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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

September 12, 1995

Statement by Laura Tyson
National Economic Adviser
Republican Proposal for Medical Savings Account
September 12, 1995

Today, a press conference was held by Republicans to extol the benefits of Medical Savings Accounts (MSAs) for Medicare beneficiaries. Although the Republicans continue to withhold detailed specifics of their MSA proposal, we have serious concerns about its applicability to the Medicare program. An MSA option for Medicare beneficiaries is likely to increase premiums for millions of beneficiaries who opt to stay in the current Medicare program.

MSAs may be attractive initially to younger, healthier and wealthier beneficiaries -- but this type of self-selection would likely benefit them while raising costs for the majority of Medicare beneficiaries. This is because MSAs lead to what is known as adverse selection -- a process whereby insurance companies are able to attract the least expensive and healthy beneficiaries and avoid the more expensive, more vulnerable population. The population that remains in the traditional Medicare program would be a smaller and sicker group of beneficiaries. As a result, the cost per person and their accompanying premiums would rise. Another adverse selection problem would arise if beneficiaries who chose the limited, catastrophic-oriented MSA benefit opted to go back into the traditional program when they became sick.

Apparently some Republicans are considering addressing these serious adverse selection problems by prohibiting beneficiaries who chose MSAs to opt back into the more traditional program to seek better coverage. With such a "lock-in" provision, if a Medicare beneficiary gets sicker than expected, he or she would be trapped in the MSA catastrophic health care plan for the lock-in period. We do not believe that this is the type of choice that most Medicare beneficiaries would want.

National Center for Policy Analysis and Medical Savings Accounts

The National Center for Policy Analysis (NCPA) is a Republican-leaning "pro-free enterprise" organization with offices in Dallas and Washington, D.C. It is largely funded by conservative foundations and by corporations. Its board of directors includes many corporate leaders whose companies help fund NCPA. One board member is Golden Rule Insurance chief and Newt Gingrich backer Patrick Rooney. Rooney has long promoted the idea of Medical Savings Accounts (MSA's)

Golden Rule Insurance Chief Proposes MSA's, Sat on NCPA Board. One of the central elements in the Republican Medicare plan is the use of Medical Savings Accounts (MSAs). The top proponent and beneficiary of MSAs is Golden Rule Insurance. Golden Rule's chief executive Patrick Rooney sat on NCPA's board of directors as recently as 1993.

Golden Rule Is a Major Republican/Newt Gingrich Campaign Contributor and Financial Backer. Golden Rule is one of the Republicans' top campaign contributors -- most notably to GOP Speaker Newt Gingrich. Gingrich has endorsed Medical Savings Accounts (MSAs) as one of several alternatives to the current Medicare system. Golden Rule gave nearly \$1 million to Republicans for the 1994 election; its top executives have given Gingrich's GOPAC over \$150,000; and the company sponsored a conservative cable TV talk show hosted by Gingrich. Gingrich's plan to make MSAs part of the Medicare system is not the only break Golden Rule has gotten from the GOP Congress. [Wall Street Journal, 5/15/95]

GOPAC fundraiser/GOP Congressman drops investigation of Golden Rule. Earlier this year a House subcommittee -- chaired by GOPAC fundraiser Rep. Joe Barton (R-TX) -- dropped an investigation into allegations that Golden Rule Insurance was cherry-picking healthy customers and denying too many claims. [Newsweek, 2/13/95]

Gingrich Promoted Golden Rule In His Course. Gingrich has praised Golden Rule Insurance in his course, in speeches to private groups and in remarks in the Congressional Record. In addition, Golden Rule advertises in *American Civilization*, the magazine of the Progress and Freedom Foundation.

NCPA Is also Funded By Conservative Foundations and By Corporations. Other major contributors to NCPA include conservative foundations, such as the Koch Foundation, the Bradley Foundation, the Murdock Charitable Trust, the Pew Freedom Trust and the Noble Foundation. The Koch family also founded the Cato Institute and Citizens for a Sound Economy. Corporate contributors include ARCO Oil and Gas Co., PepsiCo, Inc. and Proctor and Gamble.

NCPA's Other Issue Positions: NCPA advocates such positions as privatizing Social Security and some welfare programs, implementing school choice programs and market-based "solutions" to environmental problems. It strongly opposed President Clinton's health care reform plan. It also estimated high job losses as part of Ross Perot's 1992 deficit reduction plan.

EMBARGOED FOR RELEASE UNTIL
11:00 a.m. EDT
Tuesday, September 12, 1995

New Study Shows That Medical Savings Accounts Are Actuarially Sound for Medicare

Washington, D.C. — Under the Republican Medicare reform plan, private insurers will be able to put money in personal accounts which the elderly can use to pay medical bills and they will get to keep money they don't spend, according to the National Center for Policy Analysis (NCPA).

The NCPA has teamed with Milliman & Robertson, an actuarial consulting firm, to analyze the types of private-sector options the elderly will have. The study, released today on Capital Hill, says that:

- Medicare beneficiaries will be able to join a private plan that pays all expenses above \$3,000.
- The private plan will be able to deposit as much as \$2,100 in a personal Medical Savings Account (MSA) that beneficiaries can use to pay expenses below the \$3,000 deductible.
- At the end of each year, the elderly will be able to withdraw unspent funds in their MSAs or allow the money to grow with interest to pay future medical bills.
- Beneficiaries will be able to deposit into their MSA money they now spend on supplemental "Medigap" insurance (about \$1,200 a year) in order to eliminate any out-of-pocket exposure.
- They also will be able to use Medigap funds to buy additional coverage for such items as prescription drugs.

- more -

**For more information: Glenn Mitchell or Windi Fuller 214/386-6272
or Jan Faiks 202/638-4600**

Page 2

"This plan would give the elderly genuine catastrophic protection, which they do not now have," said NCPA President John Goodman. "Under the current system, about 418,500 Medicare beneficiaries experience out-of-pocket costs in excess of \$5,000 every year. In some cases these out-of-pocket costs bring financial devastation and ruin."

The elderly will also have other options. "The goal," said Goodman, "is to let private firms experiment and innovate by repackaging Medicare and Medigap insurance coverage. The elderly would then be able to choose from among many options available in the medical marketplace. Some will undoubtedly choose to be members of HMOs where important choices between health care and other uses of money would be made on their behalf. Others will prefer to manage more of their own health care dollars through Medical Savings Accounts," he said.

Whereas HMOs rely on managed care (restricting choices of doctors and access to certain diagnostic tests) to control costs, Medical Savings Account plans give patients financial incentives to reduce spending. Goodman said, "Medical Savings Accounts give the elderly a financial self-interest in eliminating waste and inefficiency. That is because they get to keep the dollars they don't spend out of their MSA."

The study also concludes that the federal government can easily meet its budget goals for Medicare by allowing the elderly to have Medical Savings Accounts. Congress's budget resolution requires that projected Medicare spending be reduced by \$270 billion over the next seven years. At least \$235 billion can be saved through the MSA option alone. "We can reach the Congressional budget goals for Medicare and give beneficiaries more protection than they now have," Goodman said.

Another NCPA study, using the National Center for Policy Analysis/Fiscal Associates Health Care Model, predicts that widespread use of MSAs by the elderly would not only reduce health care spending under Medicare, but would also result in lower health care prices for the non-elderly.

- more -

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Page 3

The study, by NCPA Senior Fellows Gary and Aldona Robbins, finds that the Republican plan would not only reduce Medicare spending but would also reduce all health care spending. Less spending by the elderly on health care would ease the pressure on all medical prices and the rate of increase in health spending would slow.

- By the year 2005, Medicare spending would be 18 percent lower than currently projected spending, and total U.S. health care costs would be 8.7 percent lower.
- While spending on health care would decrease by \$186 billion, the output of other goods and services would increase by \$241 billion.
- There would be 367,000 more jobs than otherwise, and wages for American workers would have increased by almost one-half trillion dollars between 1997 and 2005.

Medical Savings Accounts, which have been developed and refined by the NCPA, are now used by hundreds of companies and municipalities in the United States. In the 103rd Congress, more than 240 members from both parties were cosponsors of reform bills that included MSAs for the non-elderly. In this session, House Ways and Means Chairman Bill Archer (R-TX) is sponsoring an MSA reform bill for the non-elderly and there are several other bills in the House and Senate as well.

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The National Center for Policy Analysis is a public policy research institute founded in 1983 and internationally known for its studies on public policy issues. The NCPA is headquartered in Dallas, Texas, with an office in Washington, DC.

*For more information: Glenn Mitchell or Windi Fuller 214/386-6272
or Jan Faiks 202/638-4600*

Office of the House Majority Leader

For immediate release --
September 12, 1995

Contact: Michele Davis
(202) 225-6007

Today, the National Center for Policy Analysis released figures from Milliman and Robertson, a respected actuarial firm, detailing the cost savings available to seniors under a Medical Savings Account policy that private insurance firms could market under the Republican proposal to save Medicare. Majority Leader Dick Armey made the following statement:

"This study confirms what we always knew -- take the control out of Washington and give it to individuals and they will always spend less and get more.

