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MEDICAL SAVINGS ACCOUNTS

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MSAs are an integral part of several health care reform proposals. This is a debate on MSAs by several experts representing varying actuarial viewpoints on how MSAs work, change in medical behavior, anticipated cost savings, and so on.

MR. MARK E. LITOW: Harry Sutton is with Allianz Life, and he is what I call the managed care actuary. He was brought up in that background and has been involved in many controversial subjects over his years. The MSA is one of those. He's coming at the subject from quite a different background than I am coming from on the individual side. Guy King is now a consulting actuary with Ernst & Young. He was the chief actuary for the Health Care Financing Administration for 16 years and gained a great deal of respect from both sides of the aisle. I'm with Milliman & Robertson.

Harry, Guy, and I were all on the MSA task force of the AAA. Harry and I took up the poles on the task force. I would say I was the most in favor of MSAs and Harry was probably the most against them. That doesn't mean either one of us is fully one way or the other. Guy had to be somewhere in the middle, so with that, we're going to let Guy take up the moderator position. Harry and I will throw barbs at each other and let Guy referee.

MR. ROLAND E. KING: I don't know that Harry and Mark were the two poles on the MSA Task Force of the AAA, but they certainly were the most articulate people for the positions that they have. So I think you're in for a real treat. They are very knowledgeable about this area.

Many years ago, when HMOs were first getting started, they were often branded, particularly by physicians, as socialized medicine. Today, a substantial portion of the population is enrolled in HMOs. By the same token, just a few years ago, MSAs were seen as the right-wing brain child of very conservative economists. But today they are the darlings of the political establishments. In fact, the concept of MSAs is so popular with Congress that it has been said that if any form of health care reform is passed, MSAs will be part of it. Just about every major health care reform proposal does have MSA legislation in some form or another.

What is a MSA? Well, put very simply, a MSA is simply an account that's set up for an employee and owned by that employee. It is very important to emphasize that it's owned by that employee for the purpose of accumulating funds for paying medical expenses that are not reimbursed by the employee's health care plan. Usually we think of the MSA as being combined with a high-deductible or catastrophic plan so that basically the accumulated funds in the MSA are used for paying health care costs that fall below the deductible. Then, if an individual or family has catastrophic health care expenses, the catastrophic health care plan takes over.

It's important to remember that a MSA differs a great deal from a flexible spending account (FSA). Basically, under a flexible spending account the employee is planning on using the funds that he or she receives from the employer that year. It's just a way of taking advantage of the tax-favored status of the FSA. Also under the FSA concept, if an employee doesn't use those funds by the end of the year, the funds are lost and are reverted back to the employer. Also, if the MSA is structured in such a way that the employee doesn't perceive those funds to be his or hers, then it won't have the desired impact on utilization.

The theory behind the MSA concept is that it gets the patients more concerned about the cost of the care they're receiving. The patients are more involved and concerned about the cost of the care they're receiving, and their physicians are also more involved and will practice medicine in a more cost-conscious manner.

Legislation that affects MSAs is primarily oriented toward putting MSAs on a level playing field taxwise with plans that exist today. Right now, third-party payments are tax-favored. That means that very comprehensive plans, such as comprehensive indemnity plans and comprehensive HMO plans that rely on third-party payments, are the kinds of plans that receive the greatest tax advantage. MSAs can and have been implemented without legislation, but legislation that gives them the same tax-favored status as other plans would greatly enhance their viability.

Some people believe that MSAs can provide very powerful incentives for individuals to control health care costs. Other individuals believe that they would neutralize the utilization controls that are already in place. That's what we're going to debate.

If you're interested in MSAs, let me put in a plug for the first report that came out from the MSA Task Force. It's *Public Policy Monograph Number One, Medical Savings Accounts—Cost Implications and Design Issues*. More monographs that will be directed at specific legislative proposals will be coming out.

MR. LITOW: I will talk about the advantages of MSAs and why I believe they will work. I want to talk mainly about a couple perspectives on MSAs. MSAs place the consumer in a position of power. Right now, with managed care and most other features in our health care system today, the consumer doesn't have the slightest idea of what health care costs. That is the main impetus as well as the change in utilization is what created the impetus.

But other very important things are overlooked. MSAs can be a catalyst to bring healthy people into the system. Why is that important? Many people think that MSAs bringing in healthy people is a bad thing. Somehow MSAs will take all the good people and all the sick people will go away. But remember, what are we trying to do with health care reform in this country? Why do some of the states require guaranteed issue and community rating? They're trying to find ways to get everybody into the system. MSAs, rather than being a mandate of any type or a perverse incentive, will encourage healthy people to come in. That can lower the overall cost for everybody; not just the healthy, but the sick. So, if used properly, that can be a very positive incentive.

Another very important point is that MSAs were never designed to be a comprehensive solution; not at least in my eyes. MSAs are very flexible. I'm going to talk about how to

take the incentives that MSAs have and some of the incentives that managed care have and combine them. I don't believe that they are opposite ideas that cannot fit into each other.

Also, MSAs create savings in the country, which is an important ingredient for long-term care and other means. Furthermore, they also will lower administrative costs because we won't have to pay or administer many low-dollar claims, such as drug claims.

