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# THE URBAN INSTITUTE

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## Urban Institute Analyses of Medical Savings Accounts

Marilyn Moon, Len Nichols, and Susan Wall

We have released two working papers in the last six weeks after more than a year of thinking, writing shorter articles, and speaking about the issues involved. Both are available in their entirety to the public on the Urban Institute's world wide web page (<http://www.urban.org>, check under Hot Topics and health insurance market reform), or by calling the Public Affairs Office, 202-857-8702.

The first paper, "**Medical Savings Accounts, A Policy Analysis,**" focused on how MSAs might work in practice, how they interact with other insurance and reforms, and what issues are particularly relevant for state policies on MSAs.

In that paper we reached two basic conclusions: (1) state tax rates are sufficiently low that federal action will be required to encourage significant numbers of people to adopt MSAs and the catastrophic health insurance plans that go with them; (2) MSAs, because they are likely to further segment health insurance risk pools, are antithetical to other state reforms which attempt to increase the amount of pooling in small group and individual markets (guaranteed portability, limits on pre-existing condition restrictions, guaranteed renewability, guaranteed issue, modified community rating). These concerns are also relevant to the Kassebaum-Kennedy bill passed by the Senate.

The second paper, "**Tax-Preferred Medical Savings Accounts and Catastrophic Health Plans: A Numerical Analysis of Winners and Losers,**" used nationally representative data, microsimulation, and econometric techniques to address four specific questions: (1) how much might MSAs reduce total health spending; (2) who would win and lose, and how much, if all workers switched to MSAs from comprehensive plans; (3) how would premiums of comprehensive plans be affected if employers offered MSAs as a choice; (4) how would workers and firms likely respond to all of this?

All numerical estimates of MSAs are uncertain, requiring assumptions and judgment in any quantitative analysis. Simulations are necessary since there are few MSA/catastrophic plans now in existence and no publicly available data on them. Our exact methods are detailed in the appendix to the paper. No single number is highly accurate, but rather suggestive, more useful for comparisons than specific claims. The conclusions from our analysis are:

▶ Premiums for catastrophic plans will be lower than comprehensive premiums, but by substantially less than the difference in deductibles, even though use of services would decline with the higher deductible. Therefore, the likely employer contribution to the MSA will not cover the full amount of the higher catastrophic deductible. This conclusion was also reached by the American Academy of Actuaries.

▶ Because most people are healthy in any given year, roughly 3/4 of workers would gain financially if required to switch into MSA/catastrophic arrangements.

▶ The financial "winners" from switching to MSA/catastrophic plans would be younger and healthier than the losers.

▶ Workers are likely to be able to predict if they would gain from MSAs, leading to favorable selection into MSA/catastrophic plans in the long run.

▶ Because of this favorable selection, comprehensive indemnity premiums would increase if MSAs are offered as an option, perhaps considerably. Our most likely scenario, like the American Academy of Actuaries' simulation, is about a 60% increase. This will make it hard for firms to continue to offer comprehensive indemnity plans alongside MSA/catastrophic plans.

▶ Competition between managed care plans and MSA/catastrophic plans is more difficult to predict. Evidence suggests that managed care plans attract good health risks as well, making it difficult to simulate behavior about this complex choice.

▶ MSAs present a classic tradeoff that only political judgment, not numerical analysis, can resolve. The relatively healthy many would gain at the expense of the relatively sick few. Since the healthy could get sick someday, this choice is not a simple one.



Health Insurance Association of America

## MEMO

**To:** Chris Jennings  
**From:** Laura I. Thevenot  
**Date:** May 17, 1996  
**Subject:** Follow-up from our Meeting

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Enclosed are the items you requested at our meeting earlier:

- A paper that deals the differences between MEHPS and VHIA's;
- A listing of mandates in potential conferee states;
- The most recent duplication language.

On the duplication language, the retroactivity language was written with NAIC input, and we believe it is narrowly crafted to only allow relief with respect to a cause of action based on the current duplication provisions, not on unrelated fraud or other causes. It is also our understanding, from Ways and Means staff that the NAIC has informally signed off on the disclosure notices. They were changed yesterday to reflect a number of their concerns. We will follow up with Bridgett Taylor to make sure they are comfortable with the new language.

With regard to some of the points you mentioned on long-term care, Carolyn Boyer, HIAA's Washington Counsel, has been in contact with Treasury. She will follow up with Mark Iwry on the concerns you raised.

If you need any additional information, please do not hesitate to give me a call.



Health Insurance Association of America

## **HOUSE PURCHASING GROUPS WILL HARM INSURANCE MARKETS FOR SMALL EMPLOYERS**

H.R. 3103 grants marketplace advantages to multiple employer health plans (MEHPs) and voluntary health insurance associations (VHIAs) which would significantly disrupt small employer health insurance markets. The Senate's S.1028 purchasing cooperative provisions are far preferable for assuring that small businesses can join together to realize economics-of-scale in purchasing health insurance.

### **MULTIPLE EMPLOYER HEALTH PLANS (MEHPs)**

The bill encourages small employers to obtain self-insured health benefits through MEWAs called MEHPs, which would be exempt from all State insurance regulation. The less comprehensive Federal standards which the bill imposes provide insufficient financial solvency and consumer protections, exposing the MEWA's participating employers and employees to significant financial risks in the event of MEWA insolvency.

Furthermore, it is highly unlikely that the Labor Department will have sufficient resources to develop an effective regulatory presence throughout the country. (A recent Georgia State University study estimated resource requirements at a minimum of \$1.6 billion over a 7-year budget cycle.)

### **VOLUNTARY HEALTH INSURANCE ASSOCIATIONS (VHIAs)**

VHIAs pose fewer consumer threats than MEHPs, in that VHIAs are required to offer insured health plans only. However, the preemptions from State mandated benefit laws and small group rating requirements granted to VHIAs will foster market segmentation, undermining State small group reforms. In addition, the bill's multi-tiered regulatory structure for VHIAs will perpetuate the confusion surrounding MEWA regulation, rather than eliminate it as the bill's authors intended.

### **INAPPROPRIATE MARKETPLACE ADVANTAGES**

A new GAO study confirms that mandated benefits are costly. There is no rationale for relieving just one segment of the market from the burden of mandates. Federal legislation should preempt State mandated benefits for all group coverage.

California

Mandated Benefits:

Adopted Children

Alcoholism

Allied Practitioners:

Acupuncturists

Chiropractors; dentists; podiatrists; dispensing opticians; psychologists; optometrists; occupational therapists; speech pathologists and audiologists (optional); registered psychiatric-mental health nurses on referral of physician. Clinical social workers.

Dieticians: as an alternate to an exclusion. Does not require insurers to automatically pay for such services.

Marriage, family and child counselors upon referral of physician or surgeon.

Osteopaths

Podiatrists Psychologists; chiropractors; physical therapists; optometrists.

Respiratory care practitioners upon referral of physician.

Licensed midwives.

Children's Preventive Care

well child care for children 17 and 18 years of age.

Drug Addiction

Handicapped Children

Infertility/In Vitro Fertilization

Mammography/Mastectomy

Maternity and Complications of Pregnancy

Mental Illness

Newborn Children

Miscellaneous

Cancer Screening: cervical cancer

Diabetic Education:

Elderly Coverage:

Hospitals:

Medical Transportation Services:

Nicotine Use:

Orthotic/Prosthetic Devices:

Prisoner Coverage:

Prosthetic Devices/Laryngectomies:

Sterilization:

Temporomandibular Joint Disorder

Delaware

Mandated Benefits:

Allied Practitioners

Advanced registered nurses or nurse practitioners

Chiropractors.

Nurse midwives

Optometrists.

Podiatrists

Physical therapists

Mammography/Mastectomy

Newborn Children

FLORIDA

Mandated Benefits:

- Adopted Children
- Alcoholism
- Allied Practitioners
- Acupuncturists
- Ancillary Services (including pathologists, radiologists, anesthesiologists)
- Chiropractors.
- Podiatrists-HMOs.
- Child health supervision services
- Dentists included in definition of physician; podiatrists; optometrists; chiropractors (optional). U627.419 (10/1/74; amd. 1981 & 1982)
- Massage therapists
- Optometrists, nurse anesthetists--HMOs.
- Physician assistants
- Physical therapists.
- Children's Preventive Care
  - immunization for Hepatitis B vaccines as appropriate.
- Drug Addiction
- Handicapped Children
  - Severe disability, including spinal cord disease/injury resulting in permanent and total disability; amputation of extremity which requires prosthesis; permanent visual acuity of 20/200 or worse; neurosensory deafness--cannot refuse but need not cover handicap already sustained.
- Mammography/Mastectomy
- Maternity and Complications of Pregnancy
- Mental Illness
- Newborn Children including premature birth.
- Surgical Centers
- Miscellaneous

Limited Mandated Benefit Packages

Requires coverage for enteral formulas for the treatment of inherited diseases of amino acid, organic acid, carbohydrate fat metabolism and malabsorption not to exceed \$2,500 annually. Allows insurers to charge an additional premium for such coverage. Diabetics.

