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An Update on Medical Savings Accounts (MSA)

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Moderator: MARK E. LITOW
Panelists: ROLAND E. KING
HARRY L. SUTTON, JR.
Recorder: LARRY J. PFANNERSTILL

Summary: This panel will update the audience on the issues addressed and findings reached by the American Academy of Actuaries (AAA) work group responsible for MSA.

Mr. Mark E. Litow: All members on this panel were part of the AAA MSA workgroup. The Workgroup published a monograph in October of 1995 entitled "Medical Savings Accounts, An Analysis of the Family Medical Savings and Investment Act of 1995." The monograph included several illustrations on the potential impact on the uninsured and the marketplace that MSAs might have as a part of health-care reform.

Of course, those illustrations have been used particularly by politicians and legislators as the answer. That is not the case. In fact, we had disagreement among nine members on that committee. We had some people who came from a managed care background, some people who came from an individual background, and some people who came from a government background. Today's panelists have all three of those backgrounds. We've had no fisticuffs, but we have had many interesting debates, and we expect that to continue. We do not have all the answers. We will try to provide our insight and perspective, but we may disagree on some things. We're going to talk quite a bit about HR3103, which is the bill that was recently enacted into law.

Harry Sutton will give a brief overview of the law and talk about some of the administrative issues. Harry is a health care actuary at Allianz. For many years

Harry has debated numerous topics, many controversial. Harry really comes from a managed care background, so he's coming at it from a different perspective than our next panelist, Guy King.

Guy was the chief actuary of the Health Care Financing Administration for 16 years. He is leading the debate on Medicare. He will give you several perspectives on how he sees MSAs fitting in with Medicare. Then I will talk about pricing issues and rating issues relative to MSAs. There will be many ideas brought out there.

I was on a radio talk show in Milwaukee and the first question the reporter asked was, "Are MSAs a comprehensive solution?" I said, "No, they're just part of the solution." He said, "Well, OK. Then we don't care about them. On to the next subject." Many people view health-care reform that way. Is there any one solution that's the right solution? If it were that easy, I think we'd have one. So keep that in mind. MSAs are being promoted as part of a solution, not the whole solution.

We'll start the program with Harry, who will talk about HR3103 and some of the administrative issues that go with it.

Mr. Harry L. Sutton, Jr: You'll see that I call the bill the Kassebaum-Kennedy bill. If I were a Democrat, I'd call it the Kennedy-Kassebaum bill, but it was drafted by Senator Kassebaum. On the Washington scene, it was meant to be a farewell because she's retiring from, I think, four terms in the Senate. The bill was fairly straightforward, with the exception of the MSA part, because Senator Kennedy was violently opposed to the MSA aspect. The Republicans had withdrawn it for Medicare. Guy will talk a little bit about what he thinks about Medicare and MSAs. I'll discuss a brief overview of the law and talk about some of the administrative aspects of trying to live with the law if, as a carrier, you want to get into this field. A carrier could be a mutual fund company, an investment banker, an insurance company, or something else. It's not very clear. I must say, as far as I know, there has been no real interpretation of how to get along with this law. The administration issues and the guaranteed issue provisions, along with small-group reform, will be very difficult to get in place in the order in which this bill requires them. But I'll only talk about certain administrative aspects of it.

Let's briefly run through the provisions of the law. This law is greatly simplified over the consensus bill that was vetoed by the President. Senator Kennedy made a compromise that affected very few people. It doesn't apply to Medicare. It covers small employer groups, which was a major portion of the bill. Other than the portability part of the act, which was the original basis of the bill, it also impacts small-group reform for employers of 2–50 lives. This will require almost every state to file a proposal for exemption from federal regulation and, in many cases, will

require state legislatures to pass new laws about small group insurance. It covers self-employed individuals, as well as small employers.

The law defines a high-deductible plan. For individual coverage, the plan has an annual deductible of $1,500–$2,250 with a maximum out-of-pocket payment of $3,000, and for family coverage it's a deductible of $3,000–$4,500 with a maximum out-of-pocket payment of $5,500. Now, there's typically a problem, which our committee has pointed out in earlier versions of the bills and also after the passage of this one: Very few carriers write a deductible of $3,000 that would apply to the first member of the family. In other words, the bill has a family deductible, so no benefits are paid until one person in the family or the total family has total expenses in excess of $3,000. Most plans that carriers write have a deductible that applies to each individual, and they may be limited to a minimum of two or three individuals or have an aggregate deductible. This appears to be a true family deductible. We had argued against that, but it went through anyway. The MSA contributions, which maybe were affected by the Academy's earlier reports, are limited to something less than the deductible. The aggregates in the earlier version were such that the savings amount would be so large that you could give away the entire deductible. In other words, if you had a $2,000 deductible, the employer could give $2,000 to the employee and then he or she would essentially have 100% coverage including the MSA.

The law provides for a four-year experimental period to cover 750,000 account holders. The system is supposed to count an employee and spouse as only one account holder, even though they have two separate MSAs or high-deductible plans. So you could have a husband and wife each buying individual coverage with a $1,500 deductible and each have their own MSA. They could possibly have a different benefit plan except for differences in the amount they could deduct when they put into the MSA. They could put in less of the deductible amounts than they could if they had a family plan.

A few of the problems in keeping track of this are listed below:

- Requires a trust account for individual
- Does not count previously uninsured (six months)
- Each trust shall report, by August 1, the number of MSAs issued during January through June of the current year
- Trust must report "Taxpayer Identification Number (TIN)" and previously uninsured individuals
- At calendar year-end, trust fund transactions for tax year reported to individual and IRS

- Trustee can be bank, insurer or other; can this include Third Party Administration (TPA), mutual fund, investment manager?