"I've been an advocate of Medical Savings Accounts for years, because I believe individuals make better decisions than a centralized bureaucracy. Medical Savings Accounts will be an important part of our legislation to preserve and protect Medicare. We will give senior citizens control over their own health care spending. Senior citizens are wiser than any government bureaucrat I know, and are in a better position to make important medical decisions. A central tenet of our Medicare reform is this: we trust older Americans enough to give them the power to use their Medicare dollars as they see fit to meet their retirement health care needs."

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Office of Economic Policy

Department of the Treasury • Washington, D. C. 20220

FAX

Date: Sept 12, 1995

Number of pages including cover sheet: 1

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To:	<u>Chris Jennings</u>	<u>456-7431</u>	
From:	<u>Glen Rosselli</u>	<u>202-622-2633</u>	<u>622-0090</u>

REMARKS: Urgent For your review Reply ASAP Please comment

Medical Savings Accounts for Medicare

We have not yet studied the proposal in detail but based on what we have heard this Medical Savings Account (MSA) proposal raises major concerns.

- It raises risks of cost increases or benefit reductions for those that want to stay in the traditional program. If healthier individuals opt for the MSA option, the traditional plan would over time be left with sicker, more costly individuals. To cover the extra cost, the government either would have to spend more, traditional Medicare participants would have to contribute more to maintain current benefits, or benefits would have to be decreased.
- It is difficult to design MSAs that allow choice over a long period of time. One way to address this issue is to lock people into an MSA for a long period, the result of which would be that many people would not have the coverage they need when they need it most. If Medicare participants are given the choice to switch back to the traditional plan when they need it most, costs could rise substantially. But any effective means to limit costs might severely limit choice in future years.

It is essential that any proposal for medicare reform maintain benefits at reasonable costs for the most vulnerable members of our population. MSAs run the risks of raising costs for less healthy individuals and limiting choice.



Publisher of Consumer Reports

DVP

TRANSMITTAL SHEET

DATE: 10/3/95

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FROM: Gail Shearer

OF PAGES (including transmittal sheet): 3

MESSAGE: _____

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October 3, 1995

President Bill Clinton
1600 Pennsylvania Avenue, NW
Washington DC 20500

Dear President Clinton:

As representatives of organizations dedicated to expanding access to quality health care while containing costs, we were deeply troubled by reports in the press that you look favorably on the possibility of experimenting with Medical Savings Accounts (MSA's) for Medicare beneficiaries.

Republican proposals before both the House and the Senate would allow seniors to opt out of traditional Medicare coverage by electing to buy a private catastrophic health insurance policy and creating a Medical Savings Account to cover other health care expenses. We believe that MSA's will lead to the demise of Medicare because:

- A disproportionate number of healthy seniors will select MSA's. In the extremely likely case that risk adjustment efforts will be minimal, money will be drained from Medicare funds that are meant to cover the sick in order to cover MSA's and catastrophic policies for the healthy. Participants will even be allowed to withdraw funds for non-health purposes.
- This diversion of funds to the healthy will drive up costs in the traditional Medicare program by an estimated 21 percent in the seventh year¹.
- The increase in costs for traditional fee-for-service plans will lead to "look-back" payment reductions to fee-for-service providers, leading to an exodus of fee-for-service providers and continued selection of the next healthiest tier of seniors into MSA's. This cycle could ultimately lead to the demise of the Medicare system.

¹The actual increase could be much higher, depending on the final details of the program design. The 21 percent estimate is based on assumptions and analysis by Jack Rodgers, Price Waterhouse LLP and James W. Mays, Actuarial Research Corporation, "Medical Savings Accounts for Medicare Beneficiaries," prepared for The Henry J. Kaiser Family Foundation, August 1995, Table 2.

2

- If efforts are made to adjust for risks, they will inevitably lead to a new bureaucratic administrative system to adjust for individual seniors' health status. It will be extremely difficult, if not impossible, to construct a "fair" payment system, since individuals with different behavior such as exercise, diet, and smoking habits will all have differing views on fairness. It will be almost impossible to match Medicare's excellent record of low administrative costs.

As you know, the battles to preserve funding for the Medicare and Medicaid programs will be intense. We plan to fight the disastrous cuts that are now under consideration in Congress. We respectfully request that you do all in your power to defeat proposals that threaten to sabotage the long-term viability of the Medicare program. We believe the ill-conceived idea of Medical Savings Accounts is such a proposal.

Sincerely,

Christine Lubinski
AIDS Action

Jeff Jacobs
American Public Health Association

Bob Griss
Center on Disability & Health

Nancy Chupp
Church Women United

Cathy Hurwit
Citizen Action

Mern Horan
Consumer Federation of America

Gail Shearer
Consumers Union

William H. Bywater
International Union of Electric,
Electrical, Salaried, Machine
& Furniture Workers
AFL-CIO

Sandy Harding
National Association of Social Workers

Dr. Martha Sotomayor
National Hispanic Council on Aging

Shelley Moskowitz
Neighbor to Neighbor

Kathy Thornton
NETWORK:
A National Catholic Social
Justice Lobby

Bob Nicholas
Teamsters

Evelyn Dubrow
UNITE
(Union of Needletrade,
Industrial and Textile Employees)

Patrick Conover
United Church of Christ,
Office for Church in Society

KASSEBAUM-KENNEDY HEALTH REFORM LEGISLATION

Background:

On April 23rd, the Senate passed (by a 100 to 0 vote) an amended version of the Kassebaum-Kennedy insurance reform bill. The previous week, every Democratic Senator joined with five Republican Senators to support an amendment (in a 52-46 vote) to strike Medical Savings Accounts (MSAs) from a Dole Amendment to the legislation. (The Republicans that supported the amendment were Senators' Bond, Gorton, Chafee, Kassebaum, and Hatfield). This was played by the media and the Democrats as a stinging defeat for Senator Dole.

As of May 15th, the conferees for the Senate-House conference had not been selected because Senator Kennedy has continued to object to the Members Senator Dole planned to appoint to the Committee. In an almost unprecedented move, the Majority Leader attempted to stack the conference with Members friendly to the House MSA provision. (He was not at all subtle in picking Members who normally would not be on the conference and bypassing those who would have.)

Kassebaum-Kennedy Insurance Reforms

The underlying Kassebaum-Kennedy insurance reform provisions address some of the major problems in today's insurance market. According to the General Accounting Office, it would benefit as many as 25 million Americans. Like the President's balanced budget proposal, this legislation provides for:

- **Guaranteed Access.** Insurers would be required to offer health plan coverage to all groups, regardless of the health status of any member of the group. In addition, employees could not be denied group coverage based on their health status.
- **Guaranteed Renewal.** Insurers would be required to renew coverage to groups and individuals as long as the premiums are paid and employers could not have their coverage terminated if their workers incur large medical costs.
- **Limits on Imposition of Pre-existing Condition Exclusions.** Insurers could not impose pre-existing conditions for people who have switched jobs and have maintained coverage for longer than 12 months. (They could not impose a pre-existing condition for longer than 12 months for those who have not had continuous coverage.)
- **Increased Access to Individual Policies.** Individuals with previous coverage would have access to the individual health insurance market (if certain conditions are met.)
- **Promotion of Purchasing Cooperatives.** States would be given assistance to help certify and encourage the development of purchasing cooperatives to help small businesses gain leverage in buying more affordable and accessible health insurance.

Senate Amendments to Kassebaum-Kennedy

The Senate defeat of the MSA amendment covered up some significant additions to the underlying insurance reform bill. They included:

- (1) Expansion of the self-employed tax deduction to 80 percent over 10 years (the President's balanced budget has a phase-in to 50 percent, as does the House-passed version of Kassebaum-Kennedy);
- (2) Clarification that tax treatment of private long-term care policies should be the same as traditional health insurance (the President's balanced budget does not have this provision, but the President advocated for a similar provision in the Health Security Act; the House-passed bill has a similar provision);
- (3) Strengthening of Medicare fraud and abuse prevention/enforcement (the President's balanced budget has a similar provision, as does the House-passed insurance reform bill -- although it is flawed as it, in some cases, weakens enforcement); and
- (4) the Prohibition of health plans from imposing limits or caps on mental health services if similar limitations are not imposed on coverage for other conditions (the President's balanced budget does not allow plans to discriminate by disease category, but does allow plans to have differential coverage limits; the House-passed insurance reform bill has neither the President's nor the Senate-passed provisions.) This last item was sponsored by Senator Domenici and Senator Wellstone and won by a surprisingly large 65-33 margin.

Outstanding Issues Going Into Conference: The House-passed bill has at least 5 major provisions that are extremely problematic. They were well aware that we had grave concerns about them, but they went ahead and included (1) Medical Savings Accounts, (2) Caps on punitive and non-economic medical malpractice awards, (3) **the deregulation of state oversight over MEWAs -- Multiple Employer Welfare Arrangements** -- that the Governors, the Insurance Commissioners, the consumer groups, the insurers and many providers believe will severely undermine the insurance market by providing for an under-regulated environment in which healthy employees/employers can be selected away from unhealthy populations, (4) the elimination of the prohibition against insurers selling Medigap policies that duplicate benefits that beneficiaries already receive through their Medicare coverage, and (5) the weakening of certain Medicare fraud and abuse enforcement provisions.