GEORGIA

Mandated Benefits:

Adopted Children  
Alcoholism  
Allied Practitioners  
Applied psychologists; chiropractors.  
Dentists.  
Optometrists  
Podiatrists.  
Drug Addiction  
Handicapped Children  
Mammography/Mastectomy  
Maternity and Complications of Pregnancy -  
48 Hour maternity hospitalization  
Mental Illness  
Newborn Children  
Surgical Centers  
Miscellaneous  
College Students: Contract shall continue coverage of  
dependent child until 25  
Heart Transplants:  
Temporomandibular Joint Disorder

ILLINOIS

Mandated Benefits:

Adopted Children  
Alcoholism  
Allied Practitioners  
Dentists.  
Osteopaths; chiropractors.  
Optometrists--if optometric services covered.  
Osteopathic and Allopathic Healthcare Discrimination Act to  
accord equal professional status and privileges as is granted  
to physicians.  
Podiatrists.  
Psychologists.  
Drug Addiction  
Handicapped Children  
Infertility/In Vitro Fertilization  
Mammography/Mastectomy  
Maternity and Complications of Pregnancy  
Mental Illness  
Newborn Children  
Miscellaneous  
Ambulance Service: HMOs  
Breast Implants: Removal of breast implants when medically  
necessary treatment for sickness or injury.  
Organ Transplants:  
Outpatient Services: HMOs - outpatient diagnostic and imaging,  
pathology services and radiation therapy.  
Rape Victim: testing or treatment of victim of rape  
Rehabilitative Therapy: HMOs  
Tuberculosis Sanitarium:  
Temporomandibular Joint Disorder

## KANSAS

### Mandated Benefits:

- Adopted Children
- Alcoholism
- Allied Practitioners
- Optometrists; dentists; podiatrists
- Chiropractors\*.
- Psychologists\*.
- Specialist clinical workers.
- Specialist social worker.
- Certified EMS attendants and ambulance services
- Advanced registered nurse practitioners in certain counties
- Licensed psychologists
- Children's Preventive Care
- Drug Addiction
- Mammography/Mastectomy
- Maternity and Complications of Pregnancy
- Mental Illness
- Newborn Children
- Miscellaneous
- Pap Smears:

### Limited Mandated Benefit Packages

Well Child Care: birth to 36 months of age (immunizations)

Other Benefits: Part I catastrophic coverage begins at \$5000 for individuals and \$7500 for families; Part II coverage consists of optional benefits

## MISSISSIPPI

### Mandated Benefits:

- Alcoholism
- Allied Practitioners
- Chiropractors.
- Dentists.
- Nurse Practitioners.
- Optometrists.
- Psychologists.
- Clinical social workers or professional counselors
- Handicapped Children
- Mental Illness
- Newborn Children
- Miscellaneous
- Temporomandibular Joint Disorder

OHIO

Mandated Benefits:

Adopted Children  
Alcoholism  
Allied Practitioners  
Dentists.  
Mechanotherapists--group.  
Nurse midwives  
Osteopaths; optometrists; chiropractors; podiatrists.  
Psychologists.  
Children's Preventive Care  
Mammography/Mastectomy  
Maternity and Complications of Pregnancy  
Mental Illness  
Newborn Children  
Miscellaneous  
Kidney Dialysis:  
Noncustodial Children:  
Pap Smears:

OKLAHOMA

Mandated Benefits:

Adopted Children  
Allied Practitioners  
Certified clinical social workers.  
Optometrists.  
Podiatrists; psychologists.  
Psychologists.  
Right of insured to select any practitioner of healing arts.  
Licensed practitioner, at option of insurer, may be compensated directly when benefits are assigned and on file and claims are processed on standard AMA forms and a duplicate copy of bill has been sent to insured.  
Osteopaths, chiropractors, podiatrists, optometrists, dentists.  
Handicapped Children  
Home Health Care  
Mammography/Mastectomy  
Maternity and Complications of Pregnancy  
Newborn Children  
Surgical Centers  
Miscellaneous  
Christian Science Care and Treatment:  
Off Label Use Drugs:

TEXAS

Mandated Benefits:

Adopted Children

Alcoholism

Allied Practitioners

Osteopaths; chiropractors; podiatrists; dentists; optometrists.

Psychologist services--group.

Psychologists

Audiologists, speech language pathologists; certified social workers-advanced clinical practitioners.

Licensed dietitians or provisional licensed dietitians under such supervision when recommended by doctors of medicine or osteopathy.

Professional counselors.

Marriage and family therapists.

Chemical Dependency Counselors.

Licensed Psychological Associates.

Drug Addiction

Handicapped Children

Infertility/In Vitro Fertilization

Mammography/Mastectomy

Maternity and Complications of Pregnancy

Mental illness including hospital, surgical and medical

benefits, expense incurred service or prepaid basis must

offer coverage for the necessary care, diagnosis and

treatment of serious mental illness. Mental illness

includes: schizophrenia, paranoia, and other psychotic

disorders, bipolar disorders, major depressive disorders, and schizo-affective disorders.

Newborn Children

Miscellaneous

Alzheimer's Disease:

Dependent Children/Grandchildren:

Noncustodial Children:

Orthodontics:

Phenylketonuria:

Temporomandibular Joint Disorder

VIRGINIA

Mandated Benefits:

Adopted Children  
Alcoholism  
Allied Practitioners  
Chiropractors; optometrists; opticians; psychologists;  
podiatrists; clinical social workers.  
Dentists.  
Physical therapists; professional counselors.  
Clinical nurse specialists, audiologists, speech pathologists.  
Children's Preventive Care  
Drug Addiction  
Handicapped Children  
Mammography/Mastectomy  
Treatment of breast cancer by  
dose intensive chemotherapy or autologous bone marrow  
transplant or stem cell transplants.  
Maternity and Complications of Pregnancy/  
48 Maternity Hospitalization  
Individual disability income contracts must allow at least one  
month's coverage for disability arising out of pregnancy,  
childbirth or miscarriage.  
Inpatient postpartum treatment in compliance with ACOG  
guidelines. Home visits.  
Mental Illness  
Newborn Children  
Miscellaneous  
PAP Smears  
Mental Illness - specified outpatient mental health and  
substance abuse services.  
Temporomandibular Joint Disorder

HMOs

For covered female age 13 and older -- direct access to the  
health care services of a participating OBGYN for an annual  
examination. Allows insurers to require participating OBGYNs to  
provide written notice to the insured's primary care physician of  
any visit to the OBGYN.

**National Conference of State Legislatures  
National Association of Insurance Commissioners**

May 8, 1996

The Honorable Bob Dole  
Senate Majority Leader  
United States Senate  
S-230 Capitol Building  
Washington, D.C. 20510

The Honorable Newt Gingrich  
Speaker of the House  
H33, The Capitol  
Washington, D.C. 20510

Dear Senator Dole and Mr. Speaker:

On behalf of the National Conference of State Legislatures ("NCSL") and the National Association of Insurance Commissioners' ("NAIC") Special Committee on Health Insurance ("NAIC Committee"), we are writing to express our views relating to H.R. 3103 and S. 1028, recently passed by the U.S. House of Representatives and the U.S. Senate, respectively.

The NCSL is a bipartisan organization created to serve the legislators and staffs of the nation's 50 states, its commonwealths and territories, and the District of Columbia. The NAIC, founded in 1871, is our nation's oldest association of state officials. Its 55 members are the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S. territories. The NAIC Committee, which consists of 37 of the states' chief regulatory officials, was established by NAIC members to review federal health insurance initiatives affecting state insurance regulation.

We believe that the Conference Committee, once appointed to resolve the differences between the proposals, will have a tremendous opportunity to approve legislation to enhance consumer protections and portability in health care coverage. However, the conferees will also have to resolve a significant difference between the two bills in the area of state authority over insurance as they attempt to reconcile two vastly different approaches to employer group purchasing arrangements.

Commendably, the broad outlines of the federal portability standards within both H.R. 3103 and S. 1028 reflect, and thereby acknowledge, the efficacy of already existing state reforms. *However, the acceptance in conference of Title I, Subtitle C of H.R. 3103 would, at best, severely undermine, and at worst, potentially eviscerate the historic role of the states as regulators, innovators and implementors of health insurer solvency, market conduct and health insurance reform policy.* We respectfully request that Congress continue to be mindful of the ability of the states to experiment with novel solutions to new and developing problems in the areas under their jurisdiction and reject this section of H.R. 3103 in conference. Such an action would be consistent with the articulated goals of the 104th Congress to minimize the centralization of governmental authority in a large, expensive federal bureaucracy. The states have demonstrated, and continue to demonstrate, responsiveness and concern for the insurance marketplace and its consumers. States must be able to continue in this important role.

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As detailed herein, the acceptance of H.R. 3103's sweeping and preemptive provisions relating to self-funded Multiple Employer Welfare Arrangements ("MEWAs") and Voluntary Health Insurance Associations ("VHIAs" -- a type of fully-insured MEWA) would have a deleterious effect on the integrity and force of state insurance regulation, consumers and, the insured marketplace. Such a decision should not be taken lightly. These provisions are, at their core, utterly inconsistent with a philosophy supportive of the states' efforts and authority relating to health insurance.

In this letter, we would like to emphasize the following nine points:

- The extension of portability reforms to beneficiaries of self-funded health care plans governed by the federal Employee Retirement Income Security Act ("ERISA"), a concept contained in both H.R. 3103 and S. 1028, would significantly enhance consumer protections in the area of health insurance reforms.
- H.R. 3101's provisions relating to MEWAs preempt state authority over those entities, including solvency regulation and, as to both MEWAs and VHIAs, undercut state authority and flexibility in the area of health insurance reform, would harm consumers, and should be rejected in favor of Section 131, Subtitle D of Title I of S.1028, "Private Health Plan Purchasing Cooperatives".
- The "savings" provisions added to the final H.R. 3103's MEWA and VHIA provisions *appear* to preserve state authority and certain state reforms; however, these "savings" are severely curtailed by complex layers of exemptions from these "savings" provisions and ambiguous legislative provisions that could be gamed.
- The legislation must clearly protect the states' ability to go further, and continue to innovate, in the area of health insurance reform.
- If the conferees accept H.R. 3103's provisions relating to administrative simplification, the interrelationship with, and effect upon, state laws addressing data collection and confidentiality of health information should be clear and state flexibility retained.
- The legislation should clearly set forth the types of state individual market reforms that meet the legislation's requirements. Objective criteria, as contained within S. 1028, best guarantee that the minimum federal standards will not have a chilling effect on state reforms of the individual market.
- We continue to recommend limited amendments to current provisions relating to Medicare anti-duplication to allow policies that sell long-term care benefits exclusively to coordinate their benefits with Medicare.
- The provisions governing the tax-deductibility of, and consumer protections for, long-term care insurance should clearly protect the states' ability to enact more stringent requirements to enhance consumer protections in the area of long-term care insurance.
- State enforcement authority in the area of health insurance should be retained, except in instances where states fail to *substantially* enforce the applicable standards.