First of all, it requires a trust agreement, and the count of enrollees does not include people who have not had private insurance for the last six months. In other words, part of the object of this is to get more people insured and decrease the number of uninsured. So, at least as I read the bill, the trust will have to report how many people had no previous health insurance coverage for the prior six months and how many have replaced their coverage. The government wants to know where the money's coming from and the effect on health insurance coverage. The bill requires reports on August 1 to include the number of MSAs issued in the first six months of the year. This was included because the government wants to stop enrollment when it appears that they're approaching 750,000 enrollees. Nobody knows what will happen. There are measuring points and stop points where the government will, at least temporarily, stop enrollment. Then, when they count everybody, they may reopen enrollment briefly.

The trust must report the TIN and whether or not the person was insured within the prior six months. I assume that's referring to adults. The trust then reports the money put into the fund and the withdrawals from the fund at the end of each year. In other words, it is similar to a mutual fund year-end report sent to the IRS and the individual. A trustee can be a bank, insurer, or other entity. This might include a TPA with a sequestered account and a mutual fund or investment manager, because all these people are thinking of setting up the MSA. These are not necessarily the only scenarios, but these are some that would work in terms of setting up the high-deductible insurance and the MSA.

The first approach I looked at was similar to what medium-to-large employers have used in setting up a flexible spending account (FSA), because in an sense this is like an FSA without the use-it-or-lose-it provision. Based on the last reports that I've seen, apparently 20% of the employers who are offered an FSA actually use it for medical expenses; the average amount employees contribute is somewhere in the $500–$700 range. That's probably because people are conservative and they don't want to put away part of their salary and then lose it to the employer. With the MSA approach, they will not lose it. On the other hand, it's similar to an FSA plus an IRA, or a combination of a savings plan and a tax-deferred pension vehicle like an IRA or a 401(k) plan.

The first approach to present to you is where the employer wants to integrate the MSA with the administration of an existing group health plan. Remember now, this pertains to small employers. Not too many employers of 50 or less employees already have an FSA or a Section 125 plan, except possibly to force the employees'

contributions on a pre-tax basis, which saves the employee the income tax on the money. However, TPAs and insurance carriers who administer FSAs usually pay the claims on the indemnity plan as well. Most HMOs, because they have very limited out-of-pocket payments, really don't integrate with an FSA, unless you will pay for dental claims or medical expenses that are not covered.

The money has to be set up with an individual measured fund through a trustee. I asked a couple of carriers and mutual fund managers what the administration costs would likely be under this scenario. I'll share their responses after reviewing some administrative details. The carrier would administer the MSA exactly like an FSA, except it doesn't remove the funds and return them back to the employer at the end of the year. But with a small employer, it's relatively expensive to set up a 402(k) plan with an FSA. Both the mutual fund companies and the large carrier I spoke with concentrate on the small employer market, but do not usually administer plans with as small as 50 lives, let alone five or ten lives.

POSSIBLE ADMINISTRATIVE APPROACHES TO SETTING UP 402(k) FOR SMALL EMPLOYERS

Scenario 1:

- Integrated with administration of group health plan MSA handled similarly to FSA (Section125)
- Trustee needed—employer or other
- Could be set up like 401(k), administered by carrier
- Funds in common investment fund (money market or cash management)
- FSAs frequently managed by carriers or TPAs integrated with claim processing
- Account holder makes special request for reimbursement outside health plan

In Scenario 1 the FSA is integrated with normal claim processing. Normally under an FSA, because it's use it or lose it, as soon as there's a deductible to be paid by the employee, they take it out of the FSA. This is because the amount of money is fixed and the employee might as well get his or her expenditures out of the way as soon as possible. An employee who has enough left over in December can buy a pair of eyeglasses. With the MSA plan, if the medical expense is deductible on the health insurance plan, the coinsurance or deductible is subtracted from the MSA automatically and the money is paid back to the employee. If it's a nondeductible expense under the health plan, like a pair of eyeglasses, the employee normally has to make a specific request and submit the proof that he or she spent the money for the requested purpose.

COST IMPLICATIONS OF SCENARIO 1

- Additional TPA charge for FSA administration ($2–$4 per employee per month). No fund management. About 20% of employees use FSAs; average funding $500–600/year
- To administer only MSAs could be relatively expensive for small employer

Example: Large carrier: 401(k)
$20,000 projected minimum deposit
$600 annual administration fee
Plus $35 per employee
Plus $450 start-up fee (trust)
Management fees of assets invested
Targets employers with under 100 employees

Example: Large mutual fund company: 401(k)
$1,000 new plan set-up fee
$1,500 annual maintenance
$22 per participant charge (< 400 employees)
Fund management fees
$8 per distribution (targets employers of 200 employees and greater)

Problems:
- Frequent withdrawals (small claims)
- Possible low or no balance
- Use of money market funds unless fund becomes large
- Sample average rate 1992–94: 2.8%

Does not include cost of claim processing of high-deductible group insurance.

