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An Update on Medical Savings Accounts (MSA)

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Summary: Panelists discuss the SOA report submitted by the MSA Work Group and provide an update on recent activities with respect to MSAs.

Mr. John K. Heins: The two panelists that will be speaking to you will be giving you an up to the minute talk about what's happening legislatively and what's happening in the marketplace with MSAs. I will give you a high level overview of the two monographs that the American Academy of Actuaries (AAA) released over the last two years to update you on that group's findings.

The first monograph, released in 1995, was called MSA: Cost Implications and Design Issues. The second monograph, MSA: An Analysis of the Family Medical Savings and Investment Act of 1995 was issued as an addendum after the passage of HR1818, the Family Medical Savings & Investment Act of 1995, and was released in 1996.

The first monograph was a general discussion about the viability of MSAs, how they would fit into the marketplace and what the tax situation might be, since no legislation had been passed at the time the first monograph was written. The monograph is split into five sections and a conclusion, providing the committee's conclusions on the study. Section one is the description of a basic MSA. It's very

much like a flexible spending account (FSA) except that the ownership of the account is with the insured and stays with the insured, unlike with the FSA account which dries up at the end of every year.

Section two talks about potential financial advantages of MSAs. The work group focused on one very key concept that will determine whether or not MSAs are successful in reducing costs, and that is whether or not the insured looks at the account as a form of insurance, or whether as a form of their own savings. The more they think of it in terms of their own savings, the less likely they are to spend it and the more effective the MSAs will be in ultimately reducing health care expenditures. How much people view that account as savings or insurance will depend largely on plan design. The plan design for a MSA is very critical to whether the MSA will be successful in accomplishing any cost reductions.

The next section is on tax considerations. Recent legislation has been passed directed to this issue. Basically, the contributions to the MSA will be before-tax money. Contributions will go into those accounts much like an Individual Retirement Account (IRA). Individuals can withdraw money tax-free if it is to be spent on otherwise uncovered medical costs. Otherwise, withdrawals can occur only under certain circumstances and often the withdrawal will be taxable and subject to a tax penalty making nonmedical withdrawals highly undesirable. In addition, the new act says that the inside build up of investment income will be taxable as earned.

Section four in the monograph talks about the expected financial impact, and because of the induction issue, there were a couple of models that were described in the monograph. The results that came out of those models were very wide, ranging from almost no savings to significant savings. The key to whether or not there are savings depends on whether or not people are modifying their health care purchasing behavior because they feel they're spending their own money. Potentially there could be an increase in cost if the MSA does not result in reduced costs, as hoped, but also creates adverse selection on top of that. If the MSA gets exclusively healthier people, leaving a more unhealthy class for other insurance options, there may, in fact, be an increase in costs for health care.

The fifth and final section does a cost comparison of MSAs and the accompanying high deductible insurance coverage against products that are currently on the market. Essentially the review shows that the MSAs insurance option can be provided on a consistent cost basis with current products. To that extent, the MSA is viable financially.

The second monograph directly addresses the Family Medical Savings & Investment Act. One of the more interesting restrictions in the regulation is that either an employee or an employer may contribute to the MSA, but not both. Apparently the reason for this was simply another way of limiting the amount of revenue that is able to go into the savings account. It doesn't seem to make a lot of sense, but that's what they ended up with. The regulation allows an individual to set up an MSA, if they have accompanying coverage with a minimum deductible of $1,500 for an individual, $3,000 for a family. The contributions, regardless of who makes them, are nontaxable, inside build up of investment is taxable, and withdrawals for approved medical expenditures that are not otherwise covered are nontaxable. One of the issues that is left unclear is what exactly are qualified expenditures. That is something that will need to be addressed.

The monograph talks about how MSAs will effect the marketplace, and it looks at it from both the perspective of the employer and the insured employee. The work group felt that for self-employed people and for some small group markets, there may actually be a fairly quick entry into the marketplace by MSAs. MSAs may be highly attractive in certain markets. Large employers will need to be convinced that a MSA will produce a cost savings for them and will offer benefits to their employees. It may take a few more years for large employers to embrace MSAs, if at all. From the employee side, it was expected that younger, single, and healthy people would find the MSA a very attractive option and those are the people that would obviously save the most money using an MSA. Risk adverse people would not care for this option. Most other groups of people were deemed not likely to embrace MSAs, since it wouldn't be to their advantage.

The next section discusses how quickly the marketplace will react to the legislation and the thought was that in some small group markets perhaps fairly quickly. Generally in larger group markets and in larger employers, it was assumed it would probably take several years to demonstrate that MSAs are an effective way to reduce costs.

The next section talks about how MSAs would effect the uninsured population. Generally the decision was not much. The work group felt that it might be valuable to people who are transitioning between jobs, if they could withdraw money out of the MSA to pay for transitional insurance. However, as it's set up right now, it's not expected that transitional insurance would be considered a legitimate expense and so the uninsured population would likely be unaffected.

The last section talks a little bit about the effect on the marketplace and discusses some of the problems with and the need for clarification within the current regulation. It's unclear as to how MSAs will interact with FSAs and what domain

each will have. It is also crucial that this legislation be coordinated with other legislation effecting the health care industry.