#### **Important Extension of Consumer Protections and Portability Reforms**

We commend the provisions in both S. 1028 and H.R. 3103 that extend portability and other reforms to individuals covered by self-funded health care plans governed by ERISA. As you are aware, these reforms are already available to most beneficiaries of insured products. The NCSL and the NAIC have long called for a more "level playing field" in the marketplace in this area. We believe that the core of the group-to-group portability provisions within both bills will benefit many consumers who currently suffer from "job-lock" or the reimposition of preexisting condition limitations when they have responsibly maintained continuous health care coverage. In addition, the underlying structure and goals

The Honorable Bob Dole and Newt Gingrich

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of the provisions in both bills relating to portability from the group to individual market appear to attempt to preserve state flexibility in this area while also attempting to ensure meaningful coverage options.

However, as noted below, each bill's portability provisions are drafted somewhat differently and have the potential to interact with state laws in a different, and in some instances preemptive, fashion, even if that was not the intent. As the conferees discuss and negotiate several larger policy differences between the bills, we hope that attention will be paid to some of the more "technical" differences between the bills which have significant consequences. We continue to offer to help work with you toward the goal of setting clear, minimum federal standards which do not seriously alter, or place into jeopardy, states' existing authority over insurance.

### **Damaging Effects of Provisions Relating to MEWAs and VHIA's**

H.R. 3103 and S. 1028 take very different approaches to the issue of employer group purchasing arrangements. The contrast between the bills' approaches on this issue is striking and of momentous import to consumers and state authority over the health care insurance market. S. 1028's provisions relating to private health plan purchasing cooperatives would largely complement state authority over health insurance and state insurance reform efforts. In contrast, H.R. 3103's MEWA and VHIA provisions would significantly undermine state authority and state-level solvency and consumer protections in the area of health insurance, as well as state-level insurance reform efforts. *As we have stated in the past, we strongly oppose Subtitle C of Title 1 of H.R. 3103.*

Notably, the final provisions in the House bill in this area contain several differences from the original H.R. 995. At first glance, the final language appears to attempt to save certain state reforms. However, the final language contains ambiguities and a confusing series of exemptions. This labyrinth guarantees, and at worst might be read to obfuscate, its net effect: the provisions do not meaningfully preserve state authority and reforms. We would welcome the opportunity to discuss the issues raised by the many layers of the bill's provisions in this area. A brief synopsis of some of the issues includes:

- The bill contains four layers of exemptions, including exemptions from exemptions from exemptions, whose conditions are extremely vague and therefore open to varying interpretations and possible "gaming;"
- the bill's "savings" provisions do not clearly preserve states' abilities to regulate the exempt entity, even in those states that may be able to apply some of their small group laws to such plans;
- the bill's notice and enforcement provisions are woefully inadequate if their aim is to provide the states with a meaningful way to intervene in the activities of entities which are operating outside of state or federal law; and
- the bill's "class exemptions" and "transition" periods provide entities with an opportunity to operate for a significant amount of time without receiving full certification from the Department of Labor that they meet the bill's requirements.

These are but a few of our concerns with this Subtitle. However, through these provisions, and other criticisms we have, there runs a common theme: the strides made by the states in the area of insurance reforms and stamping out fraudulent health care plans are threatened rather than preserved. If this failure was unintended, we offer to help you better understand its likely effect. These provisions ask the states to accept a serious impingement upon their authority in exchange for a very uncertain, and likely shaky, future for consumers and state policymakers.

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### **State Flexibility**

We understand that members of the House and the Senate intended that the portability and insurance reform sections of their respective bills build upon existing state laws and preserve the states' ability to go further. The NCSL and the NAIC Committee respectfully request that the conferees carefully craft a "savings clause" that reflects their stated intent that federal standards operate in harmony with existing state law as well as their continued recognition that the states remain the primary regulators of the business of insurance in the United States. The "construction" clause in Section 201 of Title II of S. 1028 more clearly reserves flexibility to the states in the area of insurance regulation and reform.

Both bills' approaches to preemption raise some issues of ambiguity with respect to their effect on state law. Some level of uncertainty is possibly inherent within any attempt to craft legislative language that accurately reflects the framers' intent on every possible question that might arise in the course of a federal-state partnership, such as that contemplated under the bills.

S. 1028 saves state laws related to specific areas of health insurance reform "that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals". In addition, the bill saves certain state laws that might otherwise be found to be in "direct conflict" with the group portability provisions of the bill. In the area of individual market reform, the provisions allowing for state alternative mechanisms appear to set forth the overriding test for state individual market reforms. If this is an accurate interpretation, we believe that this test currently contains ample flexibility for the states in the area of individual and group market reform. We would, however, welcome the opportunity to provide you with examples of the types of state reforms which we understand to be protected by the bill, for possible inclusion within legislative history (preferably within a Conference report).

It is our understanding that H.R. 3103 similarly seeks to allow the states to go further in the area of insurance market reforms. In fact, additional amendments made during several committees' markups further enumerated savings for some state reforms. We appreciate this intent; however, we have serious concerns that the current provisions of the bill would not effectuate that intent. The bill laudably attempts to limit its preemptive effect. However, it does this by limiting its savings of state laws to those laws relating to matters "not specifically addressed" in certain sections of the bill. Because the bill touches upon several areas of insurance reforms, however cursorily at times, state laws that relate to any of these areas are in jeopardy. We believe that members of the House did not intend for their legislation to have a chilling effect on innovative state-level insurance reforms and would welcome the opportunity to work with conferees of both Houses to craft language to address these concerns.

### **Individual Market Reform**

S. 1028 and H.R. 3103 each commendably attempt to set a minimal federal standard to guarantee that individuals who have been covered under a group health insurance contract for a set amount of time have access to health insurance coverage. Importantly, each bill also provides the states with the ability to "opt out" of each of the bill's standards if the state program meets certain set criteria. Prior to passage, the sponsors of S. 1028 made technical changes to their bill as originally introduced to lessen the discretion of the Secretary of the Department of Health and Human Services ("HHS") in reviewing a state plan. Both bills give the states an ample opportunity to correct their plans in response to the Secretary's concerns. However, S. 1028's criteria for alternative state plans are a bit more objective. It also reserves the opportunity to recognize models for individual reform currently under development by the NAIC. We find both of these aspects of S. 1028 to be worthy of incorporation in the final bill.

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Importantly, we would like to alert you to a possible drafting error within H.R. 3103 that could have the *possibly* unintended effect of limiting states' abilities to go further in the areas of individual reform. The bill only clearly saves the *states'* ability to implement certain reforms and offer coverage beyond the scope of the bill's requirements; therefore, there remains an ambiguity as to whether a state could require *insurers* to make coverage available beyond the bill's scope. This ambiguity is likely unintended and we can provide technical, drafting suggestions should you desire.

In addition, we would like to raise questions with respect to the definition of "qualifying coverage" within H.R. 3103. It is defined as: "the weighted average actuarial value of the benefits" provided by an individual insurance carrier in that market, or, at a state's option, provided in the state's individual health care insurance market overall. This concept has not been widely tested in the marketplace and would appear to lodge significant discretion in the hands of the health insurers with respect to benefit package design, and the possible use of package design as an indirect means to attract individuals with low health care needs, while dissuading its purchase by "higher risk" individuals. S. 1028's explicit and objective safe harbors for state individual market reforms, which do not constrain the states to a particular, and ambiguous, definition of "qualifying coverage", better ensure the goals of meaningful portability and state flexibility.

#### Long-Term Care Insurance

Both S. 1028 and H.R. 3103 contain provisions, with slight differences, relating to the tax treatment of long-term care insurance. These provisions are extremely important because the deductibility of qualifying policies will likely drive the direction of the marketplace. Nonetheless, it appears that the states could still impose additional standards beyond those set forth for federal tax deductibility. This is less clear in the section governing consumer protections. We would ask that the states' latitude be made clear in both sections.

During the debate over S. 1028 on the Senate floor, Senator William V. Roth, Jr. provided the following response to a concern raised by Senator Edward M. Kennedy on whether the provision retains states' ability to enact more stringent long-term care consumer protections, "[I]t is not the intent of the leadership amendment to preclude States from enacting stronger long-term care consumer protections. A clarification of this issue can be addressed in the conference report to the bill if necessary." See Congressional Record, April 18, 1996, p. S 3608.

We appreciate this statement of intent relating to state flexibility and would ask for clarification on this point. This is especially important since the bills' provisions do not contain the same level of consumer protections as current NAIC models and state reforms in several areas. For example, the bills contain a very different approach from the NAIC models and state reforms in their definitions of, and conditions for, "benefit triggers", or events which cause a policy's coverage to "kick in." Unless the possibility of additional state requirements is made absolutely clear, states might not be able to enact greater consumer protections.

The possible preemptive effect of each bill's section relating to consumer protection standards is particularly stark. The requirements within the bills differ from the NAIC's current Long Term Care Insurance Model Act and Regulation. In fact, the consumer protection provisions of the bills reference an earlier NAIC model that does not have, among other areas, current provisions in the area of insurance suitability. As the NAIC and many states have taken further steps than those contained within the bill, it is imperative that this flexibility be retained. This section does contain language allowing the states to enact requirements "not in conflict with or inconsistent with" these provisions. Does this clearly

The Honorable Bob Dole and Newt Gingrich

May 8, 1996

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preserve states' ability to go beyond the bills' provisions? We would ask for amending language in the preemption section to make this clear and would prefer that the clarification be made in legislative language.

### **Administrative Simplification**

H.R. 3103 contains a section on Administrative Simplification not contained within the Senate bill. These provisions have a potentially sweeping effect on the information gathering and record retention of personal and general health information by state regulators and policymakers. Our initial examination of these provisions raises three primary concerns.

First, we recognize and appreciate the bill's provision that exempts from preemption those state laws that are more stringent than federal standards with respect to the privacy of individually identifiable health information. However, this exemption does not entirely alleviate our concerns because the bill does not specify the federal standards governing the privacy of individually identifiable health information, but leaves such standards for promulgation by the Secretary of Health and Human Services (HHS). It is therefore impossible to know how the legislation will affect the existing requirements of various states relating to such information. States may not know whether to enforce their own existing laws, and consumers may be worse off than under the existing system.