The Senate-passed bill does not include the first four provisions and improved on the problematic fraud and abuse provisions. We believe that we can and should work out some of the minor concerns we have with the Senate provisions (mostly relating to the long-term care tax clarifications and the fraud and abuse provisions). However, the real fight will be on the House-passed provisions. The business community might help us fight the House-passed controversial provisions. However, they will also be focusing their guns on the Domenici/Wellstone mental health parity provision. (They believe it is huge, new Federal mandate.)

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

Summary

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

Concerns

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

- Allowing individuals to switch plans enables individuals to game the system.
- Allowing individuals to keep their MSA accounts when they opt back into a comprehensive plan rewards gaming.
- **MSAs are untested.** MSAs could have substantial negative effects on the health insurance market and on individuals, especially those with poor health.
 - MSAs as defined in the proposal are untested and objective researchers (e.g. the American Academy of Actuaries) are concerned about potential effects. Data from existing MSA plans has not been made available for review.
 - Reports that existing MSA plans reduce costs for some employers, even if verified, would not necessarily imply that tax incentives for MSAs would reduce overall health care costs. For example, an employer that currently offers an MSA may be reducing its own costs by shifting costs to another employer that provides health insurance to the worker's spouse.
- **Tax benefit for the healthy and wealthy.** MSAs would enable more individuals to pay out-of-pocket medical expenses on a tax-preferred basis. MSAs would also permit individuals with low medical expenses or substantial financial resources to save \$2,000 a year (or \$4,000 for a family) on a tax-free basis.
 - There are no income limits in the proposal. Tax benefits would be much greater for high-income participants than for low-income groups for several reasons. Within any age group, high-income individuals are more likely to participate than low-income individuals. High-income individuals tend to save more than low-income individuals. Finally, high-income individuals are in higher income tax brackets than low-income individuals.
 - Individuals who wished to maximize tax-favored savings would be free to pay their medical expenses out of their other funds, and essentially let the MSA serve as an additional IRA without income limits. Healthy individuals may receive windfalls at the expense of less healthy individuals to finance these additional savings accounts.
 - For healthy individuals, assets in MSA accounts could accumulate to substantial sums. These amounts could well exceed amounts necessary for health care.
 - Because the MSA balance would not be included in the taxable estate, individuals could use MSAs to avoid estate taxes when they die.

- The 10 percent penalty on nonmedical withdrawals from MSAs would not be high enough to recapture MSA tax preferences in many cases.
- Allowing penalty-free nonmedical withdrawals at age 59 1/2 could encourage individuals to spend their MSA savings on non-health-care consumer goods when their health expenses are likely to be growing and they are not yet eligible for Medicare (at age 65).
- **Social Security and Medicare taxes.** Employers that currently do not provide health insurance could provide extremely minimal health insurance and establish MSAs for their employees. As a result, employers and employees could avoid Social Security and Medicare taxes on employer contributions altogether.
 - Although contributions to 401(k) retirement accounts receive tax preferences for income tax purposes, these contributions are included in taxable wages for Social Security and Medicare purposes.
 - MSAs could reduce the Social Security and Medicare wage base, especially for low-income workers.
- **Undermines health insurance protection and preventive care.** The proposal could reduce the amount of health insurance protection for individuals, as well as the effectiveness of their care.
 - Without out-of-pocket limits and a specified set of benefits for the catastrophic coverage, individuals may not have meaningful insurance protection. These individuals may not be able to pay their health expenses in the event of a major illness, leaving hospitals, Medicaid and other individuals at risk for paying the bill.
 - Because employers are likely to contribute less than the increase in the deductible, employees would be at risk for larger out-of-pocket costs in MSAs compared to current plans. According to the American Academy of Actuaries, the amount of out-of-pocket exposure can be high, especially if employees are given choice.
 - MSAs may discourage effective preventive care. The high deductible coverage associated with MSAs may lead to delayed care and under-utilization of routine and preventive health care services.
- **Undermines targeted health spending.** Under the proposal, individuals would be free to withdraw MSA funds tax-free to pay for less critical health care items that are not covered by their catastrophic insurance.
 - MSAs would discourage cost containment by enabling more employees, self-employed individuals and others to pay for these types of out-of-

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

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

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

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

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

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

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

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

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

May 22, 1996

PROPOSED COMPROMISE

1) Senate-passed bill with a compromise on Mental Health parity provision.

2) MSA compromise - one of the following 2 options:

Option #1

--Demonstration with rigorous experimental design, data requirements, and sunset that will provide a fair test of MSAs

--Demonstration could include separate measurement of the program's impact on individual, small business, and large employer market

--Participation in the demonstration limited to the minimum number of people necessary to provide an adequate test of the MSA concept, including such issues as:

- o adverse selection
- o participation by income category
- o impact on cost of conventional policies
- o impact on overall health care costs
- o impact on utilization of preventive services

--Companies authorized to sell MSA policies consistent with the experimental design, based on an RFP.

--Program could be administered by HHS or a private contractor in cooperation with Treasury.

Option #2

--Time-limited demonstration to sell MSA policies in a small number of

states or geographic areas.

--Strong evaluation component to determine whether MSAs achieve their objectives or result in problems feared by the opponents.

HEALTH INSURANCE BILL - ADDITIONAL PROPOSAL

1) Senate-passed bill with a compromise on Mental Health parity provision.

2) New MSA compromise option

OPTION #3

--MSAs could be offered through health insurance purchasing cooperatives offered under the bill.

--Cooperatives offering MSAs would be required to:

- o Offer a choice of at least one standard insurance policy
- o Utilize a risk-adjustment mechanism between standard and MSA policies

--MSA policies offered would be required to limit allowable deductibles, eg., to \$1,500 per individual or \$3,000 to family and not could not require additional co-payments after deductible was reached

--Five year sunset with evaluation to be conducted by HHS or other appropriate body. Participating insurers and coops would be required to provide data needed for evaluation.

LONDON KASSEBAUM, KARGAS, CHAIRMAN

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NAIC's Compendium of State Laws on Insurance Topics

December, 1995

Mandated Benefits--Summary

FEHBP benefits offered	Mandated Benefit	Number of States Mandating Benefits			
		Mandated Coverage	Mandated Offering	Mandated Coverage Limited*	Mandated Offering Limited*
Yes	Cancer tests ¹	41	3	1	1
Yes	Congenital Defects ²	6	1	0	0
yes	Health Exams ³	16	5	4	0
NO	Infertility Treatment	6	1	5	1
yes	Maternity	6	1	2	1
yes	Mental Illness ⁴	4	4	10	13
yes	Phenylketonuria (PKU)	8	1	3	0
yes	Prosthesis, etc. ⁵	8	2	0	0
yes	TMJ	11	3	0	0
yes	Substance Abuse ⁶	9	2	12	10

NOTE: Mandated coverage requires that insurers must include benefit in the policy or certificate.

Mandated offerings must be offered to subscribers, usually at an additional cost. Some of these requirements only apply to certain types of plans, such as HMOs. These are noted in the 2 righthand columns.

* to Certain types of Policies

¹ In state mandated benefits, cancer screening refers to mammograms, pap smears and in 2 instances, prostate cancer. FEHB screenings include those and in addition include coronary artery disease, and colorectal cancer screening.

² All of the states that mandate congenital defects define it as cleft palate. FEHB defines it more broadly, to include protruding ear deformities, birthmarks, webbed fingers or toes and others that "are a significant deviation from the common form or norm".

³ Health exams includes well baby care. FEHB benefits exceed those mandated by all states, as it covers individuals up to age 22, where as most states only mandate coverage up to 5-12 yrs.

⁴ The mental health mandated benefit in GA, LA, ME, NH, OR, RI, TX appears to exceed that of FEHB. FEHB limits mental health hospitalization to 100 days/yr. with \$150 co-pay per day. The states listed have parity laws for mental health, although NH, ME limit parity to "biologically based" illnesses such as bipolar, schizophrenia, and major depression.

⁵ This includes reconstructive surgery after mastectomy.

⁶ In most states, the mandated benefit is for alcohol only. NJ & TX mandate coverage to same levels as other illness. FEHB limits inpatient care for alcohol and substance abuse to 1-28 day maximum treatment program per life time.

~~CONFIDENTIAL~~

DETERMINED TO BE AN
 ADMINISTRATIVE MARKING
 INITIALS: NT DATE: 6-23-05

Recommended changes to Senate purchasing cooperative section

Replace Sec 131 (3) - Interstate Cooperatives in Senate bill with:

Sec. 131 (3) - Multi-state Cooperatives --

a. General -- For purposes of this section, a multi-state cooperative shall be certified by the Secretary upon demonstration to the Secretary (in such form and manner as shall be prescribed in regulations of the Secretary) that --

(i) such qualified health plan purchasing cooperative operates in a majority of the 50 states and in at least 2 of the regions of the United States,

(ii) the cooperative covers at least 100,000 participants and beneficiaries in each region it operates and,

(iii) the cooperative covers at least 5,000[**too high for small states like VT -- would a percentage be better? What? Goal is to have a significant presence in the state.**] participants and beneficiaries in each State that it operates and,

(iv) the cooperative sells to substantially diverse types of employers and,

(v) the certified cooperative does not exclude from membership any employer, in any State in which it operates, which meets the cooperative membership size maximum.

b. Enforcement -- The Secretary shall make a determination of whether such group meets the requirements of this section in a timely fashion. The Secretary shall inform each State, in which the cooperative operates, of federal certification within 90 days.

c. Definitions-- The term 'region' means any of the following regions:

(i) The East Region, includes the States of Maine, New Hampshire, Vermont, New York, Massachusetts, Rhode Island, Connecticut, New Jersey, Pennsylvania, Delaware, Maryland, West Virginia, Ohio and the District of Columbia.