Let me talk about MSAs and how they work. In designing a MSA you use a simple formula. You calculate what the change is in medical care costs. That should be a plus. If it's not, it's not going to work. You calculate the change in administrative cost under the plan and subtract out what you're going to pay back in MSA balances. If one plus two minus three is not greater than zero, that means the employer, or whoever is funding this, is going to lose money. MSAs should always be looked at in aggregate.

The fourth item can also be a minus, which is the tax effect. As Guy mentioned, MSAs do not have tax-favored status; that is the situation today. I'm going to ignore the tax effect. It's generally on the smaller side, but it can't necessarily be ignored.

When you design a MSA, what are some of the things you can do to make it fit, to make that formula come out positive? One of the things you can do is change the corridor. The corridor is the difference between the annual MSA contribution and the deductible. For instance, you may have a $2,000 deductible and a $1,000 MSA contribution. Many examples you may have seen will have the contribution equal to the deductible. That can happen in certain situations, but it's not the norm.

Also, besides modifying the deductible you don't have to return 100% of the MSAs. We designed MSAs in Medicaid and we're also designing them in Medicare. In Medicaid we very often only return a small portion of the money that the government puts into a MSA. That can be 20%. A MSA, likewise, could be shared with a physician. One of the things that I'm thinking about down the road is that MSAs and managed care will blend if the tax code so allows. Then we'll see a great deal of sharing of risk among insurers on the managed care side and among physicians as providers and the insured. As long as those incentives go in the same direction, it's a powerful tool.

What are the reasons for some of the changes in the medical costs? Essentially, it's the number of visits to the hospital and the physician. Now think about a MSA. Once a person goes into a hospital in a typical MSA design, he or she has blown through the deductible and there will be a savings there. That's where managed care comes in. Managed care does not deal well with the outpatient side. So that's why these two ideas can blend together in theory. You also have a change in the number of services. There's also a change due to negotiation by insureds. Right now we have negotiations by providers. You should always expect some underreporting in MSAs.

Now to illustrate what I'm talking about, I've been doing work on Medicare. There are several proposals I've been working with in Congress. I want to show you the distribution for Part A and then Part B so that you can see what the problems are.

Table 1 is a 1994 distribution of Part A. This is only the government's cost. It does not include any deductibles or coinsurance. The average cost, which isn't shown, is about

$27,000. This was for a $4,000 deductible with a $2,000 MSA. The savings we're expecting are about $240, which is a little less than 10%. So we're not expecting a great deal of savings on part A. Why? We're getting a drop in frequency of about 20%. We're getting some reduction in the lower hospitalizations. But we're not getting virtually anything on the top end because our managed care takes over.

TABLE 1
MEDICARE PART A SAVINGS ILLUSTRATION

Claim Amount		Probability		Change
Before	After	Before	After	Claim Cost
$ 0	$ 0	0.750	0.795	$ 0.0
1,500	1,300	0.080	0.065	(35.5)
3,000	2,700	0.020	0.015	(19.5)
4,500	4,000	0.040	0.025	(80.0)
8,000	7,500	0.060	0.050	(105.0)
18,000	17,500	0.035	0.035	(17.5)
81,933	81,933	0.015	0.015	0.0
Total		**1.00**	**1.00**	**$(257.5)**

Now look at Part B (Table 2) in which the average cost is about $17,000. Most of the cost, except for the two bottom lines, are very much within the discretion of the insured. This distribution shows a 40% cost savings, a dramatic decline.

TABLE 2
MEDICARE PART B SAVINGS ILLUSTRATION

Claim Amount		Probability		Change
Before	After	Before	After	Claim Cost
$ 0	$ 0	0.090	0.150	$ 0
400	200	0.420	0.490	(70)
1,500	1,000	0.320	0.270	(210)
3,000	2,000	0.120	0.050	(260)
8,000	7,000	0.035	0.025	(105)
26,867	25,867	0.015	0.015	(15)
Total		**1.000**	**1.000**	**$(660)**

How does that fit in with what's happening in the under-65 market today? Here I have a comparison of the $250 deductible versus the $2,500 deductible. The market premiums are 30–50% on the $2,500 deductible versus the $250 deductible. You have a difference in deductible. If you just go down and chop off the cost of $2,500, you get a 25–35% decrease. With regard to risk selection, healthier people will choose the higher deductible, and that will be worth 25–35% in general. The lower utilization net results are 20–30% leverage. Most of you know that with a higher deductible, the trend is higher on that higher deductible. When comparing the claim cost for the $250 and $2,500 deductible, there is a:

- Difference in deductibles of 25–30%
- Risk selection of 25–35%
- Lower Utilization of 20–30%
- Leverage of up to 30%

Well, it also works in reverse. Once you get a cost decrease, you get a leverage in the opposite direction, and that leverage result can be anywhere from almost nothing up to 30% on some of the models. If you multiply the midpoints of all those ranges, you get 32%. How does that fit in with the 30–50% difference? If you look at experience on $2,500-deductible plans, you'll see that the loss ratios are substantially lower. So it does fit. How are we getting that kind of savings? We're getting it mostly from the outpatient side. We're not getting it from the inpatient side.