Second, we are concerned that the federal privacy standards ultimately promulgated by the Secretary might be construed by health carriers and plans as prohibiting them from disclosing critical information to state insurance departments. We request that the federal privacy standards explicitly protect the right of state insurance departments to obtain information necessary to regulate health carriers and health plans.

Third, the bill does not contain any specific savings clause for state laws addressing the standards, data elements, and code sets for the financial and administrative transactions specified in the bill. The bill accords the Secretary of HHS extensive authority over these transactions. The bill is ambiguous with respect to the Secretary's ultimate authority over the data standards for patient medical records, but this ambiguity also troubles us.

Federal preemption in this area will deprive states of the flexibility to pursue innovations in regulating a rapidly evolving technology.

### **Fraud and Abuse Provisions**

We would request language, in the final bill or in the Conference Report, to clarify that state insurance departments have access to the information in the national health care fraud and abuse database established by Section 221 of HR 3103 and a similar provision of the Dole amendments to S. 1028.

### **Medicare Anti-Duplication**

In prior letters, the NAIC Committee has clearly advocated a legislative change to enable long-term care insurance policies to coordinate their benefits with Medicare. (See NAIC letter dated January 27, 1995 to Secretary of HHS Donna E. Shalala; NAIC Committee letters dated September 19, 1995 and November 18, 1995.) This remains our position. In its March 28, 1996 letter to Speaker Gingrich, the NAIC

The Honorable Bob Dole and Newt Gingrich

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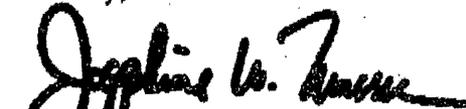
Committee commended the improvements in the final House language which went a long way to address concerns raised by the NAIC concerning earlier legislative proposals. This appreciation does not alter our preferred position on this issue, which remains a limited change in the area of policies selling only long-term care benefits. S. 1028 contains such a fix.

#### Enforcement

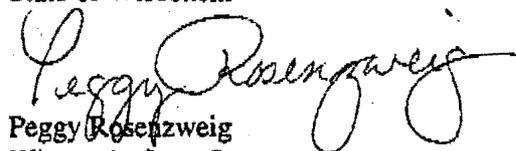
Both bills contain provisions retaining the states' authority to enforce the bills' standards for insurance reforms and portability. However, we would like to ensure that a single instance or failure of a state not be able to serve as a foundation for removing state authority. S. 1028 clearly states that federal intervention will arise in instances where the state has failed to *substantially* enforce the standards of the Act. H.R. 3103 provides for federal enforcement if there is a determination that such state "has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section." We appreciate the House bill's reference to *state* enforcement of state laws in this area. We would only suggest that the addition of the word "substantial" before "enforcement" might clarify the fact that federal intervention is not contemplated on a case-by-case basis.

Once again, we would like to commend the members of Congress for taking important steps toward enhancing the portability of health insurance. We hope that the conferees will reject provisions which broadly preempt state laws, especially H.R. 3103's provisions relating to MEWAs. We offer our continued technical assistance as you move forward on this legislation.

Sincerely,



Josephine W. Musser  
Chair, NAIC Committee  
Vice President, NAIC  
Commissioner of Insurance,  
State of Wisconsin



Peggy Rosenzweig  
Wisconsin State Senate  
Chair, NCSL Health Committee

cc: Members, United States Senate  
Members, United States House of Representatives

**GOVERNORS  
ASSOCIATION**

Tommy G. Thompson  
Governor of Wisconsin  
Chairman

Raymond C. Scheppach  
Executive Director

Bob Miller  
Governor of Nevada  
Vice Chairman

Hall of the States  
444 North Capitol Street  
Washington, D.C. 20001-1512  
Telephone (202) 624-5300

May 13, 1996

The Honorable Robert Dole  
Senate Majority Leader  
United States Senate  
S-230 Capitol Building  
Washington, DC 20510

Also sent to:  
Speaker Gingrich  
Senator Daschle  
Congressman Gephardt

Dear Senator Dole:

On behalf of the nation's Governors, we would like to offer our comments as you begin your efforts to reconcile the Health Insurance Reform Act of 1995 (S. 1028) with the Health Coverage Availability and Affordability Act of 1996 (H.R. 3103). We believe that your efforts to reform the private health coverage market are an important first step and you are to be commended for your actions. We would, however, like to share with you our concerns in a number of areas that should be addressed by the conference committee.

**Group to Individual Portability.** Both the House and the Senate bills contain provisions that are designed to improve portability in the group to individual market. Addressing the needs of persons in the individual and small group market is essential if we are ever to improve access to affordable health care. Both the House and the Senate are to be commended for addressing this difficult issue. The single largest concern is the potential for risk segmentation in the market and both bills are likely to lessen the problem. However, we are concerned that there is a greater opportunity for risk segmentation in the House bill than in the Senate. The House language calls for guaranteed issue of a benefits package whose value is not less than the "weighted actuarial value" of other packages in the market or offered by the same insurer. We believe that this could give insurers and health plans the ability to create packages that might segment the market by virtue of the benefits offered. In short, we prefer the Senate language for this provision.

Both the House and the Senate language allow states to develop their own portability mechanisms in lieu of the federal standards. In both cases, the Secretary of the U.S. Department of Health and Human Services has discretion in approving those alternative methodologies. In the House language, for example, a state alternative to the federal standard must demonstrate that it is "reasonably designed" to meet the goals of guaranteeing that a "qualifying individual" is able to obtain "qualifying coverage" that complies with the bills requirements relating to preexisting condition limitations. However, there is no clear guidance for the Secretary on this point nor clear criteria that would be used to determine if the state meets this test. As S. 1028 moved toward the floor last month, we were able to work with Senators Kassebaum and Kennedy to assure that their bill contained safe harbors which permitted automatic approval of certain state alternatives and limited Secretarial discretion in this area. The authority of the Secretary must be clear and restricted. We believe that neither of us is interested in a complicated regulatory process that could result in protracted litigation in order for states to be creative in this area. In short, the Senate language must serve as a guide during conference.

H.R.3103/S.1028 Conference

May 13, 1996

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***MEWAs and VHIAs.*** We agree that there is a need to place further regulations on MEWAs and agree that there is a need to expand opportunities for small businesses to purchase affordable health insurance. However, we are extremely concerned about the provisions in the H.R. 3103 concerning self-funded multiple employer welfare arrangements (MEWAs) and voluntary health insurance associations (VHIAs), and recommend that you work from the language in S. 1028. While we had understood that there were meaningful safe harbors for the states in the House language, careful reading belies such an interpretation. We believe that some of the safe harbors for states are substantially undercut by accompanying statutory language. Moreover, the safe harbors contain other ambiguous language that might be construed by the courts to further limit the scope of the safe harbors in the statutory language.

At this time, we will not offer specific examples supporting our concerns. Others, including the National Association of Insurance Commissioners (NAIC) have and will continue to provide further details of the relevant provisions. From our perspective as chief executive officers of states, we believe that the MEWA and VHIA provisions in the House bill run exactly counter to the steps we find advisable and necessary to continue improvements in the health care market. We do not need to look too far into the past to find traces of the adverse consequences of unregulated and poorly regulated entities. With respect to MEWAs, the problems were so significant that Congress acted in concert with the states and the U.S. Department of Labor to assure that these problems were corrected. These cooperative federal and state actions were the right thing to do. Now is not the time to reverse the trend. Now is not the time to reduce state regulatory authority, and now is not the time to destabilize the individual and small group insurance market. These provisions should be struck in conference.

***Protecting State Regulation of Insurance.*** As we said previously, maintaining and ensuring a meaningful role for states in the regulation of private health insurance is essential. Our reading of both the House and Senate bills suggest that you agree with our position and that the language has been crafted to maintain state authority and flexibility. That is, responsibilities have been 'saved' for states, and the states can go beyond the minimum federal standards. Unfortunately, we believe that the House legislative language has been drafted in a fashion that it is much more ambiguous than the Senate language on this point. With the exception of certain clear savings for certain state laws, state laws are preempted in areas "specifically addressed" by the bill. Since the bill "addresses", at least minimally, many areas, the preemptive sweep of these provisions could be very broad, however unintentional. For example, Section 131 requires guaranteed issuance of coverage in the small group market. The small group market is later defined as groups of at least two but fewer than 51. In a number of states, small group reforms include group size of 1 and in some cases groups larger than 50. The relationship between this federal preemption and state law is confusing and could result in judicial interpretations diminishing state regulatory authority to enact laws with broader guaranteed issue requirements. By contrast, the savings language in the Senate bill is much less ambiguous retaining state authority. We believe that the ambiguity in the House language is unintentional, and we are ready to work with conferee staff and the NAIC to correct the final conference language.

H.R. 3103/S. 1028 Conference

May 13, 1996

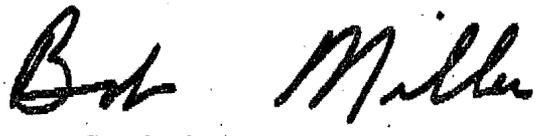
Page 3.

Thank you again for your attention to our concerns. We are committed to changes in the nation's health care system that expands the availability of affordable coverage to all Americans. Your work has been commendable, and we look forward to working with you in this most important area.

Sincerely,



Governor Tommy G. Thompson  
Chairman



Governor Bob Miller  
Vice Chairman

Medical Savings Account File

May 1, 1996

The Honorable Robert Dole  
Majority Leader  
United States Senate  
Washington, D.C. 20510

Dear Senator Dole:

Our organizations urge you not to derail passage of the Senate version of H.R. 3103. We are concerned that your support of Medical Savings Accounts (MSAs) will threaten the enactment of this bill that passed unanimously. We believe that this bill should not be loaded up with anti-consumer provisions. MSAs are harmful to consumers for the following reasons:

- MSAs can drive up premiums in traditional health insurance plans as much as 61 percent, making health coverage unaffordable for many Americans.
- High-deductible catastrophic plans present financial barriers, preventing many Americans from getting cost-saving preventive and other health care.
- According to the Joint Tax Committee, MSAs would drain \$1.8 billion from federal revenues, compounding the budget deficit.