The cost implications of scenario 1 show some of the expenses that could be expected if you are only administering the MSA and if you had it integrated, similar to a 401(k). The MSA is really intended to be an investment plan, but it probably will be more like a money market account or a cash management account similar to what Merrill Lynch founded many years ago. The first example is from a large insurance company that sells 401(k)s for the under-100-life market. The company hopes the emphasis will be larger than ten lives so that the sign-up costs are not too excessive. It wants a projected minimum deposit of $20,000. There is a $600 annual administrative fee, plus $35 per employee, plus a $450 start-up fee to set up the trusts and the mechanics needed to maintain the individual accounts for each employee. Of course, the company also charges for management fees because it intends to invest in mutual fund types of arrangements. You can see that if you only

had five employees, you might not have enough money going in to satisfy a minimum. The company also charges a percentage of the assets to manage the fund assets and it does more when it involves schools of funds that allow switching funds from time to time. You have to assume that employees with reimbursable medical expenses will tend to withdraw the money, if you're going to estimate the average amount of the funds.

The second example involves a large mutual fund company. It gears to much larger employee groups, usually with at least 200 employees, but it might lower its limit for this. The company doesn't think it makes much money with this kind of program involving a money market fund or cash management account. It might do it in order to try to get people accustomed to investing with the mutual fund company by setting up either an individual retirement account (IRA) or some other 401(k) with that employer. The company might not want to do it if it really thought it wasn't going to get enough money in to make it worth its while. Again, this is aimed at employers with at least 200 employees, which is higher than 50 employees, but the company might lower its minimum number of employees to attract smaller employers.

The expenses include a $1,000 set-up fee, $1,500 annual maintenance charge, fund management fees of $22 per participant (up to 400 employees), and $8 per distribution. The company assumes the employees will not take much money out of the fund because it usually deals with pension retirement funds.

There are several potential problems with administration of an MSA fund including frequent withdrawals and the fact that the employee doesn't have to put any money into the fund. The employee can wait until he or she has medical expenses and then put the money in. The employer is more likely to contribute funds out of each paycheck, but the individual can use this merely to get a tax deduction for his or her out-of-pocket medical expenses. When the employee has a medical expense, he or she can put the money in the fund, draw a check, and take the funds out. So the unknown for the mutual fund company is whether the employee will put any money in the MSA and will it be available for investing or will the employee take it all out to pay claims? The employee is reducing his or her salary by after-tax money and then deducting it on his or her income tax statement. He or she could merely convert these minimal out-of-pocket expenses to tax-deductible dollars as opposed to the 7.5% IRS limit. The money market fund average of this particular fund was about 2.8% over a three-year period prior to 1996. The rates fluctuated during that period because of the change in the bond rates and interest rates. This has nothing to do with the cost of administering the claims of the high-deductible insurance.

The first scenario examined how to get employers in the middle of this, similar to how they are with a Section 125 plan. With these plans, most of the claims processors of the FSA are the same as the claim processors of the employer's indemnity plan. Scenario two completely separates the high-deductible insurance from the administration and reporting of the MSA. This scheme is probably a lot cheaper to administer. The carrier enrolls the employees with a high-deductible plan and the carrier does not relate to the MSA. Each employee would set up an individual MSA account, like an IRA, to operate like a cash management account. The same mutual fund company gave me an estimate of what it would charge to set up a cash management account. Of course, it likes cash management accounts because they are used to buy stocks or mutual funds, so they usually charge less.

The example in the second scenario requires a $500 minimum deposit and a $100 minimum withdrawal.

Some other companies may have higher minimums like $200 or $500. For example, my home equity loan has a $500 minimum with unlimited check writing. Administrators charge about 1% of the funds for an administrative fee. The company doesn't charge any fee for the cash management account, and can make automatic deposits by check or can have a fund withdrawal from your checking account by electronic fund transfer.

Under this scenario the trustee would report to the IRS and give a copy to the employees. Employees can deduct the contributions going into the fund from their income, even if they don't itemize their deductions. Employees would then have to report on their returns how much they withdrew and the fund would also report how much was withdrawn. The employee would have to state on his or her income tax that it was all for medical expenses. He or she doesn't have to furnish any proof, as far as I know, but he or she could be audited by the IRS the same way as when you file your medical expenses on your tax return.

MSAs require a trust agreement that is different from the standard trust agreement or an agreement you sign with somebody for a management account or a money market account with withdrawal rights. As I said, the companies I talked to said that many of these cash management accounts are really just there to get money coming in and they don't really make any profit. It's merely a marketing mechanism to get people to invest in either stocks or mutual funds.

There are a few problems. In the second scenario, and maybe even in the first scenario, the employee may pay eligible medical expenses out of the MSA with no reference to a carrier. The carrier still would have to determine whether the person satisfies the deductible. The employee would have to retain all the receipts for any

medical bills that he or she paid and submit them to the insurance carrier, as he or she would have otherwise. If the employee is withdrawing a great deal of money that's not covered by his or her insurance plan, the employee must still pay the deductible out of his or her own pocket. My guess is that probably two out of ten employees would get over the $2,000 level, less employees if it's $3,000. In a small group, retention would be high. The estimate in the Academy report is 15%, because it used an average of large groups, small groups, and individual, rather than something relating to a particularly narrow field like this one.

Small group reform will be a problem because many states passed a prototype version of the law. They might have to change their law to permit you to write a high deductible. It might be only on the individual side, and it might not be in the small group. The carriers that talk mostly about entering this market sell individual insurance, so they underwrite everybody.

Guaranteed issue brings in another element. They will be issuing these high-deductible plans to people who may not be insurable. So nobody is too sure what will happen with that.

Four or five states have major individual insurance reforms. Massachusetts would rule out any private insurance other than one prototype, which is not the high-deductible plan according to the federal rule. So will they change the law that is in force in Massachusetts but never has been implemented? Will they change it to permit an MSA? Nobody knows, but the way the law is written nobody could sell a high-deductible policy.