That is all the comments I have on the monographs. I wanted to bring you up to date on the work that the Academy work group had done. I will now turn over the discussion to Mark Litow. Mark is a principal in the Milwaukee office of Milliman & Robertson, sat on the work groups that produced the two monographs, as did Bob Kelly, and has been involved with MSAs for several years.

Mr. Mark E. Litow: I want to talk about Medicare and MSAs. I love talking about subjects that are controversial. First I want to give you an update of where Medicare and MSAs are. A budget proposal has passed through the House. However, I am not sure if the Senate has voted on it yet, and if the Senate changes the proposal, we'll have to wait and see what happens. I was provided, by Senator Connie Mack (R-Florida), an early version of some of the provisions. They had a provision that MSAs would become part of the risk contract process in 2004. There was also talk about MSAs being offered as a pilot program with, I believe, a maximum of 300,000 policies. Senator Edward M. Kennedy (D-Massachusetts) would probably like it to be about 5,000, but we'll see what happens with that. We really won't know a lot of the details until the whole budget has passed.

A lot of people think that MSAs can't work for Medicare. The reason they think this is because, unlike the under 65 market where you have a heavier percentage of outpatient care versus inpatient (especially with the impact of managed care over the years), Medicare is reversed. Medicare has a much higher percentage of inpatient, probably at 60% or so, versus 40% outpatient. Clearly that means MSAs would have to integrate with forms of managed care to be effective. I believe this is quite possible but this is another area of big disagreement. MSAs primarily work on outpatient utilization. They will reduce inpatient utilization a little bit but the area where they save the most money is on outpatient, because that is where discretionary spending by the consumer is key. When a person gets really sick and goes into the hospital, they go to the provider and say “get me well.” That's where managed care really has recognized the majority of its savings. If you look at utilization differences, you always see that managed care produces a lot of savings on inpatient and not too much on outpatient. MSAs work just the opposite.

To begin with, I want to talk about some background information on Medicare. For those of you who don't know and several of you do, I'm not exactly a big fan of Medicare. If we allow Medicare to go fifteen years, we're going to end up with Oregon Medicaid, in other words, the government is going to tell you when you get care and when you can't. If we're going to combine MSAs with Medicare or consider any of the other reform options, then we’re going to have to understand

what the issues are for Medicare. One of the things I've been working on is a proposal to revamp the whole Medicare system, and basically we're looking at phasing out Medicare over 50–60 years. There are several problems with the Medicare currently.

First, you know the bad condition of the funding scheme. In 1996, out of a $107 billion federal deficit, $66 billion was just what Medicare created. Forget about the trust funds, because that's only accounting. We're talking about how much revenue comes in from Medicare through taxes from employers and individuals and Part B premiums and how much goes out in terms of benefits. The deficit last year was $66 billion. That number by the year 2010 is going to be in excess of $350 billion under quite optimistic assumptions. Congressional Budget Office's (CBO) numbers are more like $500 billion. If you add that up over a period of the next fourteen years, you'll have a number well in excess of $3 trillion for Medicare alone. If you think that we have problems now with a more than $5 trillion total deficit, just wait around and see what happens.

Another problem relates to risk contracts. The big issue here also is funding. Risk contracts have positive selection. That's no great surprise. Medicare ends up being a high risk pool. Most people think that risk contracts attract beneficiaries with average morbidity between 80–85% of all Medicare beneficiaries on an ultimate basis with the first year being around 65% and grading up over time.

The system design of Medicare is flawed because it provides primarily a predictable benefit. The design includes a $100 deductible for Part B services but then it doesn't cover catastrophic costs, like if you're in the hospital more than 60 days and you run out of your lifetime reserve days. The design of the system encourages heavy utilization and it also requires people to buy Medicare supplement coverage or sign up with a risk contractor, because a lot of people can't afford the catastrophic costs.

Another issue is price controls. Just think about it in terms of a business. Everybody has their own computer system out there to game it. The cost shifts that come out of Medicare, as well as Medicaid, are transferred to the under 65 market. Medicare is a serious problem, and yet people talk about MSAs creating adverse selection in Medicare. Medicare has more adverse selection than it can handle right now. It's similar to the individual and small group market where they're worried about adverse selection but put in reforms that cause nothing but adverse selection.

Table 1 is a summary of the deficit that I was talking about and the President's proposal, I think they compromised at $115 billion instead of $100 billion. Even with those numbers, you can see what a disaster it is because even if we did this all

the way to 2010, we could save $500 or $600 billion but we'd still be at a $2.6 trillion deficit in 2010 and that's assuming 5% interest for that period. If interest rates go up, it gets much worse. You can see that it's just a long term problem.