We firmly believe that H.R. 3103 represents a positive step towards achieving greater access to health care for many Americans and, therefore, should be adopted without any further delay. Our organizations would like to arrange a meeting with you and your staff to the discuss the major risks that MSAs pose for consumers and taxpayers.

Thank you for your consideration of this matter. We look forward to working with you as consideration of the Senate version of H.R. 3103 proceeds.

Sincerely,

AIDS Action Council  
American Federation of State, County and Municipal Employees  
American Federation of Teachers  
American Public Health Association  
American Speech-Language-Hearing Association  
American Nurses Association  
Association for Education of Community-Based Rehabilitation Personnel  
Center on Disability and Health  
Church Women United  
Citizen Action  
Consumers Union  
Families USA  
Gay Men's Health Crisis  
Human Rights Campaign

International Union of Electronic, Electrical, Salaried. Machine and Furniture Workers (IUE)  
Justice for All  
National Association of Developmental Disabilities Councils  
National Association of People with AIDS  
National Association of Protection and Advocacy Systems  
National Association of Public Hospitals  
National Association of School Psychologists  
National Association of Social Workers  
National Association of State Directors of Special Education  
National Community Mental Healthcare Council  
National Council of Senior Citizens  
National Education Association  
National Parent Network on Disabilities  
National Organization for Rare Disorders  
Neighbor To Neighbor  
NETWORK: A National Catholic Social Justice Lobby  
Service Employees International Union  
The ARC  
The Council for Exceptional Children  
The Learning Disabilities Association  
UAW  
United Cerebral Palsy Associations  
United Church of Christ, Office for Church in Society  
United Mine Workers of America  
Women's Legal Defense Fund

April 17, 1996

Dear Senator:

The Senate will shortly consider S. 1028, the Health Insurance Reform Act of 1995. At that time, several amendments may be offered which reflect provisions adopted by the House last month. Because we believe that such amendments would have a negative effect on consumers and health care quality, we ask that you vote against any amendments that would limit accountability for the practice of dangerous medicine, provide taxpayer subsidies for Medical Savings Account, jeopardize patient confidentiality, preempt state consumer and quality protections, or allow the sale of duplicative health insurance policies to Medicare beneficiaries.

● **Medical negligence.** At a time when consumers are concerned about financial incentives for undertreatment and cuts in medical quality, the American civil justice system provides an important counterbalance. Health care providers, pharmaceutical companies and medical device manufacturers know that they can be held accountable for negligent care, knowledge which results in many providers practicing safer medicine. Numerous studies have shown that medical malpractice premiums and defensive medicine are not significant factors in overall health care costs — the Congressional Budget Office has found that premiums represent less than 1 percent of costs, the Office of Technology Assessment concluded that less than 8 percent of all diagnostic procedures were due to defensive medicine. Drastic changes in the civil justice system will not lower health care costs, they will simply shift costs to consumers and increase the number of consumers injured due to medical negligence.

● **Medical Savings Account (MSAs).** MSAs disrupt the health insurance market by creating financial incentives that encourage division of health care risks. Actuarial studies conclude that MSAs would appeal to relatively healthy and wealthy individuals. The American Academy of Actuaries estimates that this selection process could result in higher premiums (as much as 61 percent) for those remaining in traditional health insurance plans. The Joint Committee on Taxation also estimates that a deduction for MSAs would drain nearly \$2 billion from federal revenues, compounding the national debt. Finally, there are likely to be few, if any, consumer protections for the high-deductible plans which would have to be purchased in conjunction with MSAs. Even after paying the cost of the deductible, consumers could face additional cost-sharing, limitations in necessary benefits or denials of physician-approved treatment.

● **Protection of Patient Confidentiality.** Our organizations would oppose any amendment to restrict current state and federal regulations that protect patient information confidentiality. Under the name of "administrative simplification," such an amendment would threaten medical record confidentiality by failing to impose strict confidentiality rules for the electronic transfer of medical information, or strict penalties for companies and individuals who do not protect the confidentiality of such information.

●**State Consumer and Quality Protections.** Many states have enacted legislation to protect consumers in managed care and other insurance plans; others are considering proposals to do so. Any amendment which would exempt employer-offered insurance currently regulated under state law would decrease the availability of consumer protections designed to assure access to quality benefits. Examples of state regulations which could be preempted include prohibitions on "drive-through" deliveries, appeals/grievance procedures, and requirements to provide patients with access to appropriate health care providers or specific benefits, including emergency and preventive services.

●**Private Health Insurance Duplication.** We oppose legislative changes in the current definition of private insurance duplication that would allow for the sale of unlimited hospital indemnity and dread disease policies to senior citizens as long as those policies pay benefits. Prior to 1990, the sale of numerous wasteful and duplicative health insurance policies was a major drain on seniors' resources. Making it easier to sell unneeded policies to seniors would drive up health care utilization and ultimately drive up Medicare costs, while wasting consumers' money on unnecessary duplicative coverage.

Our organizations ask that you oppose these amendments when S. 1028 is brought to the Senate floor.

American Federation of State, County and Municipal Employees

AIDS Action Council

American Public Health Association

American Psychological Association

Business and Professional Women/USA

Center on Disability and Health

Citizen Action

Clearinghouse on Women's Issues

Consumers Union

Gay Men's Health Crisis

Human Rights Campaign

International Brotherhood of Teamsters

International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers (IUE)

Justice for All

National Association of People with AIDS

National Association of Protection and Advocacy Systems, Inc.

National Association of Public Hospitals and Health Systems

National Association of Social Workers

National Coalition for the Homeless

National Council of Senior Citizens

National Education Association

National Health Law Program

National Hispanic Council on Aging

National Minority AIDS Council

National Osteoporosis Foundation

National Puerto Rican Coalition, Inc.

National Therapeutic Recreation Society  
National Women's Conference Committee  
National Women's Health Network  
Neighbor to Neighbor  
NETWORK: A National Catholic Social Justice Lobby  
Older Women's League  
Service Employees International Union  
The Joseph P. Kennedy, Jr. Foundation  
United Church of Christ, Office for Church in Society

# Consortium for Citizens with Disabilities

MSA File

## Health Task Force Co-Chairs

Jeff Crowley (202) 898-0414  
Bob Griss (202) 842-4408  
Kathy McGinley (202) 785-3388  
Peter Thomas (202) 466-6550

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## CCD REITERATES ITS STRONG OPPOSITION TO MEDICAL SAVINGS ACCOUNTS

April 17, 1996

The Health Task Force of the Consortium for Citizens with Disabilities (CCD) reiterates its strong opposition to any proposed amendments to the Kassebaum-Kennedy Health Insurance Reform Act (S. 1028) that include medical savings accounts (MSAs).

CCD has worked diligently to support passage of the Kassebaum-Kennedy legislation as a modest step forward that does two important things for people with disabilities:

- It limits pre-existing condition exclusions to 12 months, and
- It makes health insurance more portable if individuals switch jobs.

The CCD has also supported the efforts of Senator Jeffords to enact a lifetime coverage limit that cannot be set below \$10 million of coverage. While the average lifetime health care costs for nearly all types of disabilities is well below \$1 million and while very few people actually exceed their lifetime cap, the impact of exceeding a cap is catastrophic for the individuals involved. Senator Jeffords' efforts to establish \$10 million as a lifetime cap is a reasonable complement to the reforms proposed by Senators Kassebaum and Kennedy.

CCD believes that the modest improvements afforded to people with disabilities and the nation by the Kassebaum-Kennedy bill and the Jeffords Amendment pale in comparison to the harm that could result from efforts to enact legislation supporting medical savings accounts (MSAs). MSAs have the potential to completely undermine our national system of health insurance. **If medical savings accounts are attached to this legislation, CCD will vigorously oppose S. 1028.**

Key concerns of people with disabilities include:

- **MSAs will further divide an already fragmented health insurance market.**
- **MSAs are financially unrealistic for people with disabilities.**
- **MSAs may cause individuals to forego preventive and early intervention services.**

For a more detailed understanding of CCD's position on medical savings accounts, please review the attached document.

# **CONSORTIUM for CITIZENS with DISABILITIES**

*A coalition of national consumer, service provider, and professional organizations, which advocate on behalf of persons with disabilities and their families.*

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## **MEDICAL SAVINGS ACCOUNTS**

Many Members of Congress believe that Medical Savings Accounts (MSAs) have the potential to reduce health care costs and increase the number of Americans with insurance. There have been suggestions that MSAs be implemented not only in the private sector but in the Medicare program as well.

The Consortium for Citizens with Disabilities Health Task Force has major concerns with the emphasis presently being placed on Medical Savings Accounts as a solution to our health system's problems of access and affordability. The use of MSAs is not only untested, but also has the very strong potential for making comprehensive health insurance less affordable for persons with disabilities and serious chronic illnesses. *Because of our many concerns, discussed below, and in the absence of other reforms, the CCD Health Task Force opposes the establishment of MSAs as either an incremental reform or as a solution to the health care problems facing millions of uninsured and underinsured individuals in the U.S.* Most importantly, the CCD Health Task Force believes that allowing employers and the self-employed the option of establishing tax deductible MSAs in conjunction with high deductible catastrophic insurance coverage is not the solution to our nation's health system problems because:

- MSAs do not address the need for insurance by millions of working Americans whose employers will not contribute to the cost of health insurance; and
- MSAs do not address the need for insurance by millions of low-income individuals who are self-employed or unemployed and who cannot afford to buy health insurance.

### **Key Concerns for persons with disabilities:**

- **Unfair risk selection:** MSAs will further divide an already fragmented health insurance market - removing the youngest and healthiest from the large insurance pool. Consequently, persons who remain in, or select, low deductible, comprehensive insurance coverage will be subject to a significant increase in the cost of their insurance premium. It is persons with chronic

medical conditions, such as the older employee and persons with disabilities or chronic illnesses, who will be left in the low-deductible plans. Furthermore, individuals with MSAs could easily change to a low-deductible plan when they become sick or anticipate medical bills (e.g., childbirth expenses), thus exacerbating the problem of shifting the cost of care to the low-deductible plans and increasing the premiums of such plans.