Lastly, I would like to discuss some of the major outstanding issues. There is nothing in the statute that makes it clear the employer couldn't keep a Section 125 plan along with an MSA plan. The law also essentially says that both the employer and the employee cannot simultaneously contribute money to the MSA. If the employer pays the full premium on the high deductible and puts a small amount of money into the MSA, the employee cannot contribute. However, it's not clear whether there's a way around this provision. I just want to raise the issue.

I think an FSA has two parts. A very common part is to reduce the employee's wages to pay his or her contribution of a share of the premium on the regular employer medical plan. I presume that can still be done. But if the employer goes through the FSA approach of reducing the salary voluntarily of the employee to put money in the FSA, it may be illegal. Whether it's employer money or employee money may be in the eye of the beholder, but I'm not sure where it is in terms of the IRS, particularly if the employer only puts a few hundred dollars in and the employee is prevented from putting in any other money. There is a way around

that complex rule if the employer could put no money in and instead raise the employee's pay. The employee could then put in his or her own money and get a tax deduction for the whole thing. So the employer can get around it.

In the situation where the employer has already set up a Section 125 plan, it would seem to be easier to reduce the employee's pay and put the money in monthly or every pay period, similar to an FSA. It's certainly not clear if that is allowable. The law says, "MSA contributions are not available under cafeteria plans. Subsection (f) of Section 125 of such code is amended by inserting "106(b)" before "117." You have to look at the law to figure out what that means. Essentially it implies that you can't have a payroll reduction for the employee to put money into the MSA as you do in the FSA. I don't know whether that changes the employee's money into employer money. It would be a technical question to determine whether it's no longer the employee's money and the employee is not violating the law. At first everybody I talked to thought the employee could do it that way. The way they probably can do it is just have after-tax money withheld and sent by the employer into the MSA. That's after-tax money, not employer money. Then the employee can take a deduction. It wouldn't be workable if the employer puts any money in, because they both cannot put money in at the same time. If the employer intended to keep the employee harmless and contribute the same amount to the high deductible plus the MSA, the employer would have to increase the employee's pay.

This is just an idea of the complexity of the law. It's not as complex as the original bill proposed by Congress that taxed the income. Generally all contributions in the MSA fund are assumed to be tax free, as long as they do not exceed the maximum allowable, and the expenses withdrawn are legitimate medical expenses under the IRS rules.

Mr. Roland E. (Guy) King: Harry's comments about whether this should be called the Kennedy-Kassebaum bill or the Kassebaum-Kennedy bill bring to mind a story that Representative Bill Gradison told about himself after the enactment and subsequent repeal of the Medicare Catastrophic Coverage Act. He's a Republican and collaborated on the Medicare Catastrophic Coverage Act with Pete Stark, a Democrat. In the House of Representatives, Gradison liked to tell people to call it the Gradison-Stark bill. Then when things began to unravel a little bit, he said, "Well, why don't you call it the Stark-Gradison bill?" Then after it was finally repealed, he began referring to it as the Stark bill.

Before I talk about my view on MSAs in the Medicare program, I'd like to talk about how MSAs would work in the Medicare program. We can look at the Medicare Preservation Act (MPA) as a model. It was vetoed. It's no longer applicable, and

that was many months ago. We don't have to deal with the specifics of it, but we can talk generally about the way it would work.

There were basically two types of MSAs in the MPA. There was an MSA that was very similar to the one that Harry just discussed. A capitation payment would be made to a Medicare beneficiary. With that capitation payment, beneficiaries would be required to purchase a high-deductible plan and the remainder would be placed in an MSA for them to withdraw to use for medical purposes. If they withdrew it for purposes other than to pay for medical coverage, the money was taxed at that point as ordinary income.

The other type of MSA in the Medicare program would have been compatible with managed care plans and, I think, in fact, would have enhanced managed care plans. For anybody who enrolled in a managed care plan, the plan is paid the adjusting average per capita cost. The plan must compare its average annual revenue (APR) with the adjusted community rate (ACR). Any difference between those amounts must be given to the beneficiary in the form of extra benefits. Basically it allows a managed care plan to earn the same rate of profit on Medicare beneficiaries that it earns on the rest of the commercial population enrolled in the HMO. The perfect fit with MSAs and managed care plans is that the difference between the APR and the ACR could be returned to the beneficiary in the form of a contribution to an MSA instead of in the form of extra benefits, if that's what the beneficiary so desires. So MSAs, in that regard, fit in perfectly with the managed care program and the capitation program that's currently in effect. The MPA contemplated expanding this in order to save the Medicare program from bankruptcy.

What I'd like to do now is discuss some conventional views. We'll start with the conventional viewpoint on the compatibility of MSAs with the Medicare program. Then I'd like to give my own view, which, in most cases, is the opposite of the conventional wisdom on MSAs. I'd say probably the most important aspect of conventional wisdom that underlies all of the thinking in Congress, particularly among Democrats, is that only healthy people in the Medicare program will choose MSAs. Because Congress thinks that healthy people will choose MSAs, they then think that MSAs will experience favorable selection and will end up costing the Medicare program money rather than saving it money.

There are several authoritative studies that have validated this point of view. Probably the most significant one is a major study that was done by Lewin VHI that said that favorable selection would occur in the Medicare program. The study was completed on the basis of analyzing the financial gains and losses that would occur for a Medicare beneficiary in an MSA program versus in traditional Medicare.