TABLE 1
MEDICARE ESTIMATED DEFICIT (DOLLARS IN BILLIONS)

Year	Today	President
1998	$86.9	$81.9
1999	99.1	89.1
2000	112.6	95.6
2001	127.6	102.6
2002	144.1	107.0
Total to 2001	$622.8	$522.9
Total to 2010	$3,218.5	$2,571.8

When discussing utilization and price controls, keep in mind that price controls create this tremendous U-shaped effect. Everybody games the system. We unbundle services, provide extra visits, put up computer systems to figure out which code we can provide more for, and all this creates a tremendous excess utilization pattern under Medicare as shown in Table 2. Part of the reason Medicare's trend, not the whole reason, is so high relative to the under 65 market is due to those price controls, which have averaged about 2.3% over the last fifteen years. Our estimate today is that the providers under Medicare are paid at about 65% of the private market. When I say private market, I mean a combination from managed care all the way to indemnity plans. On the other hand, utilization in Medicare is about 70% higher. There's no age adjustment or anything. That's basically saying when I turn 65 my utilization under Medicare is up 70% within 24 hours. You see reports about home health care abuses, skilled nursing care abuses, and all these other abuses under Medicare which all contribute to the excess utilization. If you compare a private policy, on average, versus the Medicare policy for the same benefits, you find out that Medicare costs 10% more despite having 35% lower reimbursement. That should tell you something about where we're going on Medicare.

TABLE 2
EXCESS MEDICARE UTILIZATION ESTIMATES AT SELECTED INTERVALS

Year	Annual Excess Utilization	Cumulative Excess Utilization
1982	-	10.4%
1984	1.2%	13.0
1987	1.7	18.5
1990	2.4	26.0
1993	4.9	40.4
1996	6.2	68.2

Table 3 shows the effect of price controls from the model I was talking about and how long it saves money, because we do save money under price controls. We bring down the costs initially, however utilization starts to increase and eventually catches up. In our model, it took 18 years for the utilization to catch up and overpower the price control. This is happening now with Diagnosis Related Group reimbursement since 1983 and the Resource Based Relative Value Scale reimbursement more recently. These things are all coming into play and creating this tremendous impact from price controls.

TABLE 3
AVERAGE ANNUAL EFFECT OF MEDICARE PRICE CONTROL
1982-1996 NO INFLATION

Year	Price	Utilization	Annual Cost	Aggregate Savings
Base	1.000	1.0000	1.0000	-
1	0.977	1.0006	0.9976	0.0224
2	0.977	1.0017	0.9787	0.0438
4	0.977	1.0063	0.9832	0.0930
8	0.977	1.0289	1.0052	0.0953
12	0.977	1.0334	1.0101	0.0567
18	0.977	1.0334	1.0101	(0.0036)

Table 4 shows how cost shifts work from one market to the next and this I would deem as an illustration because if any one of you did this chart, you'd all come up with different answers. The fourth column shows the extent of excess utilization in Medicare and Medicaid at 5% and 4% respectively. If you go back and track

Medicare for the last fifteen years, you will see that this increase in trend occurs every year. That's why you have cumulative excess utilization of 68% from Table 2. In addition, look at the effect cost shifting has on the individual and small group markets to understand why those markets have had so much trouble.

TABLE 4
MARKET AND TOTAL ILLUSTRATION OF ADVERSE SELECTION
CREATED BY COST SHIFTING

Type of Coverage	Base Charge and Utilization Trend	Cost Shift	Managed Care Utilization	Increased Utilization Trend	Subtotal Trend
Medicare	3.5%	-1.0%	0.0%	5.0%	7.6%
Individual	3.5	5.0	0.0	0.1	8.8
Small Group	3.5	4.5	-0.5	0.1	7.8
Large Group	3.5	0.5	-1.8	0.1	2.3
Uninsured	3.5	-1.0	0.0	0.1	2.6
Medicaid	3.5	-1.0	-1.0	4.0	5.5
Composite	3.5%	0.2%	-0.8%	2.2%	5.2%

The last thing I want to show you is, no matter what we do for a short term solution, how difficult this problem is for Medicare. Right now we've been running 8–10% trends in Medicare, including eligibility changes for a number of years. In Table 5, you can see that for us to hold the deficit at around the $66 billion mark in 2002, which is the year they're trying to balance the budget, trends would have to stay below 3%, assuming revenue goes up by 4.5% a year. That's never going to happen. Even if we lower the status quo trend by two or three points, you'd save a lot of money, but we're still in trouble. This tells you that the short term solutions, no matter what we do, will not solve the problems. As the number of retirees keeps going up and the number of workers keep shrinking, we run out of time. Eventually Medicare is going to be a huge drag on this country.

TABLE 5
DEMONSTRATION OF PROBLEM

		Status Quo		No Deficit Change	
	1996	**Trend**	**2002**	**Trend**	**2002**
Cost	$191.2	0.083	$308.5	0.030	$228.3
Revenue	125.4	0.045	163.3	0.045	163.3
Deficit	$65.8		$145.2		$65.0

How can MSAs work in Medicare? There are two scenarios here we're talking about. Short term programs such as a voucher system or risk contracts and a long-term program which restructures the very nature of Medicare funding. We did a study for the National Center for Policy Analysis and we had 12 actuaries read the report and I think all 12 disagreed on the major assumptions. However, I look at that as being real healthy. It shows the amount of disagreement and it also shows the amount of debate we need on this topic. This is really a major problem and MSAs are not a comprehensive solution by any means. Nobody should think they are, because they are not going to address the majority of the inpatient problems in the country. There isn't anything currently proposed that is a comprehensive solution by itself.

The real issue here is how are you going to fund costs for Medicare and long-term care. People have to start building asset accumulation. We talk about the spread between the inflation rate and the interest rate and how key that is, because we all know how well compound interest works. The key with the MSAs is to put the money in and let it build up. You'll make a lot more money than the government will. I would argue that the government would earn zero interest, or maybe negative, because of the deficit. Whatever your rationale on that is, there's no question we're going to be a lot better off if people start putting the money away for themselves. In addition, we won't have price controls with the resulting effect on utilization.