(ii) The Southeast Region, includes the States of Texas, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Tennessee.

(iii) The Midwest Region, includes the States of Montana, South Dakota, North Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Wisconsin, Michigan, Illinois, and Indiana.

(iv) The West Region, includes the States of Oregon, Washington, Idaho, Nevada, California, New Mexico, Arizona, Wyoming, Hawaii, Alaska, Colorado, and Utah.

Add Section (g) (2)(E) MULTI-STATE COOPERATIVE EXCEPTION**(I) Limited Preemption of State Mandated Benefits Laws --**

(A) In General-- A health plan issued through a certified multi-state cooperative must offer, at a minimum, (i) a benefit package equivalent to the actuarial value of the FEHBP standard Blue Cross option and (ii) specific treatment services that are required in the majority of the States.

(1) Initial Benefit Plan Design Requirements for Multi-State Cooperatives-- Small group reform alternative benefit options enacted by any State within 2 years after enactment of this legislation, in which the multi-state cooperative does business, must be considered by the multi-state cooperative when designing the initial benefits plan offered by health plan issuers for that multi-state cooperative.

(2) Delayed Effective Date of Subsequent Enactment of State Alternative Benefit Plans or Amendments to Existing State Alternative Benefit Plans for Small Group Employers -- A multi-state cooperative must amend the benefit plans offered by health plan issuers of the cooperative to reflect modifications to laws authorizing the issuance of alternative benefit options to small employers, in each State the cooperative operates, every 3 years.

(ii) Cooperatives with Employer Membership Levels Set Above a States Small Group Reform Requirements

(A) Limited Preemption of State Rating Laws - When the majority of a cooperative's employer membership, in each State in which it operates, consists of employers that are not within the States small group reform rating laws and the cooperative sells to individuals, that State retains the option in determining if the State's small group rating law shall apply.

(B) The Secretary shall, in such form and manner prescribe in regulations, rating requirements for health plan issuers in the multi-state cooperative that ensures:

(1) a health plan issuer may reduce premium rates negotiated with a multi-state purchasing cooperative to reflect savings derived from administrative costs, marketing costs, profit margins, economies of scale, or other factors, except that any such reductions in premium rates may not be based on the health status, demographic factors, industry type, duration, or other indicators of health risk of the individual members of the cooperative.

**NEW SECTION: Federal Certification for Existing Multistate Bona-Fide Association Plans
Sec. 131 (4)**

(a) CERTIFYING AUTHORITY

(1) **Multistate Bona-Fide Association Self-Funded Plans** --For purposes of this Act, the Secretary shall be the appropriate certifying authority with respect to a bona fide association plan which is a multistate self-funded health plan.

(b) CAPITAL REQUIREMENTS

(1) **In General** -- The solvency requirements established under paragraph (2) shall, on and after the effective date of such regulations, apply to a plan described in Sec().

(2) Solvency Requirements --

(A) **In General** -- Except as provided in subparagraph (B), the requirements under this paragraph shall be any of the following standards developed by the NAIC within 9 months of the date of enactment of this Act:

- (.I) Solvency standards for bona fide association plans ensure that benefits under such plan be provided in full when due.
- (ii) Rules for monitoring and enforcement compliance with such standards

(B) Failure to Adopt Adequate Standards -- If--

(I) the NAIC does not adopt standards described in subparagraph (A) within the required time period, or

(ii) the Secretary determines, within 30 days of adoption by the NAIC, that the NAIC's standards are not adequate,

the Secretary shall establish such standards not later than 15 months after the date of enactment of this Act and such standards shall constitute the requirements under this paragraph..

(.C) Proof of Involuntary Plan Termination Policy

(.I) **In General** -- The association sponsor shall submit to the Secretary Evidence of the existence of a plan involuntary termination policy. Such termination policy ---

(a) shall be submitted on an annual basis,

(b) shall be issued by

(I) a State licensed insurer; or

(ii) a United States domiciled State licensed captive insurer,

as determined in regulation promulgated by the Secretary;

(c) shall provide each participant or beneficiary 90 days of coverage beyond the date of plan termination; and

(d) shall provide for all outstanding benefit payments covered under the plan.

(ii) Issuance -- The requirements of paragraph (1) may be met through surety bonds, letters of credit, or other appropriate security to the extent provided in regulations issued by the Secretary.

(iii) Coverage-- For purposes of this paragraph () the term 'coverage' means coverage for the same benefits as described in the latest summary plan document.

(d) Availability -- A bona fide association plan may only include in coverage any business or individual who is a member of the association establishing or maintaining the plan, an employee of such member, or a spouse or dependent of either.

(1) Each association employer member shall be treated as maintaining an employee welfare benefit plan on behalf of the plan participants and beneficiaries under the certified multistate bona fide association self-funded health plan.

Sec. 131 (5) Existing Multistate Bona Fide Association Self-Funded Health Plan Defined

(a) In General -- The term "multistate bona fide association self-funded health plan" means a health plan which --

- (1) is (or is a continuation of) an existing plan,
- (2) is established or maintained by a bona fide association, and
- (3) has been in operation continuously since its establishment.

(b) Existing Plan -- For purposes of this section --

(1) In General -- A health plan is an existing plan if--

(A) on May 1, 1996, the plan was a self-funded health plan which on and after the date of enactment of this Act, the plan covers at least 500 lives for a period of not less than 3 years.

(2) Disqualification of Certain Arrangements -- A health plan shall not be treated as meeting the requirements of paragraph (1)(A) if a State demonstrates that--

(A) fraudulent or material misrepresentations have been made by the sponsor in the application,

(B) the arrangement that is the subject of the application, on its face, fails to meet the requirements for a complete application, or

(C) a financial impairment exists with respect to the applicant that is

sufficient to demonstrate the applicant's inability to continue its operations.

(c) **Multistate Bona Fide Association Defined** --For purposes of this section, the term "bona fide association" means organization with respect to which the following requirements are met --

(1) the sponsor of the association is and has been (together with its immediate predecessor, if any) for a continuous period during the 5 year period ending May 1, 1996.

(2) is organized and maintained in good faith by a trade association, an industry association, a professional association, or public entity association, for substantial purposes other than that of obtaining or providing a health plan.

(3) is established as a permanent entity which receives active support of its members'

(4) has a constitution, bylaws, or other similar governing document which specifically states its purpose and provides for periodic meetings on at least an annual basis,

(5) the association collects dues or contributions from its members on a periodic basis, without conditioning such dues or contributions on the basis of health status of the employees of such members or the dependents of such employees or on the basis of participation in a group health plan.

Enforcement Provisions (see Sec. 167 HR 3103)

Cooperation Between Federal and State Authorities (see Sec 168 HR 3103)

Filing and Disclosure (see Sec 169, 170 HR 3103)

THE WHITE HOUSE

WASHINGTON

June 3, 1996

MEMORANDUM TO THE PRESIDENT

FROM:

EO for HR
Carol Rasco and Chris Jennings *CCJ*

SUBJECT:

James Glassman's Medical Savings Account Op Ed Piece

You asked how we would respond to the James Glassman Medical Savings Account (MSA) Op Ed in the Washington Post. This memo responds to the flawed, if not completely inaccurate, claims Mr. Glassman makes in his article.

Glassman Claim: MSAs Promote Cost-Containment. Glassman states that MSAs and their high deductibles will make families smarter health care consumers. He cites the respected RAND Corporation's 1974-82 study on the removal of first-dollar coverage and its effectiveness on cost containment to conclude that "wise shopping -- and judicious use -- should have the effect of limiting increases in health care costs overall."

Response: There is NO evidence that MSAs would produce any more cost constraint than what today's market is achieving through managed care and now prevalent non-first-dollar benefit packages. In fact, in a study that will be released in JAMA in a few days, RAND concludes that MSAs would have absolutely no demonstrable impact on cost containment. This finding, which is based on an elaborate model of the impact of MSAs on the insurance market, is devastating to the advocates of MSAs, particularly since it will come from RAND. (It is important to note that the study, which cannot be cited publicly until it is published, also concludes that the damaging effects of MSAs on the insurance market have been overstated.)

Glassman Claim: Employers Will Foot the Cost of the Deductible.

Glassman says that with MSAs, "your employer puts \$2,000 into an account in your name... In effect, you're spending your own money on health care -- with the kinds of beneficial results that the Rand study predicts."