So, with that, I want to talk about selection. There are many questions about adverse selection with MSAs. There's a great deal of confusion about selection and adverse selection, and positive selection, for that matter. Selection occurs when two parties make a choice. There will be selection in a dual or a multiple-option plan. The question is, are we going to get adverse selection, which means that one of the parties is not recognizing the selection process, in this case, the insurer?

The first example of adverse selection is the Medicare risk contract. Medicare pays 95% of the age-adjusted per-capita cost on people who cost about $0.65–0.70 in my calculation. The HMO is offering free benefits to entice those people in and is still able to pay the administrative cost. Why? Because it gets people with much lower morbidity. Now maybe the managed care is having an effect of bringing it down somewhat. That's possibly true. But it is taking the healthier people out of Medicare, and so Medicare is stuck with a much higher cost. That's an example of adverse selection.

What's an example of positive selection? Well, we talk about bringing healthy people into the system. If MSAs can do that, that would be positive selection as long as the cost dropped. If lower-cost people are under a Medicare risk contract, it doesn't matter. If we save money on those people who are better risks, then we have had a positive result just as if we had saved money on people who are sicker. Another example is MSAs are having a lower out-of-pocket maximum than the prior plan. If the maximum is lowered, then sicker people will come in, and that can be a positive result.

In a MSA, you always have to recognize inflation. The deductible should change. A plan in California kept a constant deductible for many years back in the 1970s. It worked very well for a while and eventually didn't work at all because it had a $600 deductible and never changed it.

I want to talk about Table 3, in which everyone had MSAs. The total medical cost today is 77% plus 9% for what is out of pocket or 86% of premium, leaving 14% administration. That's the whole system, from managed care to indemnity plans, without any discount.

TABLE 3
ILLUSTRATION OF COSTS TODAY VERSUS A MSA

If 100% have MSAs. . .					
	Today	Insurance	MSA	Out-of-Pocket	Total
Medical Cost	77%	33%	32%	—	65%
Administrative Cost Insurance	14	6	1	—	7
Out-of-Pocket	9	—	—	4%	4
MSA Balance	—		14	—	14
Total	100%	39%	47%	4%	90%

Note—There was no change in type of care or delivery.

If everybody has a MSA, the insurance plan will come in at 39% whereas before it would have been 91%. That is a dramatic reduction, but those types of reductions are certainly possible. The MSA contribution in this example is 47%: 32% to medical cost, 14% to the MSA, and only 1% to administrative costs as a percentage of premium. When you add all that up, the medical cost has gone from the 86% to 69%, which is the 32% plus 33% plus 4% for out-of-pocket costs.

There is a 17% cost savings. The administration cost drops 7%, which makes 24% available, and then you're paying back 14% on the MSA. These numbers will vary dramatically from plan to plan, and it's important to compare your own before and after.

You have to look at the design very closely. It's an easy concept on the surface, but it's not an easy concept underneath. Unless you do the proper evaluation, problems will evolve. You will end up paying out too much in the MSA. Your design will not fit right. But if you look at those things and you start to figure out how to blend the incentives that we have on the outpatient side of managed care, I believe that MSAs will offer a great deal of potential and will lead us in the right direction. I expect during the next ten years that we'll see a much different system. Managed care will be a part, but you might not recognize it the way it is today because I believe the two concepts will blend together.

MR. HARRY L. SUTTON, JR.: To give you a little background, Mark has been an expert in the individual insurance business. The people who came up with this idea in Texas, I think, were far right. Some of us think that Congress today is far right, at least in the House. So they are perhaps adapting. My interpretation of the original concept was that it tried to put the patient and the physician back together again, and HMOs tended to interfere with the management of the physician/patient relationship. They were trying to get rid of that.

I'm talking more from the employee benefit side and looking at the MSA as an employee benefit. It will also make a difference whether the employer uses it as his indemnity plan for all employees or whether the MSA is a dual-choice arrangement with a high-option indemnity plan. The selection factors would then have a big effect on the result.

Looking at it from the employer's side, we're changing from a standard comprehensive major medical plan to a high deductible. The employer will save money by greatly increasing the deductible for its employees, and that savings is supposed to be put into the MSA. Also, 80–90% of employers have contributions from employees, so that will have

some effect on the results. Whether you divide it up like the Academy studies show or whether you just put the employee contribution into the MSA will also have an effect on the result.

One of the strongest advocates of this approach is the Council for Affordable Health Insurance (CAHI). Mark and a number of other actuaries have been strong advocates. As Mark said, we have many points of agreement as well as some of disagreement. I would love to have a MSA, even though I'm on Medicare at the moment. (I might even do it on Medicare if I could get away with it.) However, I think some of the people who are advertising the advantages of MSAs are overstating the advantages and are stating things that they want to do with MSAs, which could cause problems.

We're talking about integrating the MSA concept into an employee benefit plan. All the illustrations from the CAHI, or at least the ones that I picked out, show that the employer can give away the whole deductible into the MSA and still save money or come out even. The MSA can be used for any eligible IRS expense, including medical services not covered by the health insurance plan. One of the problems with this is illustrated by the story of the woman who had her teeth repaired or replaced for $2,000. If she ever went into the hospital, she'd still have to pay $2,000 out of her own pocket to get into the benefit on the health plan.