Under the voucher principle in the study for the National Center for Policy Analysis, we talked about risk adjusted vouchers. We have risk adjustments today under risk contracts for institutional, noninstitutional, and age differentials, and as actuaries we could go a lot farther if we wanted to. There are very tough issues here, and I think the government has been working for years on how to risk adjust. Remember, any insurance program, it doesn't matter if it's managed care, MSA, or whatever, when people are buying the program, whether it's a group or individual, you automatically have risk selection. You can't avoid it. You have to deal with it to

minimize adverse selection. That should be the goal but the government doesn't understand that. The government is very interested in revenue impact. Then we grade that in over a long period of time so that those people below age 45 will have enough time to accumulate sufficient funds to fund Medicare from their individual accounts. So that the population has control of these finds and does not rely on the government for services. What we're really talking about—I don't know if you want to call it an MSA—is an accumulation account, but that's part of the process to avoid future problems under Medicare.

In this program, we tried to start phasing out price controls. We also increased the Part B deductible to $1,400, the Part A deductible to $750, and a couple of other changes to cost sharing. Why did we do that? Because when a person under Medicare has a choice and if they're healthy, they're going to go into the MSA program or in a managed care program through a risk contract versus Medicare. We encourage them to do this. Then we let them go back and forth between the programs, so that if they get sick, they simply go back into Medicare. Medicare becomes the high risk pool. It doesn't take Einstein to figure out this arrangement can't possibly work. We tried to create a situation where people had a balancing item by creating a real choice between Medicare, MSAs, and managed care. This kind of program would also dramatically reduce utilization under Medicare but politically, may be impossible to implement.

Tables 6 and 7 show the results using this particular voucher program. The tables show how an MSA would work with and without managed care. There was a prescribed voucher amount that the government would establish each year and we trended that. Then out of that money (in 1996, roughly $4,800), we'd pay for a catastrophic policy with a $3,000 deductible and we estimated the cost of that policy to be a little over $3,300, given utilization changes. The remaining money would be available to fund the savings account, about $1,500, with a 2% MSA administrative fee. That wouldn't even touch any of the money beneficiaries currently spend on Medicare Supplement premiums. We felt the MSA was a fairly attractive option for people. We did trend up the deductible each year with inflation since a big component of MSA savings is the leverage you get off the deductible. Managed care reduced the inpatient costs more, therefore, we had more money to go into the MSA, about $600 more.

TABLE 6
MSA TEST WITHOUT MANAGED CARE

	1996	1999	2002
Voucher Amount and part B Premium	$4,848	$5,940	$7,092
Policy Premium	$3,311	$4,827	$5,674
MSA Admin.	2%	2%	2%
Available for MSA	$1,507	$1,092	$1,390
Policy Deductible	$3,000	$3,676	$4,388
Average Med Supp Premium	$1,178	$1,423	$1,719

TABLE 7
MSA TEST WITH MANAGED CARE

	1996	1999	2002
Voucher Amount and Part B Premium	$ 4,848	$ 5,940	$ 7,092
Policy Premium	$2,699	$4,144	$4,591
MSA Administration	2%	2%	2%
Available for MSA	$2,108	$1,761	$2,452
Policy Deductible	$3,000	$3,676	$4,388
Average Med. Supp. Premium	$1,178	$1,423	$1,719

The other concept I want to talk about is what is the long term solution versus the short term. I look at vouchers as a short-term solution. The government proposals project short-term solutions for Medicare over the long term and while this is saving money right, as part of the budget proposal, they have included preventive benefits adding cost to the program. Every time benefits have been added to Medicare, costs for those benefits have been higher than expected, because it is assumed the added benefits have little impact on utilization. If any of you remember, the Medicare Catastrophic Act in 1989 proposed adding a drug program and I didn't talk to one actuary that didn't estimate the cost to be at least two to three times higher than that predicted by the government and we probably were all low. The probability that these preventive benefits will add more costs than the government estimates is slightly below 100%. We have to start getting real in terms of these estimates, because all entitlement programs, it's not just Medicare, will run short of funds in 15–20 years when all the baby boomers come through.

What we're proposing from a long term prospective is to start to wean people off of Medicare. However, we're not going to abandon the seniors. What we're proposing is a long term transition where people between the ages of 45–64, could, if they choose, take their hospital insurance taxes and deposit them into their own accounts. Then the costs under the Medicare program would be reduced gradually. For instance, if I was 64 years old, I might get one year of taxes in my account and for that my Medicare benefits would be 95 or 96% of what they would be otherwise, so the two supplement each other. Then we grade that in over a long period of time so that those people below age 45 will have enough time to accumulate sufficient funds to fund Medicare from their individual accounts. Then the population has control of these finds and does not rely on the government for services. What we're really talking about—I don't know if you want to call it an MSA—is an accumulation account, but that's part of the process to avoid future problems under Medicare.