Response: There is absolutely no requirement that employers will give back to employees all or any of whatever they are saving through the reduced cost of a catastrophic benefit package. Even if one makes the economically valid assumption that employers will maintain their current health care contributions and give back the premium savings to their employees, both the American Academy of Actuaries and the Urban Institute have reported that it is impossible for savings from a high deductible premium to come close to being sufficient to fill the hole left by the deductible. (This is based on a well known insurance principle that reflects the fact that most health care costs are produced by a few, very high-cost consumers.)

6/10/96
6:30pm

June 10, 1996
12:00 Noon

POSSIBLE MSA COMPROMISE

1. Orderly Phase-In of Medical Savings Accounts. Medical Savings Accounts (MSAs) would be available initially to employees in employer-sponsored high deductible plans if the employer has 50 employees or fewer, including the self-employed. MSAs would automatically be extended to employers with more than 50 employees on January 1, 2000, unless Congress acts to delay or repeal the expansion. Expedited procedures would apply to ensure that this measure to repeal or delay the expansion was considered and voted upon in the House and Senate. ~~MSAs would automatically be extended to individuals one year later, on January 1, 2001, unless Congress acts to delay or repeal the expansion. Again, expedited procedures would apply to ensure that this measure to repeal or delay expansion was considered by both the House and Senate.~~ (separate votes for large employers and individuals).

Rationale: This approach would target MSAs to that portion of the employer market where costs are highest and access is most difficult. Therefore, it would provide additional coverage options for small employers and allow for a more appropriate and fair evaluation of the potential advantages and disadvantages of MSAs before extending them to the majority of the market. Employees who work for small employers represent approximately 28 percent of those covered by employer-sponsored health plans.

2. Minimal Consumer Protections. MSAs offered in connection with employer-sponsored high deductible plans would comply with minimal consumer protection standards as a condition of deductibility-- similar to requirements contained in the bill for deductibility of long-term care insurance. First, MSA plans would be required to disclose information about cost-sharing requirements, deductibles, and limitations on coverage, if any, under the plan. This requirement is consistent with general disclosure requirements for small employers already in the bill's portability section and would provide small employers with basic information they need to decide whether to purchase an MSA for their employees. Second, MSA plans could have a maximum deductible of \$5,000 for individuals and \$7,500 for family coverage. ~~The RAND study recently published in the Journal of the American Medical Association found that adverse selection problems are minimized significantly with lower deductible levels.~~ Third, cost-sharing would be no more than 30 percent of the allowed amount for any given service under MSA plans. Because there are no cost-sharing limits under the House MSA proposal, individuals could face substantial payments for medical coverage under a tax-preferred MSA even after they meet or exceed the plan's deductible. Finally, States could impose requirements beyond these minimal standards, and the NAIC would be directed to develop model standards that the States could adopt voluntarily.

(\$5,000 and \$7,500 amounts will be individual for individual)

30% sunset in 5 years)

- 2 -

3. Study On Adverse Selection by Independent Organization. In determining whether to make adjustments and expand the MSA program, Congress would be aided by a study regarding the effects of MSAs on adverse selection. The Chairman of the House Ways and Means Committee and the Senate Finance Committee would request ~~the American Academy of Actuaries, or other independent organization~~ to prepare a study regarding the effects of MSAs in the small group market on adverse selection, health costs, use of preventive care, and consumer choice. This study will be submitted to such Chairman by January 1, 1999.

4. Tax and Structure Changes. Structure and tax changes would be included, as agreed to by Chairmen of House Ways and Means and Senate Finance Committees. Under these proposals: (1) the exemption from the estate tax would be deleted; MSAs would be subject to estate tax under rules similar to individual retirement accounts (i.e., if the beneficiary is not the decedent's spouse, the MSA account balance would be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the MSA); (2) the additional tax on withdrawals for nonmedical purposes would be increased from 10 percent to 15 percent; (3) penalty-free withdrawals for nonmedical purposes could be made after age 65 (instead of after age 59 1/2); (4) in any year in which a contribution is made by an individual to a MSA, withdrawals from MSAs maintained by that individual would not be includible in income only if they are for medical expenses of the individual, and the individual's spouse and dependents, who are covered by a high deductible plan; and (5) the statements of managers would reflect Congressional intent that a high deductible policy is intended to provide meaningful health care coverage and the legislative language would specifically direct the Treasury Department to monitor the market for high deductible policies and report to the Congress if the need for additional anti-abuse rules develops (i.e., if individuals are obtaining high deductible policies that do not provide meaningful health care coverage).

Possible Medical Savings Account Compromise

Summary: Implement a staged, phase-in of Medical Savings Accounts (MSAs), which is preceded with a 3-year demonstration designed to study the potential benefits and problems with MSAs. This study would provide recommendations about the feasibility and advisability of expanding them nationwide. The results of the study, conducted by an independent recognized expert body would be provided to the Congress for its consideration. A fast-track procedure for affirmatively extending MSAs to large employers would require an up or down vote within 90 days of the receipt of the report. If the Congress passes this legislation, an automatic extension to small business occurs unless the Congress rejects it in a fast-track vote. In the third stage, an automatic extension to the individual market occurs unless the Congress rejects it on a similar fast-track vote. At each stage of Congressional consideration of further extension of MSAs, the nationally recognized authority would supplement their first report with recommendations related to the expansion to other markets.

Proposal

Demo: A 3-year demonstration project (similar to Empowerment Zones) would be conducted on the feasibility and advisability of implementing MSAs through the tax code. The tax provisions for the MSA demonstration project would be similar to those in the House-passed health insurance reform bill (except that the favorable tax treatment for MSAs would expire at the end of the study period and certain safeguards would be built into the design of the MSA to minimize adverse effects on health markets, the tax system, and to assure that the high deductible policy provides meaningful health coverage).

State and local governments would compete for 4 separate slots for the MSA demonstration project. At least one slot would be reserved for a rural area. Applications by two or more States would be permitted to create a regional demonstration project. Selections would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Treasury, based on the overall strength of the application. Evaluation of submitted applications would be based on the strength of the experimental design and its ability to measure the effects of MSAs.

In the third year of the demonstration project, an evaluation would be completed by an independent, recognized expert body. The report of this evaluation would be forwarded to Congress with recommendations about the feasibility and advisability of extending MSAs nationwide.

Stage I: When the report is received marking the end of Stage I, a fast-track procedure would be started under which the Congress would have 90 days to consider whether to extend MSAs to large employers (at least 100 full-time employees) nationwide. Any Member could request floor action on the proposal to extend MSAs to all large employers (private businesses, non-profits, and governments). This extension could not take place without being enacted into law in the prescribed time period. In the second year after this extension takes place (if it occurs), a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to smaller employers.

Stage II: When the second report is received (two years after the implementation of the large business MSA), another fast-track procedure would be initiated under which the Congress would consider the extension of MSAs to small employers (under 100 employees). Under this procedure, the extension would take place automatically 90 days after receipt of the Stage II report, unless both Houses of Congress voted to prohibit it. (Any House or Senate Member could request this fast track vote). In the second year after this extension takes place (if it occurs) a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to the individual market.

Stage III: When the third report is received (two years after the implementation of the small business MSA), another fast-track procedure would be started under which the Congress would consider the extension of MSAs to the individual purchaser market. The extension would take place automatically 90 days after receipt of the report, unless both houses of Congress vote to prohibit it. -- (under the procedures outlined in Stage II).

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COUNTER PROPOSAL

1. 4 YEAR EXPERIMENT WITH STUDY AND EVALUATION BY GAO. FIRMS WITH 100 AND LESS, AND THE SELF-EMPLOYED ELIGIBLE FOR MSA PROGRAM.
2. AFFIRMATIVE VOTE REQUIRED FOR EXPANSION OF MSA PROGRAM.
3. AMOUNT OF CONTRIBUTION LIMITED TO \$2,000 FOR INDIVIDUALS AND \$4,000 FOR FAMILIES. CONTRIBUTIONS CAN BE MADE EITHER BY EMPLOYEES OR EMPLOYERS, BUT NOT BOTH.
4. THE FEDERAL GOVERNMENT DOES NOT DICTATE HEALTH BENEFITS NOW AND THIS IS NOT THE TIME TO START. INSTEAD, HIGH DEDUCTIBLE PLANS WOULD BE REQUIRED TO CAP CO-INSURANCE OF ALLOWABLE CHARGES FOR COVERED SERVICES AT 30%. IN ADDITION, THE STATES WOULD BE GIVEN 5 YEARS TO IMPLEMENT MODEL NAIC REGULATIONS FOR THE HIGH DEDUCTIBLE PLANS.

DRAFT**PROPOSED LEGISLATIVE LANGUAGE FOR MEWA DEMONSTRATION PROJECTS**

Amend section 514(b)(6)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) by changing the present paragraph (B) to (B)(i) and adding the following language as paragraph (B)(ii):

(I) In General. The Secretary of Labor shall conduct demonstration projects to assess the feasibility and impact of permitting selected multiple employer welfare arrangements (MEWAs), as defined in section 3(40), to be exempt in whole or in part from State insurance regulation.

(II) Project Objectives.