Funds going into the MSA would be tax-deductible to both the employer and the employee. The MSA could be funded by the employer or possibly from employee contributions. The reduction in total medical expenditures is large in Mark's example—31–32%. The savings would then be treated as in an IRA or 401(k) plan, which could be withdrawn at various ages or used for other purposes such as long-term care, which would still be a medical expense. The laws would have to change to accommodate that. But essentially, it's also being used to create additional pension benefits. Whether that would integrate with existing rules on 401(k)s and IRAs is unknown at this point.

Now the CAHI, in Table 4, shows that you can fund the full deductible when you're switching to a high deductible. In fact, if you're in Chicago, you can fund the whole thing and still give the employer $500 back, which I happen to doubt. But there are circumstances, depending on the nature and size of the group, the administrative cost, and other things that could save a large sum of money.

There was an article published in *The New England Journal of Medicine* ("Why We Need Medical Savings Accounts," 30, 1994: pp. 1752–53) by Phil Gramm. It shows that the employer cost is $5,000, and the employee contributes $500. That can give the employee $3,000 in his or her MSA, the employer can fund the high deductible for $2,000, and everybody does well. I'm not opposed to MSAs, but I think that some of these examples in an employee benefits environment, and in a large-scale employer environment, are misleading.

Now, one of the carriers, which is Golden Rule, published all those studies showing that you can fund 100% of the deductible when you switch from a high-benefit plan to a low one. And yet, its own plan only puts in $2,000. It does depend somewhat on what the benefit plan was before it was changed to the high deductible. It also gives its employees a choice of the old plan or the MSA plan with the high deductible. It shows, in the

newspaper ads at least, that it gives the employees about $1,000 back each, but it doesn't show what happened to the 10% or so of the employees who kept the old plan. I think it does say that its total plan saved money, but I'm not sure.

TABLE 4
MEDICAL CARE SAVINGS ACCOUNTS—HERE'S HOW IT WORKS

	Heartland America*	Chicago
Currently Typical cost of employer-provider family health plan. Employees are paying part of this cost.	$4,500	$6,000
With Medical Care Savings Accounts Cost for catastrophic insurance coverage of medical expenses about $3,000 (coverage to $1 million)	1,500	2,500
Medical care savings accounts—for medical expenses up to $3,000	3,000	3,000
Savings for employer	0	500
The employee would have $3,000 in a personal medical care savings account to pay for medical care. If that isn't enough, the catastrophic policy would cover expenses above that amount. If it was enough, employees would keep what was left, and the money would earn interest. What are the chances for savings? Good, because in most of America, less than 15 of 100 people have more than $3,000 in medical expenses.		

* Heartland America includes Peoria, Cincinnati, Soranton, Louisville, Little Rock, Dayton, Nashville, Des Moines, Oklahoma City, Minneapolis, Omaha, and Memphis.
Source: data from the Council for Affordable Health Insurance.

I would recommend in the Spring 1995 issue of *Health Affairs* an article by John C. Goodman and Mark Pauly. It gets to one of the main issues in trying to reduce at least fee-for-service-type health care expenditures—that is the fact that it's tax-sheltered. The cost to many employees is close to zero. Therefore, when you receive a free good, you tend to overutilize it because you're not paying for it. They suggest replacing the tax deductibility of the employer contributions by a fixed tax credit. Then all the operations of the MSA and insurance plans would produce taxable income to the employee. On the average, the tax credit would be an offset. Many of us like this approach because now the employee is deciding both on the insurance and how much money is to be put in the MSA. The employee is now using after-tax dollars of his or her own. If he buys a high deductible and puts very little money in the MSA, he makes money on the tax credit. I have the same problem with some of the other examples that show a huge savings to the employee.

I have my own reactions in looking at continuance tables, and this is one of my major differences with Mark, if we have one. Over a period of time, more and more of the expenditures for health care are concentrated in a smaller number of people at the upper end of the scale. Twenty years ago nobody had their hearts reamed out. Nobody had

organ transplants mainly because they weren't done. The catastrophic claims were at a much lower level than they are today. Now there are million-dollar claims.

So the question is, with the total claim cost concentrated on a smaller and smaller number of employees, will the MSA reduce cost? I don't question that. The high deductible will reduce the cost of the lower-cost claim people. I don't think it's going to have much effect on the higher-cost claim people. I would tend to use the continuance table without assuming that the high-cost claims will drop very much, even though some of the outpatient costs at the bottom may drop.

I see it like the dynamic scoring they try to do in Washington when they're going to change the tax rates, and they want to predict the revenue they're going to gain or lose from that. They're trying to predict what 130 million taxpayers will do with a changed tax law. So far, they aren't very good at predicting any of that. I take the negative stance in predicting this, whereas Mark takes the more favorable one. I think people are assuming falsely that there will be tremendous savings. I just don't happen to agree with the amount of savings.