This proposal has about 13 different steps in it right now, and I'm sure it will change dramatically as we continue to get more feedback about the structure. We're also looking to increase the eligibility age for Medicare. When the program started in 1966, the average age that people lived to at that point in time was around age 67. The average age people live to today is about 77.5. It's up about ten years, and we haven't changed the eligibility age at all. It's not a great surprise that we have all the problems. Another thing I didn't know until we did some research was that Medicare was originally proposed as a program to help the poor, and after ten years of debates, at the last minute the politicians expanded it from the poor to the whole population.

Table 8 shows you the current system projected to 2059 under three options: the current system, proposed short term solutions and this long term solution. These are billions of dollars. The short term proposals still result in $5.5 trillion of debt in 2059, whereas this long term solution actually would begin to accumulate money by that time. In the long term proposal, 60 years down the road Medicare is basically gone and now we have got some money coming in because we're still getting hospital insurance taxes from the young people. MSAs can be a part of that both from the standpoint of covering people above age 65 and as part of a private market. The private market can provide coverage a lot better than the government.

Mr. Heins: Bob Kelly is an assistant vice president with Blue Cross/Blue Shield of New Jersey and will be discussing practical implications of bringing MSAs into the marketplace and also interaction of MSAs with managed care.

Mr. Robert A. Kelly: I agree with Mark's comments with regards to Medicare. I'm personally an MSA advocate simply because MSAs point to privatization, and I

think privatization is the only way to save the health care system that we have in place right now. When Medicare was born in the 1960s, it seemed like the variable milk of human kindness. Who could argue with providing health care for the elders? There's a saying that I read that captures my feelings on this topic perfectly—Attempts to create heaven on earth, invariably produce hell.

TABLE 8
MEDICARE DEFICITS (DOLLARS IN BILLIONS)

Year	Current System	Proposed Short Term	Proposed Long Term*
2000	$112	$97	N/A
2010	342	210	210
2025	1,407	606	406
2040	5,155	1,637	567
2059	24,914	5,452	(129)

*Preliminary numbers only. Proposed long term numbers may change significantly.

I would like to talk about two things, the integration of managed care with MSAs, and some comments about what I've seen out in the streets so to speak, on who is offering what since the law has allowed MSA and given them preferential tax treatment. The notion that MSAs are not compatible with managed care is a piece of disinformation and that is very typical in the MSA debate. Actually that notion is essentially a paternalistic one. What it says is that people are not capable of managing their own care, because basically what MSAs do is empower the patient. Managed care or the care manager, is he or she who decides whether a particular procedure is performed or not. That's where the rubber meets the road in what is meant by managing care; he or she who makes that call is essentially the payer or the one who takes the financial risks associated with the delivery of health care.

Table 9 is meant to be illustrative of a 50-year trend or so. Fee for service, where the insurer/employer has the responsibility for the financial risks, is a financially unstable system. When medical care is needed, you end up in a situation where the member and the physician both have no incentive to economize on the transactions, so both of them will say let's go for it. Then we came to managed care as we know it today, and it has two defining features. One is the introduction of utilization management on the part of the companies, and the other is the shift of risk from the insurance companies or the HMOs over to the provider. The MSA model simply moves as much as possible of the risk over to the member. In my mind it's wonderfully compatible with managed care, except that the care

managers, to the extent possible, will be the member as opposed to some third party. This seems rational to me.

TABLE 9
HISTORICAL & PROSPECTIVE

Risk Takers			
Service	**Traditional FFS**	**Managed Care**	**MSA**
PCP	Insurer	Provider	Provider/Member
Specialist	Insurer	Provider	Member
Drugs	Insurer	Insurer	Member
Hospital	Insurer	Provider/Insurer	Provider/Insurer
Benefit Configuration			
PCP Services	Fully Insured		
Other	High Deductible Plan (Indemnity, PPO, or HMO)		

Let me take you on a quick trip to Mars. I don't think this will ever happen, but consider this structure. Member comes to doctor and gets diagnosed as having a certain form of cancer. The carrier offers the member $70,000 and says, I will send you to a center of excellence for $70,000, however, if you want to go to a different center, or if you want to navigate the fee-for-service system by yourself, here's $70,000 in cash. One step further would be to say, here's $70,000 in cash, you can take a world cruise if you like. This seems to me to be a *rational* plan design.

We have a health care crisis. Do we have a cigar crisis? Do we have an orange juice crisis? Nobody cares what percentage of gross national product (GNP) is spent on orange juice or cigars, but we are very interested on how much of it is spent on health care. The $70,000 that you can use for a world cruise or leave to your kids, would certainly drop the percentage of GNP that is spent on health care. You don't have to rebuild a house that's burnt down. That's the way casualty insurance works. In life insurance there are no stipulations on how you spend the proceeds. You can do whatever you want with life insurance and casualty insurance.

The benefit configuration shown in Table 9 is an integration of managed care with MSAs and it's the so called sandwich design. Here you have traditional primary care physician (PCP) services that are fully insured allowing you to capitate the PCP if you like. Everything else is subject to a high deductible plan, whatever the law allows. It seems perfectly straightforward. My understanding is that there are more than 40 companies out there selling high deductible insurance that's compatible

with the MSA plan design. I know of none of them that are HMOs. Everything is either through indemnity or preferred provider organization (PPO) delivery systems.