I don't believe that the facts really support that conventional view. First, the studies that validate favorable selection are flawed, because they're based on the assumption that the most important consideration for a sick person who is choosing a plan is financial. I think that is incorrect. In other words, what they're saying is that sick people are going to gravitate towards the plans with the lowest copayments, and that's going to be the overriding consideration people are going to use when they're deciding among plans. If this were the case, if the sickest people all tend to gravitate towards the plan with the lowest copayments because of the financial considerations, then all of the sickest people would be enrolled in HMOs. The facts based on the studies for HMOs don't support that conventional wisdom. In fact, the foremost consideration for sick Medicare patients who are thinking of joining a plan is not what their copayments are going to be. They want to know if they will have the freedom to choose their doctor or their hospital. As evidence of that, I point out the latest study that shows that the Medicare costs of the average HMO enrollee are 58% of those of the average nonenrollee during the last three months preceding enrollment. So, once again, a beneficiary has the opportunity to enroll in an HMO that will result in the lowest copayments that they have to pay out of pocket.

The evidence shows that sick people, far and away, do not select the plan with the lowest copayments. They select the plan that will allow them the greatest freedom to choose what doctors and hospitals they're going to use. As further evidence, an earlier study that looked into the difference in favorable selection between closed panel HMOs and open panel HMOs found that the closed panel HMOs experienced more favorable selection than the open panel HMOs. This is a situation where beneficiaries would have more freedom to choose their doctors and hospitals.

The second conventional viewpoint is that MSAs will appeal to the wealthy only, so we'll be giving a benefit to the wealthy, and poor or middle income Medicare beneficiaries won't be able to use that benefit as equitably. Under the type of program the way the MPA would have worked, poor people actually could have increased their cash income. They may have chosen not to increase their cash income, if they had health expenditures that were not currently covered by the Medicare program. A good example would have been prescription drugs. They could have used the deposits into their MSA as a vehicle to help pay for prescription drugs or other health-care costs that are not paid for by the Medicare program. Therefore, I would say that because of this MSAs should have a special appeal to low-income Medicare beneficiaries.

Another conventional viewpoint is that MSAs will undermine enrollment in managed care plans. Well, I've already given you an example of the type of MSA that was built into the MPA which will actually enhance the appeal of managed care

plans. I believe that there's room enough in the Medicare program for both managed care plans and MSAs. It'll just increase the competition if we have them both. I think that in the case where the contributions to the MSA can be substituted for extra benefits, it actually will enhance the interest of some Medicare beneficiaries in managed care plans.

Another conventional viewpoint is that MSAs won't be able to obtain the discounts that Medicare and HMOs currently obtain so the Medicare beneficiary will end up paying more. For example, hospital charges that can run as high as 200% of what Medicare or HMOs pay will cost the Medicare beneficiary more. Well, I think that by accepting that argument we are accepting the argument that the system is not going to change in order to accommodate this new benefit, and we all know that the health-care delivery system always changes to accommodate changes in the Medicare legislation. The programs are already set up. The programs that are preferred provider organizations (PPOs), HMOs, and third party administrators will negotiate on behalf of the Medicare beneficiaries with MSAs the lower payments that would be competitive with what Medicare gets or with what an HMO or a PPO gets. So I don't think that's going to be a problem, unless there's virtually no interest in MSAs and these kind of organizations just don't respond to the demand.

I mentioned earlier that the studies that showed that favorable selection will occur are flawed, because they say that the out-of-pocket payments do not support the consideration. They're flawed in another way, too, and that's because they only look at one year's worth of data. It's easy to look at just one year's worth of data, and when you do that, it essentially presumes that you can divide the Medicare population into the sick population and the well population and that, henceforth and forever more, that division will always hold true. We know that isn't the case. We know that healthy beneficiaries, especially healthy Medicare beneficiaries, will eventually get sick and have to use health care at a very high rate. In fact, we know that similar to the distribution of health expenditures for the under-65 population, the health expenditure distribution for the over-65 population is very skewed. The healthiest 80% of the population accounts for only 20% of the expenditures, and the sickest 20% of the population accounts for 80% of the expenditures. That is a very skewed distribution.

Let's look at the situation where a healthy Medicare beneficiary has entered an MSA. Now let's look at the beneficiary's options and what he or she is going to do when he or she gets sick. This is where the conventional wisdom would say, "As soon as the beneficiary gets sick, he or she will opt out of that MSA and opt into some other plan where he or she won't have to pay the same out-of-pocket payments and the beneficiary will just save the MSA for other purposes." Let's take a look at the beneficiary's options. First, most sick people will not choose an HMO.

They will not opt out of their MSA and into an HMO because, in an HMO, their choice of provider would be restricted. When a beneficiary is sick, as we've seen from earlier evidence, that's exactly when he or she doesn't want to have the choice of provider restricted. So not many people are likely to get sick and then leave the MSA for an HMO.

Well, how about regular Medicare? The beneficiary might decide to go back to regular Medicare with nothing else. Under regular Medicare, remember, there is no limit on your potential out-of-pocket payments. You could potentially have unlimited out-of-pocket payments in regular Medicare if you get sick enough and you don't have a supplemental plan. In comparison to an MSA with a $3,000 limit on out-of-pocket payments compared to what you could potentially be saving on health care, a $3,000, or $5,000, or even a $10,000 out-of-pocket limit looks pretty modest compared to what sick people really spend on healthcare. So not many people will opt out of the MSA and into conventional Medicare without a supplement plan.

There are restrictions on converting into a supplement plan. The rules, as they apply now, and I think they should continue to apply, say that a supplement plan can be underwritten for anybody who chooses that plan when over age 65. If a person chooses it when he or she turns age 65 that person can't be underwritten. But if someone is opting out of some other plan and deciding that, at age 70 or so, he or she is going to purchase the supplement plan, that plan can be underwritten and the person will pay full freight for the health-care costs that he or she is accruing.