- **Financially unrealistic for most persons with disabilities:** Among persons with high medical costs, MSAs and catastrophic insurance coverage will be subject to high out-of-pocket expenses. Currently, most employers offering MSAs pay only the difference between the premiums for the low deductible and high deductible plans as part of the MSA contribution and, thus, additional MSA funds -- a large part of the \$5,000 deductible payment -- are contributed by the person. The American Academy of Actuaries estimate that out-of-pocket costs would increase on average between \$677 to \$926 for employees with high medical expenses with high deductible, catastrophic coverage. These out-of-pocket costs are likely to increase as the difference between high and low deductible premium costs increases; primarily due to the increased cost for the low deductible plans. These additional out-of-pocket costs are unreasonable for most persons with disabilities who rely on private insurance.
- **Increased premium costs for non-MSA participants:** Adverse selection will lead to higher premiums for persons in standard, low deductible health insurance plans. It has been estimated that if MSAs are widely adopted, the cost of a standard, low deductible health insurance policy would rise by as much as 26%. Increases of this magnitude will make comprehensive, low deductible insurance unaffordable both for employers and individuals who want to purchase these policies.
- **Restrictions on deductible services -** It is likely that catastrophic health plans will restrict the type of health care expenditures that will count towards the deductible. For example, if an individual spends \$3000 on mental health services, there is no guarantee that all of these expenses will be counted towards the deductible, particularly if the insurance has limited coverage for these services.
- **MSA viewed as personal savings account:** If the MSA is viewed as a personal savings account (rather than insurance), some individuals may forgo preventive and early intervention services if they are allowed to use money left in their MSAs at the end of the year for personal expenses other than health care. Furthermore, persons with limited incomes may select MSAs due to their lower costs and, consequently, may face difficult choices between necessary health services and other basic needs (housing and food). This concern also raises the question of whether it is appropriate to allow pre-tax dollars to be used for non-health expenses.

- **Added tax expenditures:** The Joint Commission on Taxation estimates that making MSAs tax deductible could drain nearly \$2 billion dollars from the federal budget between now and the year 2002. It is difficult to justify asking taxpayers to pay this additional cost at a time when other health programs are being cut and when there are so many serious concerns surrounding MSAs.
- **Cost conscious consumers:** There is no evidence that MSAs will make consumers more cost conscious when they are seriously ill. Physicians -- not consumers -- determine what treatment is needed. If surgery is recommended, consumers don't look for the cheapest surgeon, they look for the best surgeon. Furthermore, once an individual has reached his or her deductible limit, there are no financial incentives (for the patient or provider) to conserve resources and, thus, perpetuating the problem of current traditional indemnity programs.

Should you require more information regarding this document or the CCD Health Task Force position, please contact:

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Amputee Coalition  
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202 785-3388

Jeff Crowley  
NAPWA (National  
Assoc of Persons  
with AIDS)  
202-898-0414

Bob Griss  
Center on Disability and Health  
202-842-4408

April 1996



# CENTER ON BUDGET AND POLICY PRIORITIES

Revised March 26, 1996

## MSA PROVISION IN HEALTH CARE REFORM BILL CREATES TAX SHELTER AND CASTS DOUBT ON EXPANSION OF INSURANCE COVERAGE

by Iris J. Lav

The main purpose of the health care reform bill is to extend health insurance coverage to some people who currently cannot obtain it. For a number of reasons, inclusion of a Medical Savings Account (MSA) provision in the bill could make it more difficult and less affordable for employers to offer adequate health insurance to employees most in need of it — potentially undermining the basic purpose of the legislation.

- The MSA provisions approved by the House Ways and Means Committee would create new tax shelter opportunities. Under these provisions, use of an MSA to accumulate funds for purposes other than medical costs would be highly advantageous to substantial numbers of higher-income taxpayers. As shown below, a taxpayer in the 36 percent bracket could increase the value of his savings by 20 percent to 30 percent by placing funds in an MSA and then withdrawing them for purposes other than medical care, rather than by depositing the funds in a regular savings account.
- Healthier employees would be most likely to choose MSAs over conventional insurance plans. These healthier employees would hope to keep and use their unspent, tax-advantaged MSA deposits for other purposes.
- Because a number of healthier employees would no longer be in conventional insurance plans, the people served by the conventional plans would tend to be less healthy on average. This would raise the cost to employers of providing such plans and could lead some employers to cease offering conventional insurance coverage.
- Low- and moderate-income employees would receive little or no tax advantage from using MSAs because they either do not pay income taxes or pay taxes at much lower rates. In addition, low- and moderate-income employees rarely have the resources to pay large unplanned out-of-pocket health care costs; thus, they are less likely to be able to take the risk of using a high-deductible plan with an MSA. Furthermore, low- and moderate-income employees would be those harmed the most if the self-

selection of healthy people into MSAs resulted in employers dropping comprehensive insurance coverage or imposing higher costs for employees' shares of insurance premiums.

- In short, proposals to use the tax code to grant substantial advantages to high-deductible insurance plans with MSAs as compared to conventional insurance are likely to result in fewer, rather than more, people remaining adequately insured.

## **MSA Provisions**

Under the MSA proposal in the health care reform bill, qualified taxpayers (either directly or through their employers) are allowed to contribute yearly amounts to an MSA, up to a specified ceiling. To be qualified, taxpayers must have insurance coverage through a high-deductible health plan. Taxpayer (or their employers) may contribute the amount of the deductible to the MSA, up to a maximum of \$2,000 for an individual and \$4,000 for a family.

Amounts that individuals contribute to MSAs may be deducted on their income tax when determining adjusted gross income, which means they may be deducted whether or not the individual itemizes other deductions. If MSA contributions are made by employers on behalf of individuals (presumably even if salaries are reduced to allow the contributions to be made), the amounts contributed are not counted as wages or salary for purposes of computing income, FICA (Social Security and Medicare), or unemployment taxes. The interest earned on amounts accumulated in MSA accounts also is exempt from taxation.

Taxpayers may use the funds in their MSAs to pay medical expenses. This includes expenses that count toward meeting the deductible of their health insurance plan as well as expenses for medical services such as eyeglasses or dental care that may not be covered under their plan. Premiums for long-term care insurance also may be paid from the account. Funds withdrawn from MSAs that are used to pay permitted types of medical expenses are never taxed.

If funds are withdrawn from the MSA for other purposes, they are subject to income taxes as ordinary income in the year they are withdrawn. If the taxpayer is below age 59 ½, amounts withdrawn for other purposes also are subject to a 10 percent penalty. After the taxpayer attains age 59 ½, funds may be withdrawn from MSAs for any purpose without incurring a penalty.

## MSAs Create a Tax Shelter

For higher-income taxpayers who anticipate remaining healthy, MSAs represent a new, tax-advantaged way to accumulate savings. Because contributions made by or through an employer are permanently exempt from Social Security and Medicare payroll taxes and are exempt from income taxes until withdrawn, and because the interest earned on amounts remaining in the MSA is allowed to compound without yearly taxation, the 10 percent penalty on withdrawals for purposes other than medical expenses is not sufficient to prevent MSAs from becoming a tax shelter.<sup>1</sup> Even after the penalty is paid, the after-tax return to savings in an MSA would under many circumstances exceed the return to conventional savings.

**Figure 1**  
**Value of \$3,000 of Gross Income Saved in MSA**  
**Compared with Current-Law Savings**  
**Taxpayer in 36 Percent Federal Income Tax Bracket**

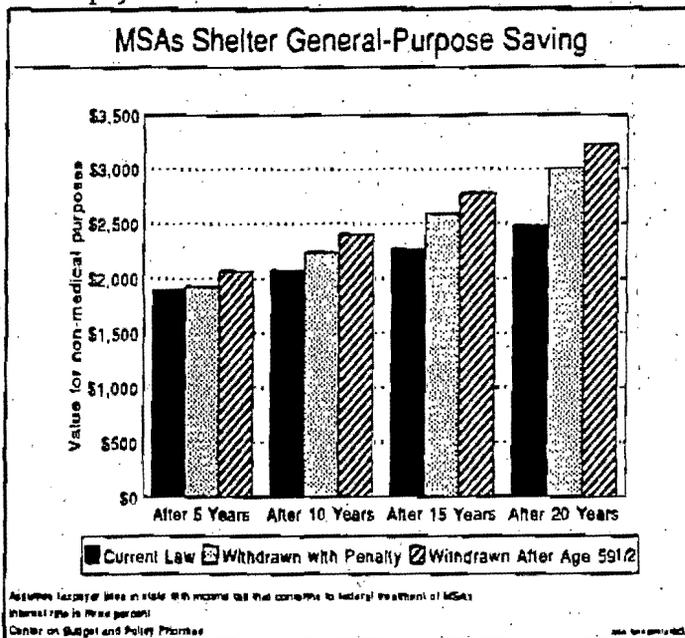


Figure 1 shows the difference to a taxpayer in the 36 percent federal income tax bracket between saving \$3,000 of gross earnings under current law and saving the same amount in an MSA. Taxpayers in the 36 percent tax bracket generally have a gross income above \$130,000 a year. In each case, the deposit is held at a three percent rate of interest. Under current law, the taxpayer would have \$1,742 in after-tax funds to deposit in a conventional savings account. (The \$3,000 gross earnings would be reduced by a 36 percent income tax, an effective state income tax of 4.5 percent after accounting for deductibility against federal taxes, and a 1.45 percent Medicare tax. Taking away 41.95% of \$3,000 leaves \$1,742.)<sup>2</sup> If those funds remain on deposit for 10

<sup>1</sup> For Individual Retirement Account deposits, only income tax is deferred. FICA taxes must be paid on earnings deposited in IRAs.