In most cases, the premiums for the catastrophic coverage, based on experience and even reflecting a reduction in utilization, are much higher than the examples published in the advertising or educational materials. In actuality, they haven't been used that way. The amount available for the MSA, therefore, to hold the employer constant would be less because the premium was higher. The gap in between coverage, or the corridor, as Mark called it, is much higher than the advocates are giving in their examples. The CAHI also is advocating that you can spend money on costs that aren't covered under your insurance plan, which could save money, and I have no objection to that. You're still taking money out of the MSA that reduces your coverage in the catastrophic plan because those expenses do not count toward the deductible, unless it's redrafted that way.

Now if you use the examples that I gave you, in which the MSA has the full amount of coverage, essentially you're changing from a $200 deductible, 80% plan to a 100% plan, and the employee is held harmless. When we add the high-deductible coverage, we typically have no coinsurance above that level and the amount in the MSA, therefore, the employee could assume that he or she has 100% coverage and spend everything. It could induce an increase in cost, in my opinion. To induce the reduction in cost that Mark wants to get, there almost has to be a corridor left in there. But many advocates are showing that the patient is getting 100% coverage and cost is being reduced, which is contrary to the way I think it would work.

If the employers are going to offer choices, such as a high-option, high-cost indemnity along with a MSA and along with HMOs, they are going to have to model the selection. If they do that, the MSA amount will drop because the high-deductible premium would drop if you only switched the younger employees. The MSA may not look like a good deal.

This is included in some of the advertising material for individuals. Fifteen percent of individuals have claims over $3,000, but they spend 80% of the total dollars, including the amount under $3,000. If you truncate $3,000, that's somewhere between 60% and 65% of the claims in the current 1995 continuance table. I have not readjusted this for a drop in claims over the deductible, assuming they would also be affected to some extent.

I could also argue with the presumed reduction in expenses. Every time a claimant gets more than $3,000, you will have to verify every single amount withdrawn from the MSA to determine if it was an eligible claim, particularly if you don't say the MSA eligible is the same as in the insurance plan. You will have to do all the claim analysis for almost 80% of the total claims.

One of the other options that people are talking about is building a PPO. That would require balance billing for outside services and part of the expenses not counting against the deductible, or not even being paid out of the MSA. A Rand study headline says that going from 100% coverage to a high-deductible plan would reduce the average cost about 31%.

But the average plan in force today is not full coverage, with the exception of the United Auto Workers Plan. Usually, we're talking about $200-deductible, 80% plans, which are more like a 25% coinsurance rate, in my opinion. The savings from that are only about half the savings if you were going from unlimited coverage to a high deductible.

What is the American public looking for in a solution to health care? My conclusion is something for nothing. That's the way I kind of view the advertising for the MSAs.

I'd like to talk briefly about selection. Table 5 is from the Academy's study. It shows how the results of a MSA would vary among people of different ages and sexes. For the average, 73% have savings, and 27% are losers. There's not much difference between the average loser and the average gainer. However, 17% of the people in the MSA have no expenditures at all. Switch to males, average age of 27 and 28% of them have no expenditures in a given year. The MSA would be refunded or kept to their credit, depending on how the MSA would be set up.

But because those years are also child-bearing years for women, the women don't fare as well. If you go to the end, age 57, the males start to lose more money and have more losers, and the number of people who have the maximum gain dwindles. The women are more equal to men at that stage; in fact, maybe even slightly better than men in terms of the growth.

When you look at who is going to select the MSA, the employers would model that a fair number of the younger employees would go into the MSA and, therefore, you'd have to lower both your premium cost and your MSA amount to reflect the cost of the left cells. If you assumed a certain level of selection, the high-option indemnity plan, assuming you offered it as an option, could go up 50% in value.

The HMO would opt into the MSA because HMOs see that they can do better there. It also makes a difference of how easily they can switch back and forth. Can you switch from a MSA with a high deductible back to a full-coverage plan without any problem? In the event there's still a high deductible. Also, some of the high-cost people, knowing they've had claims, might be unwilling to take the high-deductible risk and would opt into the HMO. Both of those changes would affect the increasing cost under the HMO. Today, most HMOs have a version of experience rating so they can adjust, but their premiums would go up. If you still offer the high-cost indemnity plan, most of those people would probably stay in it even though the cost was increased to them.

TABLE 5
MSAs: COST IMPLICATIONS AND DESIGN ISSUES

Winners and losers: individual plan, age and gender distributions, based on the medium (50%) effect

Category	Total	Aged 20–34		Aged 35–49		Aged 50–64	
		Men	Women	Men	Women	Men	Women
Percentage Winners	73.5%	85.5%	70.1%	78.9%	72.8%	65.1%	67.4%
Average Gain	N/A	$514	$465	$474	$438	$434	$442
Percentage Losers	26.5%	14.5%	29.9%	21.1%	27.2%	34.9%	32.6%
Average Loss	N/A	$444	$561	$465	$565	$471	$573
Percentage with Maximum Gain	17.4%	27.7%	19.5%	19.8%	17.5%	5.2%	14.9%
Average Gain	N/A	$623	$623	$623	$623	$623	$623
Percentage with Maximum Loss	8.2%	2.6%	11.5%	4.5%	8.9%	10.8%	12.1%
Average Loss	N/A	$877	$877	$877	$877	$877	$877

Note—It is assumed that all individuals are covered by the same plan and that the MSA contribution does not vary. The distributions would change if the MSA amounts and/or the deductibles were varied by age and gender categories.
Source: AAA

The employer could contribute just the amount for the high-deductible plan, and the MSA could be used to pay the difference in premium if the employee wanted to enroll in the HMO. We've looked at HMOs building their own MSA plans, and there are many differences, legal problems, and problems dealing with their providers. If you can go outside to use doctors not in the HMO, what do you do when you get above the $3,000 deductible and you're supposed to be using the HMO?