Since a multi-year analysis is really more appropriate, I'd like to review the data in Table 1.

TABLE 1
MEDICARE SPENDING PER PERSON FOR AGE 65 AND OVER

Health Status	Medicare Only	Employer Medigap	Ratio
Excellent	$705	$1,217	172.6%
Very Good	905	1,490	164.6
Good	1,713	2,347	137.0
Fair	2,462	3,236	131.4
Poor	4,684	6,477	138.3

Source: HCFA Medicare Current Beneficiary Survey

What are the behavioral changes that can occur as the result of an MSA where a person is really spending his or her own money rather than spending the government's money? We all know that we're more careful with our own money than we are with the government's money. These data are from the Medicare current beneficiaries survey. It shows the rate of expenditures between somebody who has Medicare only, does not have a supplemental plan, and therefore faces the very modest copayments and deductibles that the Medicare program has, compared with someone who has an employer-sponsored Medigap plan and therefore doesn't face any copayments and deductibles. You can see that even when you differentiate on the basis of health status, the person who faces copayments and deductibles spends significantly less money on health care than a person who doesn't face any copayments and deductibles.

Using behavioral assumptions that are specific to the Medicare population, I'd like to show you Table 2.

TABLE 2
WITH INDUCTION FACTORS FROM MEDICARE CURRENT BENEFICIARY SURVEY

Year	Medigap	Medicare Only	MSA with $10,000 Deductible	MSA with $5000 Deductible	MSA with $3000 Deductible
1	$986	$206	($2,385)	($866)	($49)
2	986	206	(2,385)	(866)	(49)
3	986	206	(2,385)	(866)	(49)
4	986	206	(2,385)	(866)	(49)
5	986	1,553	5,296	3,405	2,326
5-year Total	4,930	2,377	(4,244)	(59)	2,130

This is a multi-year analysis that compares how well off an average Medicare beneficiary would be under a Medigap plan, Medicare only, and an MSA with a $10,000, $5,000, and $3,000 deductible. Because nobody has five-year tracking of Medicare beneficiaries, what I've done here is used the one-year distribution and used it over and over. I've essentially assumed that for the first four years the Medicare beneficiary is in the healthiest 80%, and then during the fifth year they're in the unhealthiest 20%. So over that five-year period, they're going to be average, but their health expenditures are going to correspond much more closely to the history of health expenditures that you would expect a Medicare beneficiary to show, instead of showing 80% of Medicare beneficiaries are healthy for the whole five years and 20% are sick for the whole five years. This is a more realistic way of looking at it.

I have calculated their total out-of-pocket expenditures during that five-year period. I assumed that the health insurance always has a 15% load for administrative costs, so the Medigap plan has a 15% load and the high-deductible plans all have a 15% load for administrative expenses as well. You can see that the worst possible situation for Medicare beneficiaries to be in is to purchase Medigap insurance. If they have Medicare only, they will pay $2,337 over that five-year period out of pocket. If they choose an MSA with a $10,000 deductible, they'll actually have $4,244 in their MSA account even after having that fifth year with very high expenditures paid out of their MSA. As you can see, as you lower the deductible, the experience gets progressively less favorable. If beneficiaries have an MSA with a $3,000 deductible, they're essentially about the same or slightly better off as they are if they choose Medicare only.

This analysis is based on assumptions that were derived from the previous exhibit which applies directly to the Medicare population. What if we used assumptions that were derived from the non-Medicare population that are much more modest in terms of behavioral changes that were used by the MSA worker? You can see in Table 3 that the MSA experience isn't quite as favorable.

TABLE 3
WITH INDUCTION FACTORS FROM RAND EXPERIMENT

Year	Medigap	Medicare Only	MSA with $10,000 Deductible	MSA with $5000 Deductible	MSA with $3000 Deductible
1	$950	$261	($1,622)	($289)	$388
2	950	261	(1,622)	(289)	388
3	950	261	(1,622)	(289)	388
4	950	261	(1,622)	(289)	388
5	950	1,967	6,223	3,773	2,586
5-year Total	4,750	3,011	(265)	2,617	4,138

The Medigap plan now costs $4,750 over that five-year period. If you have Medicare only, you're paying $3,011 out of pocket. For an MSA with a $10,000 deductible, you have $265 left in your account, and for a $5,000 deductible you're slightly better off than under conventional Medicare. For an MSA with a $3,000 deductible you're slightly worse off, but you're still not as bad off as you would be if you bought a Medigap policy. You're still better off in the long run.

I should point out that we didn't accumulate any of these MSA amounts with interest because we don't know when they are going to occur. For some people it's going to occur in the first year, and for others, it's going to occur in the last year.

In summary, take a look at the Medicare legislation that will likely be passed in 1997. If it contains a provision for MSA, then it probably means that we're going to continue to have a healthy private sector health insurance program. But if MSA is left out of the legislation, as it was largely left out of the Kennedy-Kassebaum bill, then that will tell you that we're going to continue to move in the direction of more government control of health insurance.

Mr. Litow: Now we want to go back to HR3103. We'll talk about rating, but first I want to talk a little bit about the markets involved—the individual and small group markets—and how those are affected, so that you understand where I'm coming from.