- Test the administrative feasibility of regulating MEWAs primarily at the Federal level
- Create a sound basis for the evaluation of the impact of the projects on increasing coverage of small firm employees.
- Disrupt as little as possible existing insurance markets.
- Evaluate the impact on State health reform efforts and State insurance regulation of regulating MEWAs primarily at the Federal level

(III) Number and Duration of Projects. There shall be no more than six demonstration projects which will be conducted in locations specified by the Secretary. Several of the entities participating in the projects shall meet the criteria specified in paragraph (IV). The Secretary shall carry out the demonstration projects during the three year period beginning on a date no later than one year after enactment of this Act and may elect to extend the projects for an additional three year period.

(IV) General MEWA Eligibility. MEWAs eligible to apply for participation in the demonstration projects must be sponsored by employer associations and meet criteria established by the Secretary including:

(a) plan sponsor requirements such as the association must:

- (1) have been organized and maintained in good faith for 5 continuous years with a constitution or bylaws;
- (2) exist for purposes other than providing health care coverage;
- (3) have a membership comprised primarily of employers with fewer than 100 employees;

DRAFT

DRAFT

(4) be a permanent entity receiving active support of its members; and

(5) collect dues or contributions from members on a periodic basis without conditioning such amounts on the basis of health status.

(b) financial responsibility which may include requiring insurance (in whole or in part) or reserves, bonding, capital requirements, etc., as appropriate;

(c) the extent to which an association offers or intends to offer health care coverage to geographic areas in which the rate of health coverage for small employers is low;

(d) except for geographic purposes or limitations approved by the Secretary, associations would be prohibited from excluding from participation employers who meet the criteria for participation set forth in their application, and the associations would have to make benefit packages available on an equivalent basis (terms and price) to all of their participating employers; and

(e) participating employers would have to offer the benefit packages on an equivalent basis to all of their employees. The non-purchase of benefits must be at the employee's affirmative election.

(V) Criteria for Certain Multi-State MEWAs

In the selection of entities for participation in a multi-state demonstration project preference will be given to MEWAs that:

(a) have primarily independent small businesses as participating employers;

(b) sell to substantially diverse types of employers; and

(c) do not exclude from membership any employer in any State in which they operate.

The Secretary may limit the multi-state demonstration projects to States and regions deemed feasible for purposes of the projects.

(VI) Data Collection. Participating entities will be required to provide the Secretary with substantial reporting and data. Information to be provided would include financial status and claims data (to be reported quarterly at the end of each year), information on the health coverage arrangement that the entity and/or participating employers had offered prior to applying for acceptance into the program, and extensive data on the price of benefits, benefit packages, and characteristics of enrollees. The information reported would allow for a full impact evaluation.

DRAFT

(VII) Evaluation. The data gathered from the projects shall, at a minimum, be assessed to determine the impact of the projects on the efforts of the States involved to expand health coverage for the uninsured and contain the cost of health insurance for all residents. The results of any assessments shall be contained in the Secretary's report to the Congress.

(VIII) Consultation. The Secretary may consult with the States regarding the participation of any MEWAs that are currently under State regulation.

(IX) Study. In order to fully assess the potential for the delivery of health insurance through MEWAs, including association plans, additional information will be needed concerning MEWAs nationwide. Such information should include, but not be limited to, the number of MEWAs and their respective enrollments. All such plans shall register with the Secretary in a manner prescribed in regulations. The results of this study shall be included in the Secretary's report to Congress.

(X) Report. The Secretary shall submit to the Congress a report on the results of the demonstration projects relating to the expansion of health coverage among small employers, the impact on State health reform efforts and the impact on Federal resources not later than twelve months after the termination of the first three years of the project.

(XI) Authorization. The Secretary is authorized to spend such amounts as necessary to carry out these demonstration projects.

(XII) Appropriations. There is hereby appropriated \$5 million dollars per year for each of the fiscal year from 1997 to 2001 to carry out these demonstration projects.

(XIII) Waiver From Certain Federal Laws. The provisions of the Regulatory Flexibility Act (5 U.S.C. §601 et seq.), Executive Order 12866 (58 FR 51735, October 4, 1993), the Paperwork Reduction Act (44 U.S.C. §3501 et seq.) and the Small Business Regulatory Enforcement Fairness Act of 1996 (Title II, P.L. 104-221, 110 Stat. 857-875, March 29, 1996) shall not be applicable to the demonstration projects.

PROPOSED LEGISLATIVE LANGUAGE AMENDING ERISA SECTION 3(40)

Section 3(40) is amended by adding at the end the following:

"(iv) an entity accepted by the Secretary for purposes of a demonstration project described in section 514(b)(6)(B)(ii)."

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United States Senate

COMMITTEE ON LABOR AND HUMAN RESOURCES

WASHINGTON, DC 20510-6300

TO:

Chris Jennings

FR:

David Nexon

DATE & TIME:

NUMBER OF PAGES:

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3

RETURN FAX NUMBER:

(202) 224-3533

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- BRIAN

MESSAGE:

Please HAND-DELIVER TO CHRIS - *ASAP*

FAX NUMBER:

456 - 7431

PROPOSED COMPROMISE

- 1) Senate-passed bill with a compromise on Mental Health parity provision.
- 2) MSA compromise - one of the following 2 options:

Option #1

--Demonstration with rigorous experimental design, data requirements, and sunset that will provide a fair test of MSAs

--Demonstration could include separate measurement of the program's impact on individual, small business, and large employer market

--Participation in the demonstration limited to the minimum number of people necessary to provide an adequate test of the MSA concept, including such issues as:

- o adverse selection
- o participation by income category
- o impact on cost of conventional policies
- o impact on overall health care costs
- o impact on utilization of preventive services

--Companies authorized to sell MSA policies consistent with the experimental design, based on an RFP.

--Program could be administered by HHS or a private contractor in cooperation with Treasury.

Option #2

--Time-limited demonstration to sell MSA policies in a small number of

states or geographic areas.

--Strong evaluation component to determine whether MSAs achieve their objectives or result in problems feared by the opponents.

HEALTH INSURANCE BILL - ADDITIONAL PROPOSAL

1) Senate-passed bill with a compromise on Mental Health parity provision.

2) New MSA compromise option

OPTION #3

--MSAs could be offered through health insurance purchasing cooperatives offered under the bill.

--Cooperatives offering MSAs would be required to:

- o Offer a choice of at least one standard insurance policy
- o Utilize a risk-adjustment mechanism between standard and MSA policies

--MSA policies offered would be required to limit allowable deductibles, eg., to \$1,500 per individual or \$3,000 to family and not could not require additional co-payments after deductible was reached

--Five year sunset with evaluation to be conducted by HHS or other appropriate body. Participating insurers and coops would be required to provide data needed for evaluation.

MEMORANDUM

June 10, 1996

TO: Distribution
FR: Chris Jennings
RE: Republican MSA Proposal

Attached is the Republican MSA proposal which we received today as well as talking points based on our initial analysis.

Please feel free to give me a call at 6-5560 with any questions or concerns.

Initial Response to the Republican MSA Proposal

- We just received the Republican's latest MSA proposal and have just started the process of reviewing and evaluating it.
- This proposal represents an important step forward from the Republican's previous proposal for a full blown MSA. However, it appears that it does not adequately address the concerns we have previously raised.
- Specifically, the scope and design of the proposed MSA appears to be too broad. Moreover, the proposed procedure of automatically extending MSAs to the remainder of the marketplace without an affirmative vote by the Congress is of significant concern.
- We also want to make sure that the objectivity and legitimacy of any MSA evaluation cannot be called into question. We are concerned that the current outline of the study may fall short in that area.
- We look forward to working with Republicans and Democrats on an appropriate compromise that is acceptable to all parties.

6/10/96
6:30pm

June 10, 1996
12:00 Noon

POSSIBLE MSA COMPROMISE

1. Orderly Phase-In of Medical Savings Accounts. Medical Savings Accounts (MSAs) would be available initially to employees in employer-sponsored high deductible plans if the employer has 50 employees or fewer, including the self-employed. MSAs would automatically be extended to employers with more than 50 employees ~~on January 1, 2000, unless Congress acts to delay or repeal the expansion.~~ *and individuals* Expedited procedures would apply to ensure that this measure to repeal or delay the expansion was considered and voted upon in the House and Senate. ~~MSAs would automatically be extended to individuals one year later, on January 1, 2001, unless Congress acts to delay or repeal the expansion. Again, expedited procedures would apply to ensure that this measure to repeal or delay expansion was considered by both the House and Senate.~~ *(separate votes for large employers and individuals)*

Rationale: This approach would target MSAs to that portion of the employer market where costs are highest and access is most difficult. Therefore, it would provide additional coverage options for small employers and allow for a more appropriate and fair evaluation of the potential advantages and disadvantages of MSAs before extending them to the majority of the market. Employees who work for small employers represent approximately 28 percent of those covered by employer-sponsored health plans.