<sup>2</sup> The 36 percent bracket applies to individuals with taxable incomes over \$118,000 and married filers with taxable incomes over \$144,000. Taxable income is gross income minus all permissible exclusions and deductions from income. Thus, a taxable income of \$140,000 generally would correspond to a much higher gross income, perhaps in the \$170,000 to \$200,000 range. A taxpayer in this income tax bracket has income

(continued...)

years with interest taxed yearly, they would grow to \$2,079. By contrast, under the MSA provision, the taxpayer would deposit the entire \$3,000 and interest would compound free of tax. After 10 years, the account would hold \$4,032. The taxpayer could withdraw the funds for purposes other than medical care, pay income tax and the 10 percent penalty on the withdrawn amounts, and have \$2,236 remaining.

In other words, after 10 years the value to the taxpayer of the funds saved in the MSA would exceed the value of conventionally-saved funds by 7.6%, even though a penalty was assessed for use of the funds for purposes other than medical care. If during those 10 years the taxpayer attained age 59 ½, no penalty would be assessed and the value to the taxpayer of the MSA savings would exceed the value of the conventional savings by more than 15 percent.

As shown in Figure 1, the differential value of the MSA savings grows with the length of the holding period. After 20 years, an MSA withdrawal with penalty exceeds the value of conventional savings by 21 percent, while an MSA withdrawal after age 59 ½ would exceed the value of conventional savings by 30 percent.<sup>3</sup>

It may be noted that the cost to the Treasury in foregone tax revenues also would increase over time, as growing amounts of savings are likely to be placed in MSAs and sheltered from taxation. According to the Joint Committee on Taxation, the cost of the MSA approved by the House Ways and Means Committee grows steadily from \$134 million in 1997 to \$399 million in 2002. In years subsequent to 2002, the cost would continue to rise.

### **Heavy Use of MSAs by Healthy Taxpayers Could Undermine Insurance**

The example described above illustrates why using MSAs in conjunction with a high-deductible insurance plan could be highly popular with taxpayers who anticipate that they will remain in good health. This is particularly true for higher-income taxpayers who can afford the risk of paying some out-of-pocket health expenses if a

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<sup>2</sup> (...continued)

that far exceeds the maximum earnings on which Social Security payroll taxes must be paid. As a result, the taxpayer would receive an exemption — through using an MSA — only from the Medicare tax, which is paid on all earnings. The taxpayer is assumed to live in a state with an income tax that conforms to federal treatment of MSAs. Thirty-seven of the 42 states that levy a personal income tax generally define gross income in the same way as it is defined for federal tax purposes. These states would be highly likely to conform to a change in federal tax laws relating to MSAs. The assumed marginal state tax rate is seven percent, which is the rate at this income level in the median state.

<sup>3</sup> Similar differentials would apply to many taxpayers in the 28 percent federal income tax bracket, many of whom would receive an exemption from Social Security as well as Medicare payroll taxes.

**Moderate-Income Families Choosing MSAs Risk Unaffordable Medical Expenses**

Some moderate-income families that use MSAs with a high-deductible insurance plan may not have sufficient resources to cover their exposure to health care costs. Consider, for example, the Jones family, which carries an insurance plan with a \$3,000 deductible through the husband's employer. Like many moderate-income families, mortgage and living expenses consume all of the Jones' income and they are mildly over-extended on credit-card consumer debt. The Jones' keep \$5,000 for emergencies in a money-market fund but have no other liquid assets.

Assume the Jones' had \$1,000 in MSA savings on January 1. Mr. Jones' employer makes deposits to his MSA of \$110 a month during the year (reflecting the difference between the employer's premium for the high-deductible plan and the premium for conventional insurance). By early November, the family had received an additional \$1,100 into the account from the monthly deposits, and had paid \$1,500 from the account for various medical bills that counted toward the insurance plan's deductible, leaving \$600 remaining in the MSA.

In mid-November, the Jones' teen-age son broke two teeth in a sports game. The \$1,000 cost of necessary dental work did not count toward the deductible amount of their insurance, but it was a permitted use of MSA funds. The Jones' decided to use the remaining \$600 in the MSA to pay a portion of the dental bill, adding \$400 from their money market account. Then in late-November, Mr. Jones became ill and required emergency surgery. The family withdrew an additional \$1,500 from their money market fund to cover their remaining \$1,500 deductible for that year. The family was left with \$3,100 remaining in the money market fund.

In early January, as Mr. Jones prepared to resume work, complications developed and further surgery was required. Only \$220 was available in the MSA (from the November and December deposits) to pay the \$3,000 deductible for the new calendar year. In addition, Mr. Jones faced several additional weeks before he could return to work and did not have sufficient sick leave to receive his salary for the period of anticipated absence. Paying the \$2,780 deductible not covered by the MSA reduced the family's money-market savings to \$320. As a result, the family did not have sufficient funds to meet living expenses during the unpaid leave.

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\* The American Academy of Actuaries estimates the employer cost of the annual premium for a family plan with a \$3,000 deductible would be between \$3,900 and \$4,050, while the employer cost for a \$200 deductible plan would be \$5,250. This examples uses a difference of \$1,320, reflecting the higher end of the estimate.

family member becomes ill and the resulting insurance deductibles and co-payments exceed the amounts in the taxpayers' MSAs. (See box above for an example of the risk

to moderate-income families). For these healthier, higher-income people, a high-deductible plan with an employer deposit to an MSA is the best of both worlds — it provides both a reservoir of funds for potential medical costs and tax-sheltered savings.

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

Consider an example in which there are five people with health insurance provided by one company.<sup>4</sup> Together, the five people have \$15,000 a year in medical expenses. The insurance company charges the group of five a premium of \$14,000 a year for insurance, out of which it reimburses the group for approximately \$11,000 in medical expenses. Note that in this example the result is the same whether the medical expenses of the five people are distributed as in column A or column B below. So long as the five people remain in a group, the employer would pay an average of \$2,800 on behalf of each employee.

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

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

<sup>4</sup> The following example is not based on actuarial analysis. The numbers used are for illustration only.

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

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

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

The American Academy of Actuaries has noted, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."<sup>5</sup> One could add that the greatest burden is likely to be borne by low- and moderate-income families who would get little or no tax benefits from MSAs, cannot afford the risk of large uncovered medical expenses, and would face higher costs for comprehensive insurance if MSAs spread broadly.

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<sup>5</sup> American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995, p. 23.

**Overview:**

**S. 1028: The Health Insurance Reform Act**

**April 16, 1996**

## S. 1028: The Health Insurance Reform Act

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*The Kassebaum-Kennedy bill contains insurance reforms to make health coverage more accessible, portable, and affordable. The bill would restrict pre-existing condition exclusions, and require insurers to issue and renew coverage without regard to an individual's or group's health status or claims experience. The bill also encourages the development of purchasing cooperatives to assist small employers and individuals negotiate better rates with insurance companies and health care providers. The GAO estimates that over 21 million people could benefit from the enactment of this legislation.*

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### Title I

#### Subtitle A: Group Market Rules

Provisions would increase access and coverage protection for people in group plans by:

- Guaranteeing an employer access to insurance regardless of the health status of any its employees.
- Guaranteeing an employer the right to renew coverage, except for fraud, nonpayment, or misrepresentation of material fact.
- Providing portability of health coverage and limitation on preexisting condition exclusions.
  - preexisting condition exclusions cannot exceed 12 months.
  - any preexisting condition exclusion period is reduced, month-for-month, by previous coverage.
  - the “look-back” period may not exceed 6 months.
- Establishing special enrollment periods for people who have experienced a change in employment or family status.
- Requiring insurers to disclose in their marketing materials for small employers the insurers' rights to change premiums, preexisting condition provisions, and descriptive information about the benefits and premiums under all plans for which the employer is qualified to purchase. Similar information must be provided to participants in employer-sponsored self-insured plans.
- The provisions apply to insured and self-insured (ERISA) plans of all sizes.

### **Subtitle B: Individual Market Rules**

Provisions would increase access and coverage protection for people in individual plans by:

- Requiring individual plan insurers to provide access to people who have had group coverage for 18 or more months but who have lost it, who have exhausted COBRA coverage (if available), and who are not otherwise eligible for group coverage.
- Guaranteeing renewability of individual health coverage, except for fraud, nonpayment or misrepresentation of material fact.
- Encouraging greater state experimentation to increase access and coverage in the individual market.
  - The guaranteed access provisions of this subtitle will not apply if the Secretary of HHS certifies that the state has developed effective alternative means of improving access and affordability in the individual market.

### **Subtitle C: COBRA Clarifications**

Provisions make modifications to existing COBRA eligibility rules by:

- Allowing extension of COBRA from the standard 18 months to 29 months in cases where a family member or the former employee becomes disabled during the initial COBRA coverage period
- Allowing newborns and adopted children to be covered immediately under a parent's COBRA policy.

### **Subtitle D: Private Health Plan Purchasing Cooperatives**

Provisions create incentives for employers and individuals to form private, voluntary purchasing cooperatives to purchase health insurance and negotiate with providers and insurers. To qualify as a purchasing cooperative, an organization must not bear insurance risk, offer a range of plans, and assure broad representation on its board of trustees.

- Certain state laws that could prevent the formation of purchasing cooperatives are preempted.
- Cooperatives must comply with state insurance laws.

## **Title II**

### **Application and Enforcement**

- States may establish standards that are more protective or beneficial to individuals.
- The act would essentially preserve the current division of responsibility between the state and federal governments.
  - ERISA preemption is not altered.
  - States are given the authority to enforce the law, but if they choose or fail to do so, the Secretary of Labor would enforce the act.

## **Title III**

### **Miscellaneous Provisions**

- Would allow federally qualified HMOs to charge deductibles to members who have medical savings accounts.
- Includes a “sense of the Committee” statement that medical savings accounts should be encouraged.



