Mexico | 59A-23D-1 to 59A-23D-7, 7-2-5.6 | Employer may establish an MSA for employees. The employer must provide a qualified higher deductible health plan, contribute to the MSA and appoint an account administrator. Funds used for eligible medical expenses are exempt from taxation. |
| Oklahoma | Tit. 63 §§ 2621 to 2623 | MSA shall be an account to pay eligible medical expenses of an account holder. The program shall include the purchase of a qualified, approved health plan or the deposit by an individual on behalf of an employee into a medical savings account of all or part of the premium differential realized by the employer based on the purchase of a qualified health plan for the benefit of the employee. Beginning 1/1/96 the amount of deposit shall not exceed \$2,000 for the account holder, \$2,000 for the spouse of the account holder and \$1,000 for each dependent child of the account holder. The maximum deposit for subsequent years shall be based on the CPI. Contributions and interest earned are tax exempt. |

| STATE | CITATION | PROVISIONS |
|---------------|---------------------------------------|--|
| Texas | SB 604 (1995) | The Health and Human Services Commission shall develop a plan for a pilot program that uses Medicaid funds to establish an MSA for recipients of acute care services under the Medicaid program. |
| Utah | § 31A-32-101 to 31A-32-106, 63C-3-104 | MSA can be established by employer or resident. The contribution into the account may not exceed the greater of either \$2,000 in any tax year or an amount equal to the sum of all eligible medical expenses in that tax year which an insurance carrier has applied to the employee or account holder's deductible. Contributions, interest earned and reimbursement made for eligible medical expenses are tax exempt. The Health Policy Commission will evaluate MSAs. |
| Virginia | 38.2-5600 to 38.2-5603 | Dept. of Medical Assistance Services to develop a plan to use MSAs for the working poor. Dept. of Workers Compensation shall create and use medical savings accounts and work in cooperation with the Dept. of Taxation. Dept. of Taxation to develop a system of refundable tax credits. Joint Commission on Health Care to monitor the plan. Implementation of plan contingent upon passage of federal legislation authorizing plan components. |
| West Virginia | §§ 33-15-20, 33-16-15 | Resident may establish a medical savings account. A percentage may be designated that may be withdrawn if not needed for medical expenses. Any amount used for other than to pay medical expenses shall be taxed as income of the payee. Withdrawal requirements applicable to insurers offering group A/H, public employee insurance agency and ERISA health plans. |

Every effort has been made to make this information as correct and complete as possible. For further information about Medical Savings Accounts, please consult the laws listed above.

* Although the statutory framework exists for MSAs in these states, the NAIC has no statistical information with respect to the number of persons who have utilized these plans.