2. Minimal Consumer Protections. MSAs offered in connection with employer-sponsored high deductible plans would comply with minimal consumer protection standards as a condition of deductibility-- similar to requirements contained in the bill for deductibility of long-term care insurance. First, MSA plans would be required to disclose information about cost-sharing requirements, deductibles, and limitations on coverage, if any, under the plan. This requirement is consistent with general disclosure requirements for small employers already in the bill's portability section and would provide small employers with basic information they need to decide whether to purchase an MSA for their employees. Second, MSA plans could have a maximum deductible of \$5,000 for individuals and \$7,500 for family coverage. *(The RAND study recently published in the Journal of the American Medical Association found that adverse selection problems are minimized significantly with lower deductible levels. Third, cost-sharing would be no more than 20 percent of the allowed amount for any given service under MSA plans. Because there are no cost-sharing limits under the House MSA proposal, individuals could face substantial payments for medical coverage under a tax-preferred MSA even after they meet or exceed the plan's deductible. Finally, States could impose requirements beyond these minimal standards, and the NAIC would be directed to develop model standards that the States could adopt voluntarily.*

(+5,000 and +7,500 amounts will be individual for individual)

30% sunset in 5 years)

- 2 -

3. Study On Adverse Selection by Independent Organization. In determining whether to make adjustments and expand the MSA program, Congress would be aided by a study regarding the effects of MSAs on adverse selection. The Chairman of the House Ways and Means Committee and the Senate Finance Committee would request ~~the American Academy of Actuaries, or other independent organization~~ to prepare a study regarding the effects of MSAs in the small group market on adverse selection, health costs, use of preventive care, and consumer choice. This study will be submitted to such Chairman by January 1, 1999.

4. Tax and Structure Changes. Structure and tax changes would be included, as agreed to by Chairmen of House Ways and Means and Senate Finance Committees. Under these proposals: (1) the exemption from the estate tax would be deleted; MSAs would be subject to estate tax under rules similar to individual retirement accounts (i.e., if the beneficiary is not the decedent's spouse, the MSA account balance would be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the MSA); (2) the additional tax on withdrawals for nonmedical purposes would be increased from 10 percent to 15 percent; (3) penalty-free withdrawals for nonmedical purposes could be made after age 65 (instead of after age 59 1/2); (4) in any year in which a contribution is made by an individual to a MSA, withdrawals from MSAs maintained by that individual would not be includible in income only if they are for medical expenses of the individual, and the individual's spouse and dependents, who are covered by a high deductible plan; and (5) the statements of managers would reflect Congressional intent that a high deductible policy is intended to provide meaningful health care coverage and the legislative language would specifically direct the Treasury Department to monitor the market for high deductible policies and report to the Congress if the need for additional anti-abuse rules develops (i.e., if individuals are obtaining high deductible policies that do not provide meaningful health care coverage).

June 21, 1996

RECOMMENDED TELEPHONE CALL

TO: Senator Edward Kennedy

DATE: June 21, 1996

RECOMMENDED BY: John Hilley

PURPOSE:

To discuss the status of negotiations on a Medical Savings Account compromise and strategy to get the Kennedy/Kassebaum bill enacted.

BACKGROUND:

There have been ongoing negotiations with Republicans in an attempt to achieve an acceptable compromise on MSAs. This issue is the primary road block to getting a bill passed through the Congress with the support of both Democrats and Republicans.

TOPICS OF DISCUSSION:

1. The Senate passed Kennedy/Kassebaum bill is very good for the country and for the Democrats. Obviously, it looks like the price of getting this bill through both houses of Congress is some version of MSAs. However, even though the Republicans will get some credit for the MSAs, the Democrats will get the lions share of the credit.
2. The major challenge for us is to come up with an MSA option both sides can live with. We want to resolve this to get a bill I can sign. Based on discussions with your staff, I am trying to push Senator Lott into agreeing to the following four issues:
 - a. **Limit Enrollment During Experiment.** We need to limit the number of people that can have an MSA during the experiment period. The Department of Treasury estimates that the caps we are proposing will limit the participants to between 500,000 and 1 million people.
 - b. **Require Affirmative Vote.** We want an affirmative vote to expand the program beyond the initial limited number of people. I believe Senator Lott will agree to this as long as there is no need for an affirmative vote for those already in the program during the experiment period to continue in

the program. If we could get the Republicans to agree to caps and vote to expand, I would favor not having a vote to continue the program for those enrolled.

- c. **Guard Against Adverse Selection.** We need to agree on a deductible and out-of-pocket limit to protect against adverse selection. (The higher the deductible the more potential for major problems with healthy populations selecting MSAs and people staying in traditional plans and seeing their premiums increase significantly.)

We are starting the discussion with a \$2,000 limit per individual. The Republicans are at a \$5,000 deductible limit, but they also have no protection against additional out-of-pocket costs above the deductible. I want your feelings on where we should end up and how we get there.

- d. **Ensure Fair Tax Treatment.** We want to ensure a level playing field between the tax treatment of MSAs and traditional health plans. Currently, the Republican plan is giving a tax advantage to MSAs because it allows for a higher tax deductible contribution than what the employee would save in premiums for the purchase of a catastrophic versus a traditional health plan. They are at a \$2,000 limit and we are at a \$1000 limit.

3. Today my staff will be meeting with the House and Senate Republican policy staffs and David Nexon of your staff has been invited. Senator, I need your help. I want to work with you to achieve a health care bill we can all be proud of.

**CONTACT PERSON AND
TELEPHONE NUMBER(S):** White House Operator

DATE OF SUBMISSION: June 21, 1996

ACTION:

Workers and Dependents by Firm Size

- **There are at least 44 million workers and dependents that could be eligible for coverage if firms with 50 or fewer are permitted to participate in MSAs.**
 - 33.5 million adult workers (28.3%) are in firms with 50 or fewer employees. They and their dependents total 43.7 million people. (The total count is low because in dual wage earner families, dependents without their own coverage were assigned to the higher wage earner, who is likely to be in a larger firm.)
 - 21 million workers, 49 percent, have employer-sponsored health coverage.
- **There are at least 145 million workers and their dependents in firms that could be eligible for coverage if firms with more than 50 employees are permitted to participate in MSAs.**
 - 85 million workers are employed in firms with more than 50 employees; with dependents, this group totals 145 million.
 - 115 million, or 80 percent of those workers and dependents, have employer-sponsored coverage.
- **There are 11.7 million self-employed people; with dependents, they total 19.6 million people.**
 - 3.8 million of the self-employed have health coverage.
 - The distribution of the "self-employed" by firm size in the accompanying charts illustrates the problems of defining the term in a way that could not be readily abused. The self-employed associated with larger firms may be owners, partners or independent contractors.

Table 1
Workers and Dependents by Firm Size
 (Millions; Percentages Add Down Columns)

Firm Size	Workers*	Workers & Dependents**	Self-Employed Workers***	Self-Employed Workers and Dependents*	Total Workers*	Total Workers and Dependents*
<10	17.8	20.1 (10.6%)	9.3	16.3 (82.7%)	27.1	36.4 (17.4%)
10-24	10.5	15.2 (8.0%)	0.9	1.7 (8.6%)	11.4	16.9 (8.1%)
25-49	5.2	8.4 (4.4%)	0.2	0.4 (2.0%)	5.4	8.8 (4.2%)
50-99	10.4	16.8 (8.9%)	0.4	0.7 (3.6%)	10.8	17.5 (8.4%)
100-249	17.7	29.9 (15.9%)	0.3	0.3 (1.5%)	18.0	30.2 (14.6%)
250-999	7.4	12.4 (6.6%)	--	0.1 (0.5%)	7.4	12.5 (6.0%)
1000+	49.5	86.0 (45.6%)	0.4	0.2 (1.0%)	49.4	86.2 (41.4%)
<50	33.5	43.7 (23.1%)	10.5	18.3 (92.9%)	44.0	62.0 (29.7%)
50+	85.0	145.1 (76.9%)	1.2	1.3 (7.1%)	86.2	146.4 (70.3%)
<100	43.7	60.5 (31.9%)	10.9	19.0 (96.9%)	54.8	79.5
Total	118.5	189.8 (100%)	11.7	19.6 (100%)	130.2	209.4 (100%)

* "Workers" does not include dependent children who work.

**In 2+ worker families, dependents are assigned to the firm size of the highest paid worker.

*** "Self-employed" is self declared on CPS. People who are "self-employed" in larger firms may be owners, partners or independent contractors working for a firm.

Source: 1995 CPS

Table 2
Covered Workers and Dependents by Firm Size
 (Millions)

Firm Size	Workers*	Workers & Dependents**	Self-Employed Workers***	Self-Employed Workers and Dependents*	Total Workers*	Total Workers and Dependents*
<10	4.2	7.9	2.8	5.9	7.0	13.8
10-24	4.2	7.9	0.5	1.2	4.7	9.1
25-49	2.9	5.6	0.1	0.3	3.0	5.9
50-99	5.9	11.3	0.2	0.5	6.1	11.8
100-249	11.9	23.2	0.1	0.2	12.0	23.4
250-999	5.3	10.1	--	--	5.3	10.1
1000+	35.9	70.7	0.1	0.1	36.0	70.8
<50	11.3	21.4	3.4	7.4	14.7	28.8
50+	60.0	115.4	0.4	1.0	60.4	116.4
<100	17.2	32.7	3.6	7.9	20.8	40.6
Total	71.3	136.8	3.8	8.4	75.1	145.2

* "Workers" does not include dependent children who work.