Many of the old-fashioned integrated HMOs are not geared to do fee-for-service business or manage the MSA account. So they're going to have problems adjusting to that. You could use the PPO, but then you have slightly more administrative costs because you're going to have balance billing, and some of it cannot be used toward the deductible.

I think we should let employers experiment with this and find out what happens. Many employers that have MSAs, or something similar to MSAs have been unwilling to give out a great deal of information about the results. I would be much more comfortable if we saw the kind of savings that Mark is talking about actually emerge from some sizable employers that were willing to try it.

MR. KING: In Mark's example with the Medicare program, he predicted a 20–30% reduction in utilization. Harry's example falls somewhere between 15% and 20%. So the difference between what Harry and Mark are saying about the reduction in utilization is not that large. That's certainly well within the range of professional differences.

It points out that anytime you're going to measure a reduction in utilization, you must take into account selection bias. You can't just look at the plan experience and say that because the plan experience in this plan was 30% lower than the plan experience under this

alternative plan it means that the plan design had the effect of reducing utilization by 30%. You must take into account and somehow measure the differences in the morbidity of the two populations. Of course, that's one of the difficulties that we have. We don't have an adequate risk-adjuster yet.

What we'd like to do now is start a series of questions. I'm going to start posing questions, and I'll give both Mark and Harry two minutes each to respond to the question. With this idea of selection bias in mind, what hard evidence is there that MSAs control costs or that HMOs control costs?

MR. LITOW: Experience for the employers that have used MSAs to date, from Forbes, which has had the most dramatic reductions in cost (about 30% over two years), to Quaker Oats (which I believe has dropped its trend by a couple points), has been favorable. Some of those are situations in which everybody has MSAs. Some of those are dual and multiple options.

Harry raised a point about what happens when there is an option. Well, the experience I've seen is that there's no question that the people who stay out of the MSAs have higher claims. So, therefore, you have to adjust. If you don't anticipate the selection, just like in Medicare risk, you're going to have problems. You need to reduce your MSA contribution, your deductible levels and so forth, to correspond to that. You'll get adverse selection if you don't anticipate the selection. I think MSAs are showing savings, but there certainly is not a large volume of data. I don't think any of us can say that we have a credible band of data here that we can look at.

HMOs, I think, probably have reduced cost somewhat. Of course, you still have the same selection issues with HMOs. HMOs, in very many ways, are in a big discount game right now. They are getting some utilization savings, but the discount is producing much more of the savings from what I've seen in the utilization. So I think it's a debate. But other than laws, as Harry said, I do not see managed care and MSAs as being incompatible at all. I think you just need a philosophical change of approach.

I went to a meeting in Washington State and a couple HMOs were trying to argue that copayments on drugs and physician offices, particularly with HMOs, are worth more than large deductibles. So I said, "Do you mean the 5% copayments are worth more than 100% copayments?" That stopped everybody. But the point is that there's such a philosophical bend in managed care right now. They started as provider-controlling everything. For MSAs to come in and plan that, they will have to change their philosophy.

MR. SUTTON: Going back to the Rand study, there was an experiment in Seattle comparing the MSA randomly by selected pool, adjusting by age and sex, and comparing two groups in Group Health of Puget Sound. The MSA with the high deductible showed a drop of 30%. Those in the HMOs showed a drop of 28%. Essentially, the HMO seemed to control the cost in a different way, but it had about the same result.

Also, in looking at Medicare and the targets for HMOs, I won't argue about the positive selection. HMOs have tended to have a younger and more family-related population than indemnity in general, but now they have such large segments of the population. Kaiser has 70% of the population. Even though there is some selection, much of it has worn off over

50 years. The hospital utilization and cost are just much lower in very expensive parts of the country, such as California. So I think there's plenty of evidence, although a committee of the Academy is going to study that. Again, their utilization is extremely low, even if you adjust for the demographic differences.

MR. KING: We talked about what hard evidence there is to control cost in both MSAs and HMOs. Another question that arises is, what is the cost-containment potential of MSAs compared to that of HMOs? Are they about the same? Is one higher than the other? Or what is that situation?

MR. SUTTON: I think the HMOs are a managed care entity. Now there are all kinds of different HMOs, and some are oriented toward profit. There's a question about not-for-profit and using nonphysicians to manage physicians. But I think the potential in a well-run health plan is better.

Part of the reason is if the person with the MSA is going out to negotiate with doctors, I don't happen to believe that he or she can get a better deal from a doctor or a hospital than a big plan that either owns its own hospital or has contracted at 50% of market rates. Even though single purchasers try to control services judiciously, I don't think they can control their costs as well as the big purchasers.