One of the things that you may not know is that both Guy, another consultant and I were involved in a meeting as this MSA impasse continued on the Kennedy-Kassebaum bill. We went in and were talking about the adverse selection and so forth in the markets and how MSA would work within those markets. I found an interesting perspective. In one of the meetings, we were explaining how these markets operated and we said, "Well, there's a great deal of adverse selection in this market." I think the Republicans' first response was, "Don't even talk about that. We don't want to hear about it." We said, "Look, if you don't want to hear about it, don't ask the question."

Harry has covered many of the aspects of the law, but I want you to understand that the individual market and the small group market of 2–50 employees have loads of adverse selection in them. This particular bill will make that worse. I think the addition of the MSAs raised a real question of what will happen in these markets. I'll share a little bit about that with you.

Harry has talked about some of the limits on the deductibles, the relativities, and so forth. I would like to give you some background about the cap issue. When they asked us in the meeting, "What cap should we place on the number of MSA accounts?" I said, "That's not an actuarial issue. That's a political issue, so don't ask us." I think both Guy and I were convinced that we didn't think a cap made much sense. I think the question that's going to come up first of all is whether the cap is going to be exceeded. I don't know the answer to that, although initially I was inclined to think not. Based on some presentations I've been giving and discussions with people from some companies, however, my gut feeling is that it will be. If it will be, what will happen? There's a series of scenarios.

Judy Samtopolous, who is in the Joint Committee on Taxation, discussed a scenario that none of us had thought of. It's first come, first served, and if you don't get your plan out there immediately, or if you're beyond the 750,000 policies, you won't get your tax deduction. Well, I want to see if they sell a million and they try to do that. There will be an explosion on Capitol Hill from the people who thought they had the taxation deduction. It'll be interesting.

Another problem for the government is to try to stop a market from selling too many of the same products. It will be interesting to see what happens. If that does occur, it could end up with a Section 89 revolt. It'll be a very interesting year.

I'm going to talk about the states, and I also want to leave some time for questions, so I'm going to try to move relatively quickly through the exhibits.

I think the latest count I had was that 18 states had forms of guaranteed issue as well as some type of restriction on rating. Anytime there are rating bands established along with guaranteed issue, the experience of those states has not been good. Most people say that I have been negative on this stuff. Quite honestly, most of the time I may have been too favorable. The results of these reforms have been worse than expected. In general, the individual market has been going through not quite the same reforms, but a lot of the states are trying to push the small group reforms into the individual market and we're seeing the same experience. Both markets are shrinking and they're having financial difficulties.

As an indication, Table 4 contains average individual and small-group plan experience.

TABLE 4
TYPICAL INDIVIDUAL VERSUS
SMALL GROUP PLAN EXPERIENCE

	Individual	**Small Group**
Benefit	65+	75+
Expense	30	22
Profit*	5-	3-

* Before Investment Income

These are very rough average percentages of premium and reflect my own perspective of what's going on in these two markets. As you can see, the profit margins in both markets are very small, if positive at all. There are some carriers that are having a great deal of trouble and are losing a lot of money in small-group markets as well as individual markets. In many instances, the problem is regional,

depending on the reforms in that particular state. If you're in those states, I think you know what I'm talking about.

The figures contained in the next two tables came from a study prepared by the Council for Affordable Health Insurance. I'm involved with that group and had input into that study. I'd love to hear your comments on the numbers.

TABLE 5
SMALL GROUP MARKET EFFECTS OF GI AND CR

	Small Group		Individual Market	
	Direct Premium	**Indirect Insured**	**Premium**	**Insured**
Guaranteed Issue (GI)	+10–25%	-3–10%	+25–80%	-7–30%
Full Community Rating (CR)	+5–30%	-3–25%	+15–35%	-10–30%
Modified Community Rating	+1–20%	-1–10%	+2–30%	-1–15%

These are the impacts that we've generally reported in looking at experience in seven states: New York, New Jersey, Vermont, Kentucky, Florida, Massachusetts, and Connecticut. Some of those impact both the individual and small group markets. Some of those are only in one. I think the last three I mentioned were only in the small group market. So we've seen these types of impact. The community rating in Table 5 refers to any kinds of rating bands. The tighter the rating band, the worse the experience. The rule of thumb in the markets is that whatever the premium increase is on average in a market, about 40% of that is the reduction of the people covered in the market. So a 10% increase in premium causes a 4% decrease in number of people insured. That's an average. For smaller rate increases it's lower, and it goes up higher than 40% as the increase goes up.

The right side of the table contains the equivalent numbers in the individual market. One item that I want to explain about the small group and large group is that when you put in these kinds of reforms in the individual market, it's like a blast furnace. Guaranteed issue will cause the premium to increase dramatically and then start to come back down. In the small-group market, it's much slower. It's also quite dependent on the size of the groups. If you have groups of over ten employees, it's not going to be severe like it is down in the baby groups of two-to-five. As you move up in group size, it may not have much of an effect at all. There are carriers operating in primarily two-to-five employee groups and those are the ones where you're seeing the numbers in the extreme ends of the range. The individual numbers are higher than for small group. The small-group numbers take several

years to emerge. The figures shown are the ultimate numbers after three to four years.

Given that as a background, I want to talk about MSAs. Any health-care reform where you're going to measure reform requires you to know your starting base. In this bill, we're talking about doing a study in a couple of years to measure the impact of MSAs on the market. There's no way the government will be able to do that study, because it will have to know where exactly those 750,000 people were so it can measure the starting point to the end point. That's true in any plan you design or anything else. If you don't know where those people started, how are you going to measure what the impact is? Well, in politics you can put a lot of spin on the issue and try to guess where those people are. I can try to guess. But unless you know the types of things that Guy was talking about regarding selection in Medicare and where those people are coming from, you have no basis to make that study. I don't think we're going to be able to do that.