**In 2+ worker families, dependents are assigned to the firm size of the highest paid worker.

*** "Self-employed" is self declared on CPS. People who are "self-employed" in larger firms may be owners, partners or independent contractors working for a firm.

Source: 1995 CPS

Table 3
Covered Workers and Dependents As Percentage of Total, by Firm Size
 (Table 2 Divided by Table 1)

Firm Size	Workers*	Workers & Dependents**	Self-Employed Workers***	Self-Employed Workers and Dependents*	Total Workers*	Total Workers and Dependents*
<10	23.6%	39.3%	30.1%	36.2%	25.8%	37.9%
10-24	40.0	52.0	55.6	70.6	41.2	53.8
25-49	55.8	66.7	50.0	75.0	55.6	67.0
50-99	56.7	67.3	50.0	71.4	56.5	67.4
100-249	67.2	77.9	33.3	66.7	66.7	77.8
250-999	71.6	82.3	--	--	71.6	81.6
1000+	72.5	82.2	25.0	50.0	72.9	82.1
<50	33.7	49.0	32.7	40.2	33.4	46.4
50+	69.4	79.6	36.4	76.9	70.0	79.6
<100	39.4	54.0	33.0	41.6	40.0	51.0
Total	59.3	72.5	33.0	42.6	57.7	69.7

* "Workers" does not include dependent children who work.

** In 2+ worker families, dependents are assigned to the firm size of the highest paid worker.

*** "Self-employed" is self declared on CPS. People who are "self-employed" in larger firms may be owners, partners or independent

MSA OPTIONS

Options include: (1) Limit allowable policies; (2) Limit conditions under which policies could be sold; (3) cap losses to Treasury

(1) Limit allowable policies

- o limit deductible to no more than \$1,500
- o prohibit cost-sharing beyond deductible (or after \$1,000 in expenses beyond the deductible are reached)
- o Prohibit life-time and annual caps
- o Limit total amount in msa to three times deductible
- o Raise the penalties for withdrawal for non-medical purposes

(2) Limit conditions under which policies could be sold

- o Require guaranteed issue and community rating for any policies sold
- o Move self-employed into the individual market
- o Require insurer to offer both msa and conventional policy to employer; require employer to offer both policies to employees; require insurer to risk-adjust the premium
- o Allow policies to be sold only in states that legislate a risk-adjustment program. Most States already have risk-adjustment (modified community rating) program for small business coverage, which would need to be modified.

(3) Cap losses to Treasury--If tax expenditures exceed estimated amounts, reduce tax benefits of MSA (i.e. not allow 100% deductibility).

This is consistent with Republicans own Medicare proposal, which caps program spending at level written into Reconciliation bill.

from the office of
Senator Edward M. Kennedy
of Massachusetts

**STATEMENT OF EDWARD M. KENNEDY ON THE REPUBLICAN PROPOSAL ON
MEDICAL SAVINGS ACCOUNTS**

**For Immediate Release:
June 12, 1996**

**Contact: Jim Manley
(202)224-2633**

The Republican so-called "compromise" on medical savings accounts is no compromise at all. It's a capitulation to House Republicans who are more interested in serving the special interests in the insurance industry than in passing needed health reforms.

The letter released today has the support of 50 groups who speak for the public interest. It demonstrates the broad-based opposition to enacting medical savings accounts, before that controversial idea is fairly tested. The letter is written on behalf of working families, senior citizens, health care providers, the disabled, and consumers. They are the ones who have the most to lose if the current system of broad-based insurance is fragmented by medical savings accounts.

Who do we trust -- the American people, or the very insurance companies who are the worst abusers of the current system and who stand to profit most if medical savings accounts are imposed on the American people?

The House Republican leadership pretends their proposal is a fair attempt to deal with medical savings accounts. But it is nothing of the kind. Under their proposal, medical savings accounts could be sold immediately to all small business and the self-employed. That means MSAs would be available to a massive market of more than 40 million Americans -- one third of the nation's entire labor force. That's not a test -- it's a travesty.

-MORE-

KENNEDY ON MSA 2-2-2

We know that the small business health insurance market is especially vulnerable to the disruption that medical savings accounts would cause. Many states have been achieving progress in recent years in making health insurance more accessible and affordable to small business. Medical savings accounts could undo all that hard-won progress. It would be irresponsible for Congress to take that chance.

The great danger of medical savings accounts is that they will fragment the health insurance pool, siphon off the healthy and wealthy, and price conventional insurance out of reach for large numbers of American families. Medical savings accounts contradict the bedrock insurance principle of shared risk.

They will raise premiums for the vast majority of Americans -- especially those who are sick and need coverage the most. As premiums rise, more and more working families will be forced to drop their coverage, and the current worsening crisis of the uninsured will become even more severe.

The Kassebaum-Kennedy bill passed the Senate by a bi-partisan vote of 100-0, without medical savings accounts. It passed unanimously because it contained the non-controversial, bi-partisan, health insurance reforms that everyone has agreed on to make insurance portable and to reduce exclusions for pre-existing conditions.

The American people deserve to have these basic consensus reforms enacted now -- not jeopardized by the last-minute addition of this partisan Republican poison pill. Our task is to pass this bill, not kill it.

June 12, 1996

The President of the United States
William Clinton
The White House
Washington, DC 20500

Dear Mr. President:

We are writing to express our strong opposition to the modified health insurance reform legislation presented by the Republican leadership on June 10. While we are pleased that a number of anti-consumer provisions are not included in this modified bill, the addition of phased-in Medical Savings Accounts (MSAs) transforms the original legislation from a modest step in the right direction into a step backward for health care consumers.

The Kassebaum-Kennedy bill, as originally drafted, would have provided welcome improvements to the health care marketplace by severely restricting insurers' ability to impose pre-existing condition restrictions and by assuring consumers that they would not lose their health coverage when they change jobs. The underlying principle behind the legislation was that of *expanding* health care coverage by keeping people in the risk pool -- healthy and sick alike -- so that a broad community of consumers can spread the risk and share the cost.

The MSA proposal turns the very principle of spreading the risk on its head. Starting with the self-employed and small employers, the proposal would divide the community into groups of healthy and sick. MSAs will appeal primarily to the healthy, who will benefit financially by setting up accounts that are not needed to pay doctors' bills. The more people opting for MSAs, the fewer premium dollars will be available to pay doctors' and hospitals' bills for the sick. Ultimately, premiums will skyrocket for employers and self-employed people wanting traditional low-deductible coverage. Many will have no option but an MSA and high-deductible policy.

The so-called compromise proposal would then expand the MSA option to everyone in just 3 years, before the full impact of the first phase is known. Expansion would be virtually automatic, since the proposal would alter the Senate rules through "expedited procedures" that would decrease the prospects for adequate debate.

Consumers of MSAs under this proposal would be inadequately protected. They would have no assurance of any employer contribution to their insurance premium or their MSA. There is no cap on out-of-pocket costs for people with a high-deductible plan, nor any restrictions on insurers' ability to limit lifetime benefits. There is no assurance that the high deductible policies will offer comprehensive benefits, no guarantee that the self-employed will qualify for an insurance policy in an MSA plan, and no assurance that premiums will be fair. High deductible plans would be free to charge 30 percent co-insurance, even after the deductible is met.

June 12, 1996

Page 2

Therefore, we urge you to reject the June 10 compromise and to go back to the bill that was reported out of the Senate Labor and Human Resources Committee on April 18, as modified by the Manager's perfecting amendment. Only by rejecting this MSA proposal -- and any similar so-called "demonstrations" -- can Congress assure American consumers that modest health care reform will do more good than harm.

Sincerely,

AIDS Action Council
American Association on Mental Retardation
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Network of Community Options and Resources
American Nurses Association
American Public Health Association
American Speech-Language-Hearing Association
Brain Injury Association
Center for Women & Policy Studies
Center on Disability & Health
Church Women United
Citizen Action
Committee for Children
Consumers Union
Council for Exceptional Children
Gay Men's Health Crisis
General Board of Church & Society; The United Methodist Church. Ministry of God's Human Community
Gray Panthers
International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers (IUE)
Justice for All
National Asian Pacific Center on Aging
National Association of Developmental Disabilities Council
National Association of People with AIDS
National Association of Protection & Advocacy Systems, Inc.
National Association of Psychiatric Treatment Centers for Children
National Association of School Psychologists
National Black Women's Health Project
National Caucus & Center on Black Aged
National Council of Senior Citizens
National Education Association
National Episcopal AIDS Coalition
National Farmers Union

June 12, 1996

Page 3

National Gay & Lesbian Task Force
National Hispanic Council on Aging
National Minority AIDS Council
National Osteoporosis Foundation
National Puerto Rican Coalition
National Senior Citizens Law Center
National Task Force on AIDS Prevention
National Therapeutic Recreation Society
National Women's Health Network
Neighbor To Neighbor
NETWORK: A Catholic Social Justice Lobby
Service Employees International Union
The ARC
UAW
United Church of Christ, Office for Church in Society
United Food and Commercial Workers International Union
United Mine Workers of America