MR. LITOW: I would say this is one area that distinguishes Harry from myself. I don't have any disagreement, as I said in my remarks, on the inpatient side. MSAs are not going to be able to do much with the inpatient side. But there is the outpatient side. If you just look at it from a common sense perspective, where is managed care strong? Protocol. It makes a good deal of sense; large claim management also makes sense.

They give free choice to the consumer to use whatever services they want, and the provider is supposed to control it. Of course, that creates some perverse financial incentives on that side, and those don't make sense. I think those are the weaknesses of managed care, and those happen to be the strengths of MSAs. MSAs deal very well with the non-inpatient side. To me it's a matter of going to your strengths instead of your weaknesses. In that regard, I think MSAs will do a much better job on the non-inpatient side, both hospital outpatient and physician, than managed care could ever hope to do.

MR. SUTTON: I can agree with Mark to a point. Over the years that we've worked in the HMO business, the utilization of outpatient services and drugs has continued to rise sharply—3% or 4% a year. So at this point, the utilization of outpatient services and HMOs is almost double what it was when we started. I think there is a patient learning curve in the fact that it's covered in full. There is a good argument for controlling that. The HMOs think that early, easy access is important to their controlling the hospital cost. Whether that's true, we don't know.

MR. KING: We've already discussed what I prefer to call risk segmentation because it's a more neutral term than unfavorable selection. But another question that arises in light of what we've been discussing is, how does risk segmentation affect the cost-containment potential of MSAs and of HMOs respectively?

MR. LITOW: Risk segmentation, as I said before, cannot be ignored. It's a critical feature of any plan. I think risk-adjusters are a very important topic from the standpoint of selection and adverse selection. But I just think a risk adjuster is never going to work because you're trying to take something that makes the market inefficient and lay something else on top of it to bring it back to efficiency. The best thing we can do is make it efficient in the first place.

What I'm trying to say is, whether it's a MSA or a HMO, if you create options for people rather than premiums, or benefits or both, you must consider it. You have to modify your plan design. If you do not do that, you're going to allow for adverse selection. And whether it's a MSA, a HMO, or anything else that the marketplace creates, it will be much less successful and may cost money.

MR. SUTTON: On the HMO side, it's true that historically HMOs have attracted a younger subset of the employer population. After being in business for 20 years in a big way, they now have a more representative mix. But like the MSA, possibly, HMOs manage better with older or sicker people probably than they do with younger people. For example, kids spend hardly any money, no matter what kind of a system they are in.

So I think our objective is to try to get people who need to be controlled—the older and the sicker people—into these systems either way. But they may both be attractive to people who think they can save money by going into either the HMO or the MSA because they're low utilizers.

MR. KING: With the fact of risk segmentation and the fact that risk segmentation is going to occur, anytime that you offer a set of options to employees, the question arises, what are you going to do to make sure that risk segmentation doesn't wind up costing the employer more money? If the payment mechanism is set up in such a way that the savings don't accrue to the employer, rather than to the provider or the insurer, then health care costs will not be controlled.

The next question relates to that. What design features do actuaries currently use to protect employer plans against the effects of risk segmentation in HMOs? Could similar design features be used to protect against risk segmentation with MSAs?

MR. SUTTON: This is a difficult one, and I worked on both sides of the fence with employers and HMOs. Big business coalitions are experimenting with health status adjusters. Even if you can't get a good one, if the populations are large enough, you can use demographic adjusters like age, sex, and so on. Many employers have adjusted their contributions based on the age and sex of the people who select one option versus another.

With cafeteria benefits, there are all kinds of complicated, consultant-developed, selection adjusters. Depend on the lower third of the population being half of average cost and the upper third being approximately 150% of average cost, and adjust to those populations. They could do the same with the MSA.

MR. LITOW: I should have had you remove this question. This question is just loaded. But I guess the best way I can answer it is, we're working right now on a particular

project, trying to compare rates for all different types of coverages for large group, individual, small group, HMO, PPO, and fee for service.

It's a very interesting exercise. You find out what the markets do when people are competing. They can't afford to have a rate that's too different from other companies, even if their benefits are higher or lower. If a HMO goes in and offers a very rich plan and is able to secure substantial discounts, and an indemnity carrier competes with that, how does it do that? Well, it starts putting in more cost-sharing. It lowers its benefits, depending on the level of the discounts that it can obtain. And, of course, lower benefits generally mean lower utilization.

So the market generally puts in changes so that one plan can compete with another plan. The question is, will smaller benefits attract people into your plan? That's a tough question. But if you can't sell your rate in the marketplace to compete with, it won't matter what benefits you have. What we found from talking with managed care groups, indemnity carriers, whatever it is, is that they will pay attention to their competitors and if they're out of the market, they'll find ways to get back in the market and have an angle on selling the product.

I think the same thing happens in terms of selection with a HMO versus a MSA versus a traditional plan. Instead of creating one plan that's rich and that will have a cost that is much higher than the other one, in terms of selection, you need try to weigh various choices against each other—they can be equal or you can purposely drive one group of people one way and one group the other—and then recognize that in your cost. But either way, you have to take those things into account and I think that companies do that.