This begs the question that if MSAs are so compatible with managed care, how come the managed care companies are sitting on the sidelines? I think there are two reasons for that and they're both associated with the law. First, the law has these limitations on it that are really bizarre. The 750,000 limit on the number of MSA policies will eventually shut the gate on this market. What company, frankly speaking, wants to make any kind of investment under that kind of condition. That is certainly going to slow you down.

The second one relates to technical issues about the law. Those of you who have been following this are perhaps familiar with what's called the stack deductible issue. The MSA law says that in order to be eligible to have the tax shelter for your MSA, you have to have high deductible insurance. In the law high deductible insurance was defined as insurance with a deductible of $1,500 for single and $3,000 for family. What is meant by a $3,000 family deductible? My understanding is that more than half of the industry will pay benefits to an individual when he breaks through the $1,500 and will pay for the rest of the family when the family in total breaks through the $3,000.

An alternate perspective is that a $3,000 family deductible means literally what it says, the family must have at least $3,000 of expenses before they will get any benefits. This was a great topic of controversy amongst those interested in the MSAs when the bill passed. The bill is silent, and so is all of the material associated with the bill. The Internal Revenue Service came out with a revenue ruling recently that said stack deductibles are OK, but you have to go to a nonstack deductible starting in November 1997. So they essentially said no stack deductibles, but they grandfathered them to some extent.

The law does not address other issues which I think keep companies out of the market. My favorite one is an excerpt from the MSA section of the law. It says, an eligible individual is one who gets the tax benefits of the MSA. He or she has to be covered by a high deductible plan and cannot, while covered under the high deductible plan, be covered under any health plan which is not a high deductible plan and which provides coverage for any benefit which is covered under the high deductible plan. What does this mean? For example, can I have a stand-alone drug program with a $1,500 deductible and have first dollar coverage for all other health services and still have an MSA? I meet the conditions since I am covered under a high deductible health plan, the drug plan, and I'm not covered by any other plan which is not a high deductible health plan, which provides coverage for any benefit which is covered under the high deductible plan. It fits the requirements of the law

but it's obviously not the intent of the law. Then what is the intent of the law? Are you supposed to guess? Is the sandwich design OK? Can you carve out PCP services and have first dollar coverage on that and have everything else subject to the deductible? This is not certain. I suppose you could ask the Internal Revenue Service (IRS) for a private letter ruling. It's extremely irritating to have these impediments built into the law which happen to substantiate the argument that managed care is antithetical to MSAs.

There's another piece of the law that deals with the out-of-pocket limits which may discourage HMO participation. It's dangerous, because people are taking actions that will affect their taxes, but they don't know what will happen on audits. Will the tax deductibility be overturned if somebody has a high deductible plan that doesn't meet the federal requirements? For those of you who don't know, the Health Insurance Portability and Accountability Act of 1996 amended the federal HMO legislation to allow high deductible plans for HMOs. The annual out-of-pocket expenses required to be paid under the plan cannot exceed $3,000 for self-only coverage, $5,000 family coverage. Does this mean that HMOs have to offer an out-of-network benefit? Can I have a $1,500 deductible plan that is satisfied only with network utilization? This is unknown. If they go out-of-network, does that have to be applied to satisfying the deductible? If they go out-of-network and break through $3,000, does the HMO have to start paying the claims? Your guess is as good as mine. It's no surprise to me at all that the HMOs have not thrown a product out here basically because of the structure of the law.

For those of you bold enough to consider doing product development along these lines, let me share with you a couple of things that I have run into. The first thing you have to figure out is how to price the high deductible plan depending upon where your market is now. That could take quite a leap of faith to try to estimate what kind of selection or induced behavior differences you'll get by introducing high deductible plans. In New Jersey, the individual market is already basically high deductible plans, so pricing the high deductible policy was not a particular problem for me. In the small-group market though, by and large, I don't think anybody is at a high deductible level now, so you have to take a guess about what is going to happen. Are you going to have a lot of positive selection? Will the MSA induce behavior modification? You have to take a guess on that.

Some of the earlier MSA products featured an arrangement whereby the maximum out-of-pocket under the MSA plan was the same as it was under the relatively rich first dollar type of coverage plan. I think that's quite a stretch and that it's almost impossible to get those results unless you actually have some real favorable selection in the marketplace, but depending upon where you are, you may run into

that. You have to decide then whether to do indemnity or PPO. There's quite a bit of PPO out there as far as I can see. We're offering a PPO in New Jersey.

In the administration, the law says that the MSA itself must be administered by an insurance company, a bank, or someone otherwise approved by the Secretary of the Treasury. You have got to decide on whether to keep the funds on the administration in-house or to outsource them. So far outsourcing, in my opinion, has dominated the market. People have tended to go outside and there are a number of reasons for that. There are fiduciary responsibilities that you buy if you take it in-house that you may or may not want to deal with. It is often thought that in the beginning, this is going to be like a checking account where there's high transaction volume. Who needs the headache of the administration? Basically, I think people are looking towards banks and others to fulfill this role.

In-house administration does have three positive aspects. One is it simplifies your relationship with the clients, provides one-stop shopping so they don't have to deal with two vendors. That's weakened by the fact that the MSA is portable and the individual can move it around. The second positive is you get the opportunity to make some money off of fund management, and third, you can integrate it with a long-term care product if you're of a mind to do that. Basically I think the current state of the art arrangements, would favor going outside and just doing the insurance with your carrier.