# CENTER ON BUDGET AND POLICY PRIORITIES

April 16, 1996

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

by Iris J. Lav

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

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

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

### Joint Tax Highlights Benefits to Companies, Not Employees

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

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

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

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

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

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

#### **Low- and Moderate Income Taxpayers May Participate in MSAs Involuntarily**

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

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

#### **Inadequate MSA Deposits Transfer Large Costs to Moderate-Income Employees**

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

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

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

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

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



United States  
General Accounting Office  
Washington, D.C. 20548

Health, Education and Human Services Division

B-271667

April 15, 1996

The Honorable James M. Jeffords  
United States Senate

Dear Senator Jeffords:

The Congress is considering proposals intended to enhance the availability of health insurance. This debate has led to specific questions about the state regulation of health plans, including mandated benefit laws. In particular, you asked us to provide information on

1. state requirements affecting fully insured health plans and how they compare with federal requirements affecting self-funded health plans,
2. the number of states that have enacted particular mandated benefit laws,
3. estimates of the costs of mandated benefits in particular states, and
4. the extent to which commonly mandated benefits are provided by self-funded health plans that are exempt from state laws.

This letter provides interim information based on our ongoing work for you on the factors affecting the costs of state health insurance regulation. As part of this effort, we interviewed officials from the National Association of Insurance Commissioners (NAIC); several state insurance commissions; and national organizations representing actuaries, health insurers, and self-funded employers. We reviewed documents and used data provided by these groups as well as available studies on mandated benefits. In addition, we included and updated information from previous GAO reports on state insurance regulation and the Employee Retirement Income Security Act of 1974 (ERISA).<sup>1</sup> Our

<sup>1</sup>See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995) and Health Insurance Regulation: Wide Variation in States.

GAO/HEHS-96-125R State Mandated Benefits

B-271667

Table 2: Commonly Mandated Benefits

	Number of states		
	Cover	Offer	Total
<b>Treatment-related</b>			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well-child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/ in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
<b>Provider-related</b>			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14



## CHANGES TO ORIGINAL 1995 MEDICARE PROPOSAL

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

- Original Position: No MSAs; no private fee-for-service plans.
- Compromise Position: Allows 2-year nationwide MSA demonstration capped at 3% of beneficiaries with Presidential/Congressional Commission to evaluate, as well as 4-year, 10-state demonstration of private fee-for-service plans.

### PREMIUMS ABOVE MEDICARE CAPITATED PAYMENT

- Original Position: Plans not allowed to charge more than adjusted community rate for basic Medicare benefits or for supplemental benefits.
- Compromise Position: No limits on premiums for supplemental benefits, so long as full disclosure made to beneficiaries.

### MEDIGAP PROTECTION

- Original Position: Medigap plans required not only to accept all beneficiaries in annual open enrollment period, but also to offer community-rated premium.
- Compromise Position: Medigap plans permitted to charge higher premiums to those who elect Medigap after being in other managed care plans or MSA, but required to charge the same average premium charged by that plan to beneficiaries with comparable demographic characteristics (e.g., age).

### ENROLLMENT

- Original Position: Enrollment must be conducted through a third-party mechanism overseen by the Secretary, rather than through health plans themselves.
- Compromise Position: Enrollment may be conducted directly by plans after initial transition period.

### SAVINGS PROPOSALS

- Compromise savings proposals have moved toward Conference policy in a number of areas, including:
  - Managed care--Original position did not change payment methodology for managed care and proposed to reduce geographic variation in payments through a different method than the Conference bill. Compromise position

moves payment methodology toward Conference proposal; managed care payments are grown at overall Medicare per capita rates, and policy to reduce geographic variation by basing a growing portion of payment on blended rate is very similar to Conference bill policy.

- Outpatient hospital payment methodology--Original position did not include proposal to correct so-called "formula-driven overpayment". Compromise position includes proposal similar to Conference bill.
- Competitive bidding for Part B items and services--Original position included savings proposals that would have required competitive bidding in Part B. Compromise position drops these proposals and substitutes "freeze" policies as in Conference bill.
- Fraud & abuse--Original position included fraud and abuse proposals that provided additional funding to HHS only. Compromise position includes policies to combat fraud and abuse that are similar to Conference bill and provide the same level of additional funding (and savings) to HHS and DOJ.
- Income-related premium--Original position did not include this policy. Compromise position includes an income-related premium for high-income beneficiaries, starting at \$100,000 for singles (and phasing up to 75% of Part B program costs at \$125,000) and \$125,000 for couples (phasing up to 75% at \$150,000).
- Original Administration \$124 billion savings package was scored by CBO as saving \$98 billion over 7 years. Compromise \$124 billion package (not including high income-related premium proposal) includes more savings proposals because of (1) differences between CBO and OMB baselines and technical assumptions, (2) CBO's determination in February that it would no longer score savings for FY 1996, and (3) the Administration's decision to balance in 2002 (i.e., over 6 years).

## CHANGES TO ORIGINAL 1995 MEDICAID PROPOSAL

### FINANCING: MOVING TOWARDS THE GOVERNORS

- **Original Position:** Per capita cap that adjusts federal support as enrollment increases or declines. A 33 percent Disproportionate Share Hospital (DSH) cut with no hold harmless provision and no specifics as to how dollars were used.
- **Compromise Position:** Adopts the National Governors' Association (NGA) financing formula, with some modifications to assure CBO scoring. Unlike the per capita cap, this approach provides a hold harmless provision that ensures that states can keep their base allotment (they get to choose from the best of 1993, 1994, or 1995), even if they decrease the Medicaid recipient enrollment below levels of their base year. Institutes a DSH hold harmless provision and targets dollars to facilities disproportionately serving the uninsured and other needy hospitals defined by the states.

### ELIGIBILITY: EXPANDING STATE FLEXIBILITY

- **Original Position:** Maintained current law that prohibited states from rolling back their optional expansions of kids and pregnant women to mandatory poverty/coverage levels. In addition, required that states maintain current federal disability eligibility definition requirements.
- **Compromise Position:** Gives states the authority to roll back optional coverage of kids to minimum poverty/coverage levels and substitutes the disability eligibility reforms included in the bipartisan welfare bill, (which no longer requires states to cover alcoholics, chemical and substance abusers and some SSI kids.)

### BENEFITS: REDUCING COSTS AND TARGETING ABUSES

- **Original Position:** Maintained current law requirements.
- **Compromise Position:** Provides states the authority to apply nominal copayments for Medicaid HMO coverage. Also, to address concerns about EPSDT benefit abuses, authorizes the Secretary to limit inappropriately utilized benefits.

### ENFORCEMENT: DECREASING LITIGATION AND COSTS

- **Original Position:** Restructured, but did not totally repeal the Boren amendment. Retained individuals' current access to Federal court system.
- **Compromise Position:** Totally repeals the Boren amendment and requires that all state administrative appeals be exhausted prior to any court appeal on eligibility or benefits disputes.

## **FLEXIBILITY TO INCREASE COVERAGE WITHOUT WAIVERS**

- **Original Position:** Although the President's June, 1995 proposal did eliminate the federal waiver process for managed care and home and community based alternatives, states that achieved savings through the new flexibility provisions could not plow those savings back into targeted coverage expansions without a federal waiver.
- **Compromise Position:** Empowers states to use Medicaid savings to provide coverage for any population up to 150 percent of poverty without a federal waiver. (As a result, states can either pocket the savings or use it to expand coverage to any population it wants provided they are under specified poverty threshold.)

## **SAVINGS INCREASE EVEN AS CBO MEDICAID BASELINE DECLINES**

- **Original Position:** \$54 billion off of a much higher CBO Medicaid baseline.
- **Compromise Position:** \$59 billion off of the new CBO Medicaid baseline, which is over \$25 billion lower than the December CBO Medicaid baseline and \$55 billion lower than the baseline used to score the budget proposals passed by the Congress in 1995.

## CHANGES TO ORIGINAL 1995 WELFARE REFORM PROPOSAL

### ELIGIBILITY: ENDING OPEN-ENDED ENTITLEMENT

**Original Position:** Maintained the entitlement to AFDC, while requiring recipients to work, imposing time limits, and expanding state flexibility over eligibility.

**Compromise Position:** Ends the open-ended entitlement to assistance. Gives states complete flexibility to run their own welfare programs without having to seek federal waivers. Adopts the National Governors Association (NGA) proposal to require fair and equitable treatment of recipients, with modifications to ensure state accountability and require in-kind vouchers for children whose parents exceed 5-year time limit.

### FINANCING: MOVING TOWARD THE GOVERNORS

**Original Position:** Maintained existing AFDC financing mechanism, under which federal and state expenditures rise as welfare caseloads go up.

**Compromise Position:** Accepts the block grant approach from the NGA resolution and H.R. 4. Includes an economic contingency fund at the NGA base funding level, modified to allow states to access funds in the event of a national recession.

### STATE FUNDING: MAINTENANCE-OF-EFFORT INSTEAD OF STATE MATCH

**Original Position:** Maintained requirement under current law that states must match federal dollars at Medicaid rate.

**Compromise Position:** Replaces state match requirement with state maintenance-of-effort (MOE) at the level of the Senate-passed bill (80%). States that fail to meet work requirements would have their MOE increased, as in the Castle-Tanner bill. A portion of block grant funds could be transferred, but only for child care.

## **ENTITLEMENT REFORM: DOUBLING CUTS IN BENEFITS FOR LEGAL IMMIGRANTS**

**Original Position:** Cut benefits for legal immigrants by \$5 billion over 7 years by deeming SSI, AFDC, and Food Stamps until citizenship, with exemptions for the disabled and those over 75.

**Compromise Position:** Doubles the cuts in benefits for legal immigrants, to \$10 billion, by deeming Medicaid until citizenship and dropping the exemption for those over 75. This proposal is consistent with entitlement benefit restrictions in the House-passed immigration bill.

## **SAVINGS INCREASE EVEN AS CBO WELFARE BASELINE DECLINES**

**Overall Position:** \$35 billion over 7 years, off a much higher CBO welfare baseline.

**Compromise Position:** About \$40 billion off the December CBO baseline, which is substantially lower than the baseline used to score budget proposals passed by the Congress in 1995. The gross cuts are actually in the range of \$45 billion, in order to offset additional spending in the NGA plan for child care and work performance bonuses. Overall cuts are now close to every major bipartisan welfare reform bill (the Senate bill, Chafee-Breaux, Castle-Tanner), with somewhat smaller savings from immigrants.

John:

Advice that we stress  
how sensitive these documents are.  
They should not be attributed to  
US.