MR. KING: This is a tough question, and I think that both Mark and Harry indicated that, at this point in time, there isn't a systematic way of adjusting for a favorable selection by either HMOs or MSAs. If there's no systematic risk-adjuster, it's up to the judgment of the individual actuary. Making sure that either HMOs or MSAs work for the employer and controlling health care cost require an informed and experienced actuary to make these kind of judgments. Right now there isn't a systematic way to deal with the problem.

Of course, another big question that arises is, are MSAs a threat to HMOs and why? Or ca HMOs and MSAs coexist? And if they can, then why?

MR. LITOW: Well, the first thing I'd add to the last answer is it always helps to have a good set of fudge factors available when you run out of everything else. Many HMOs and big insurers do look at MSAs as a threat. Anything that threatens a marketplace, or a carrier, is going to be looked at as a threat, and it should be. In a free marketplace we want innovation and fresh ideas. Can MSAs, as Harry said, stand on their own, and will they provide a valuable contribution?

I don't think it's appropriate for us to single out any option as being either good or bad. I think we put it out there in the marketplace as an option. I think they can coexist, as my remarks indicate. The Medicare supplement market or any market in which standardized policies have been tried are a big disaster because there's no innovation. There's nothing new. We're saying that this is the ultimate. We can't do any better. That market is going nowhere fast. I'm sure some people disagree. But I think you have to remember that

when you think about MSAs or any new thing, the best feature of markets is that it brings things back into balance, and it promotes innovation. If we remember that, we'll let the marketplace decide whether these things work.

MR. SUTTON: If the playing field is level, MSAs are not a threat to HMOs, although the HMOs perceive MSAs as a threat because they can't understand how they can do MSAs themselves. As long as nothing is mandatory, the employers will make the decisions. I'm dealing in the employee benefit market. If they don't think the MSA will save any money, they won't do it and they won't be concerned about legislation that makes it permissible. If they don't think it will save money, they won't do it. Or if they don't think they can guess the selection, they won't do it. Or they'll be very conservative when they do it.

I think the HMOs are just concerned that this doesn't somehow block them out of the market. If MSAs become very successful, they may want to try their own MSAs. They need legislation to be sure they can do that because they can't offer a high deductible. There are many problems with them in the high deductible. So they want to be sure that whatever is passed doesn't block them out of the MSA market.

MR. JOHN A. MAURER: Much of the discussion is related to the question of how the MSA equates to the increase in deductibles, going from a $200 deductible to a $3,000 deductible, and whether you save enough to fully fund that difference in the MSAs. In my experience of pricing major medical policies, and I have done some work in the MSA field, too, it doesn't take more than very modest assumptions as to utilization reductions and expense savings to show in a number of instances that you can, in fact, fully fund that difference. Even though, as Mark said, it's not necessarily typical, at the same time it's not necessarily rare. And I would suggest that either those who say that it can always be done or those who dismiss it out of hand are equally misleading when they put forth this information.

One of the strengths I see of introducing a MSA catastrophic combination is that now you have something very attractive for the young, healthy, "bullet-proof" part of our society who will never spend money on insurance. But it's tied to a tax-deferred, tax-advantaged account, so they may be persuaded to get the tax advantage, to go ahead and buy the very high deductible at the same time. I think this would bring in a much better, overall average mix of insureds, with a tendency to reduce cost for everyone.

MR. KING: I just might comment that my daughter is 20 years old and bullet-proof, and she wasn't going to take her employer-sponsored health insurance because she was going to be charged $9 every two weeks to pay for that health insurance. She wasn't going to take it until I insisted that she take it.

MR. WILLIAM T. BILLARD: Dental is more preventive-oriented and MSAs could erode that. I wonder if your committee has discussed whether dental care should be included in the MSA concept.

MR. KING: We haven't specifically discussed whether dental should be included in the MSA concept. Dental could be included in the MSA concept. It's a health expenditure that the IRS considers to be tax deductible. One of the possible definitions of those

expenditures that are permissible from the MSA are any expenditure that is tax-deductible under the IRS rules.

MR. SUTTON: I agree with Mark on this point. The big savings are going to be on outpatient services. The advocates of MSAs say that if you just have this money available, people who wouldn't get a physical examination or wouldn't get well-baby care now can do it easily by taking the money out. But the outpatient services will be a big bulk of the reduction. So I have a feeling that people would not do as much chronic maintenance care and preventive care.

On the dental side, the models I've seen show more selection. There's no emergency life-and-death situation. If you're going to have your teeth replaced, you could get into it. And if you could get insurance coverage for it, you'd switch to that. It's potentially much more selective there than it is for medical services.

MR. LITOW: I was a little confused by your comment as to why dental would be harmed because, as Guy indicated, it would be tax deductible.

We have seen, from limited experience, that preventive services have not been hurt. In fact, some people have actually said that they have used preventive service that they otherwise would not have used because they didn't have a deductible and they had the money. It was their choice. That's on very low-cost procedures.

Perhaps the speaker was referring to the issue raised by Harry about the chronic people. But that insurance was never intended to cover dental anyway. We're not trying to necessarily address that problem. Not that it wouldn't be nice. If you have a severe dental problem under major medical, there are certain services that are covered. So again, I was a little confused by that question.