I've seen two kinds of banks out there on the street. One type offers almost immediate access to high-yield funds but they make withdrawals difficult by requiring paper transactions. The other type of bank I've seen has barriers to investing the money aggressively. They insist upon low interest-bearing checking accounts until the balance exceeds a relatively high number, such as $2,000 or $3,000, but the access is real easy. They have check stop, debit cards, and are ATM friendly. The other administrators out there are basically third party administrators (TPAs) that will make bank arrangements for you. People who are selling this through an agency force have a tendency to look towards the TPAs.

One of the major problems down the road for MSAs in the commercial line is going to be the claim adjudication problem. Proponents of MSAs have said it will get rid of all this paperwork. I'm not sure about that. One of the things that I think a company can bring to the table when it's selling MSA is pre-negotiated fee schedules with the providers. However, in order to police the application of those schedules, we still feel that we have to adjudicate the claims. I think that this will be common in PPO MSA plan designs, therefore you're not going to get administrative savings that would create much value.

The distribution system is probably the critical element here. You have a broker or agent who needs education. You have to get the word out there as to how this product works and what the tax advantages are. I have done a number of broker education shows, and the one question that I cannot deal with is the following: isn't 7% of $60 less than 7% of $100? You may have to consider changing your commission schedule to light a fire under the distribution system. You can always turn to them and say produce more, but basically they don't want to hear that. Put together with the claims adjudication problem, I don't have much room to increase the commission schedule if I'm still adjudicating the claims. New Jersey state law requires, in the individual and small group market, that you pay $0.75 cents on a dollar for claims, and so when my premium goes down to two-thirds of what it was before, my 25% shrinks and raising the commissions while I'm still adjudicating claims is more than a little tight.

Next I will discuss what the insurer brings to the table for MSAs. Demand management tools are a natural fit for MSAs. If the member has his or her own money on the table, he's going to want to get some kind of advice. Utilization management is also a key to MSAs. You need to retool your UM function to make it more member friendly, so that you could potentially advise a member on the ethicality of doing something like an MRI. You may be asked such questions as, "Should I spend the $800 to have the scan taken?" Your UM procedures presumably address that type of thing and now you would be offering advise to the member as opposed to putting him in handcuffs. Last but not least, what the insurer brings to the table, under the MSA, is insurance, which would be a nice change of pace relative to what is currently out there.

One last quick trip to Mars. Anybody who is seriously considering putting a product out there may want to consider the possibility of flat taxes. I know that may seem like an awfully obscure possibility considering the political environment, but Representative Bill Archer (R-Texas), the major proponent of MSAs, is, I believe, about to introduce his version of flat taxes, whether it be valued added or a national sales tax. I'm not sure what he's going to come out with, but they are serious about tax reform and privatization and you never know what might happen. I look forward to seeing the privatization of the insurance business in my lifetime.

Mr. Dale C. Griffin: One of you said you were you going to talk about what has happened in the marketplace since the new law.

Mr. Litow: Most people estimate that somewhere between 100,000 and 200,000 policies have been issued. There are a few companies that have sold a lot. Most companies are really struggling with it. There may be different reasons for that, but it is primarily marketing. Many companies felt it was just like a high deductible

policy. In fact, a lot of companies just try to sell it as a rider with little or no education of the agents. They don't understand the difference in the risk selection that Bob talked about. They're really struggling with it right now, but it's an education process and we shouldn't rightfully expect anything to move real quickly. The law, with the lack of flexibility, has created problems as well, some of which Bob talked about, and there are a lot of other issues. There are a lot of bills out there addressing these issues. I don't know if they're going to go to get rid of the cap or whether they're going to open it up to all markets. It could well be that nothing will move for a couple of years. That's very difficult to predict.

Ms. Joan P. Ogden: What I have observed with regard to the MSAs is that particularly when there's a managed care environment, if the providers are not being reimbursed directly by the insurer, any provider discounts go away. What is your view of the effect of that on the overall cost effectiveness of the MSAs?

Mr. Kelly: I expect that the PPO design will come to dominate, and I would further expect that one of the major functions of the carrier through offering the catastrophic plan, would be to pre-negotiate these schedules with providers. I don't expect a real problem in that regard.

Mr. Litow: I agree. I think there's a lot of misunderstanding among people that if you put in an MSA, you must give up discounts. I would say look at an MSA as an added benefit. You're going to control utilization. If you're going to start giving up discounts, obviously you have to look at the inpatient and outpatient costs and add it all together. You're probably not going to have enough money to go into an MSA. My expectation is that the only problem MSAs have when integrating with managed care is in strictly capitated plans without an option to go out-of-network. I think over the years you'll see that those plans will be under a lot of pressure and you're going to see more movement to point of service, and there really isn't any reason that with an MSA you cannot get the same types of discounts or close to it, but there's this big issue about control of the provider. That is a struggle for some of the HMOs to bring in, because they are very afraid of losing control. If you can get the discounts, it's a matter of lowering utilization on the outpatient services. However, if you make it into a trading ball game, outpatient utilization savings for discounts, then you're not going to have enough money to go into the MSA to make them financially viable.

Mr. John A. Maurer: Mark, you probably remember during the debate on MSAs, that MSAs were criticized as appealing only to young, healthy people and that there would be massive antiselection in the rest of the market. One of the arguments that the proponents used to blunt this was, to the extent MSAs attract young, healthy folks, that this would be very attractive to the uninsured since most of the uninsured

out there are young, healthy folks and would really cut down on the number of uninsureds. Have you done any studying, any surveys, or anything about what percentage of people signing up for the MSAs were actually previously uninsured?
Mr. Litow: I've done a political survey. It's anecdotal. We've talked to about six or seven companies now and the percentage is actually quite high. Some of the companies are counting what percentage they have of people that at least report to be previously uninsured at the time of the purchase. The highest I've heard is 50%. The lowest I've heard is about 10%. For most companies it probably averages in the low 20%, so it's pretty substantial and I think a lot of people have been surprised by that.

Mr. Chris L. Sipes: I can see the attractiveness on the individual market, but on the group side, we administer a large amount of association business, and we don't see the attraction. Groups typically have coverage with a $300 deductible or an office copayment and the high deductible program is not attractive to all the members of the group. For example, say they have ten employees, eight of the employees may be relatively healthy and see this as an advantage from a cash flow perspective. The other two employees have got some kind of ongoing conditions themselves, their spouse or whatever, and in fact they never get an opportunity to get the money saved up. I see this issue being the thing that keeps groups from making that kind of conversion, because in fact it was not a good deal for the employees of the group in total and it was in fact, a reduction in benefits. What is your perception on that or how is that being addressed?

Mr. Kelly: I don't know what to say about that. I sympathize that it's a possible outcome. My opinion is that you have to take more financial risk in order to have an equal funded MSA relative to a relatively first dollar coverage. People that are high utilizers are going to have to pay more. I believe that's true.

Mr. Litow: First of all, it's not necessarily true that people are going to have a higher out-of-pocket cost on an MSA plan than they do on their other plan. It's totally a function of plan design, and so in your case if they have a $300 deductible, the next question is what is the coinsurance. If it is 20% on the next $5,000, resulting in a $1,300 out of pocket, and if you had an MSA plan for instance that had a $1,500 deductible there would only be $200 additional maximum out of pocket for those people. I would suspect most of the people in that case, even the sick people, would probably look at it and say I may not be sick every year. There are people that are chronically ill and have high expenses every year, but if you look at the proportion of the people that fall into that bucket, it's very small. On the other hand, if the out of pocket would be $2,000 or $2,500, then those people definitely won't choose the MSA. We all know that healthy people, by and large, choose insurance coverage based on premium. Whereas, people that are not as

healthy, or in poor health, will generally choose a plan based on out-of-pocket cost and restrictions on providers. That's part of the selection game. Again, in your design of a policy, you have to reflect this. There are situations where MSAs may not be attractive relative to the base plan, but on the other hand, it may be attractive to everybody in the base plan. It really is heavily driven by design. In South Africa, where MSAs now cover one-sixth of the insured population, we see that all the time. You can take in sick groups just as well as healthy groups depending on what your plan design is and considering what your competition is for that group. Joan asked about managed care. If you lose your discounts, then you can't compete on the healthy groups. In this situation, you may not be able to compete on the sick groups. I expect MSAs to get a healthier population on average than the total population, but not any more so than might typically be experienced by a managed care plan. Unless you want to attract all the healthy, which you can probably try to do.

Mr. Steele R. Stewart: First to clarify a few points that were made. I had not heard before that the earnings in the MSA would be taxed. Did that come out in the regulation or did I misunderstand something?

Mr. Kelly: HR1818, I believe had them as taxable. This issue has flip flopped, but HIPAA has the interest sheltered.

Mr. Stewart: The second point is with regard to primary care. I thought the law did allow HMOs to have a high deductible health plan with preventive care being carved out so you could have that as full coverage.

Mr. Kelly: The provision says preventive benefits may have full coverage if required by state law. And this would not necessarily cover all the services a PCP provides.

Mr. Litow: In addition, other state laws may prevent entry into the market. Minnesota, I think, has a $500 maximum deductible for an HMO, and I don't think they've changed the law yet.

Mr. Kelly: I was very glad the law ended up providing shelter to the investment income, because one of the arguments for MSAs is to level the playing field between out-of-pocket expenses and employer provided insurance, and certainly sheltering the investment income fits in there. In my mind, sheltering the investment income is indicative of the fact that MSAs are pointing towards Medicare and the prefunding thereof. I personally was glad to see it survive the cut.

Mr. Stewart: The third comment relates to the last question, and that is, in some states the state law will allow, in combination with HIPAA, for an employer to offer

three or four products, maybe an MSA, a PPO and/or HMO. If they only have five employees, you could end up having the situation where a sick employee chooses for the first year, to get an HMO product or a traditional plan while the rest go with an MSA. Then the following year they move back out of it. The question is, what happens to an individual who has an MSA through their small employer and now gets hired by a large employer with full coverage with the large employer? What happens to the MSA?

Mr. Kelly: He's no longer eligible to make tax deductible contributions to the MSA, but he still make withdrawals from the account to cover deductibles. It remains a MSA and qualified withdrawals can be made if they're not covered by subsequent insurance. However, he or she is not eligible to make new tax deductible contributions.