Keep those figures in mind when we're talking about interactions in these markets of what we have and HR3103. In the small group market the bill requires every state to have guaranteed issue. The states will undoubtedly put in some form of rating band restriction, assuming they don't have one already. If those rating bands are wide, we may not have too many problems and MSAs may work fairly well there. If the rating bands are tight, I don't think MSAs will help too much.

In the individual market, right now HR3103 allows you to charge anything you want. There's an 18-month prior coverage requirement in HR3103. If you have coverage in another plan that continues for 18 months and you've exhausted your COBRA extension and many of your other options, you can come in guaranteed issue in the individual market. Well, that won't be too big a problem for the carriers, as long as they charge $20,000 for any sick person that comes in. But as soon as you do that, my gut feeling is the states are going to say, "Sorry, we're going to put rating bands on the individual market," and then we're going to have big problems. There is an alternative option in the bill: if you have a high-risk pool or some other options, your state won't need to establish rating bands. So that's one thing that many of the carriers are working on.

I've tried to cover that quickly, but this is a basic concept. MSAs are being put into the markets where you get the tax deduction. It doesn't mean you can't sell an MSA in a large group situation, but your employees won't have the tax deduction that they will have in the small group and the self-employed market.

The general form of an MSA contains an MSA account, a high-deductible plan, and a corridor. The corridor is the gap between the MSA annual contribution and the

deductible. One of the things we always do in designing MSA plans is to keep all the other existing cost-containment features. The first thing most employers say is, "I don't want to spend any more money than I have been" or they want to save money. The second thing is they don't want to put in a higher out-of-pocket cost to the employee. If they do put in a high out-of-pocket cost, it's very minimal. If we design plans and can't achieve that objective, employees say, "Don't bother. It's not worth it." I don't try to pull out the features of managed care plans. I try to make the MSAs an addition to them.

To measure savings when we rate a plan we start with the change in the cost of medical care, add the change in administrative costs, subtract any MSA balance, and subtract any tax effect. We must save enough money on behavior and on administration, or at least we hope to in both areas. The goal is to have MSA balances left at the end of the year that haven't been used for medical care. When I'm estimating what the costs were from before to after, I'll work through the formula. If the result is greater than zero, I've saved some money. If it isn't, I'll walk away or come up with another plan design.

Actuaries routinely pick up their $250 deductible claim experience right off the chart. Here's the plan you sold to those individuals, and they'll get the probability distribution of claims and that's how they'll estimate their savings. Well, that assumes no change in behavior. If that were true, there isn't any healthcare reform in the world that'll work. How could it work? Because we would just give money back to people who had low claims and people with higher claims wouldn't change their behavior. By definition, claim experience is at the end of the year. But don't forget, people are looking at this at the beginning of the year and every year down the road. So the question is, how do they change their behavior, if at all? Some people will, and some people won't.

We've generally seen results in the range of the figures shown in Table 6. If people have a very bad year, they will not change their behavior as soon as they blow through that deductible. We know that. It doesn't mean you can't add managed care features above the deductible or implement other cost containment measures. But until they get up to that level, the experience that I've seen both here and in South Africa, where MSAs are very big, is that people will try their darndest to get their expenses below their deductible and annual contribution. People will try to balance the quality issue versus the cost issue, which is what we're trying to do with MSAs. We see many people, even at $10,000 per family, who will try to find ways to reduce the cost and keep money in their MSA. That's where the medical savings comes from.

TABLE 6
POTENTIAL CHANGES IN MEDICAL COST WITH AN MSA*

Range of Annual Cost per Family	Average Cost	Probability		Cost in Range		MSA Balance	MSA Cost
		Before MSA	After MSA	Before MSA	After MSA		
$0	$0	0.020	0.080	$0	$0	$2,500	$200
0-1,000	600	0.190	0.275	114	165	1,900	523
1,000-2,000	1,500	0.150	0.240	225	360	1,000	240
2,000-3,000	2,500	0.130	0.100	325	250	0	0
3,000-4,000	3,400	0.100	0.040	340	136	0	0
4,000-5,000	4,400	0.085	0.040	374	176	0	0
5,000-7,500	6,000	0.104	0.055	624	330	0	0
7,500-10,000	8,500	0.080	0.045	680	383	0	0
10,000-15,000	12,000	0.070	0.056	840	672	0	0
15,000-25,000	19,000	0.046	0.044	874	836	0	0
25,000 +	60,000 (59,000)**	0.025	0.025	1,500	1,475	0	0
Total		1.000	1.000	$5,896	$4,783	n/a	$963
Claim Cost for Insurance Policy				$5,480	$2,944		

* This illustration assumes a $250 annual deductible before the MSA is implemented and a $3,500 family deductible/$2,500 MSA contribution after the MSA is implemented.

* * The MSA is expected to produce little savings for these people. However, some savings should be expected for those people where severe claims occur partway through the year.

Table 7 shows an example of the savings calculation without any tax deduction on a typical plan.

TABLE 7
TOTAL POTENTIAL SAVINGS FOR UNDER-AGE-65-ILLUSTRATION

Medical	$999
Administrative	397
MSA Balance	-963
Total	$433
Initial Cost	$5,480
Percentage Savings	8%

In this particular example we saved 8% even though we took the medical cost minus what we have left in the MSA. Medical savings amounts to: $999 = 5,480 – [2,944 + (2,500 – 963)]. There is also savings on administration because reduced claim frequency results in administrative cost savings that are $397 more than the added cost of administering the MSA. It's all built on the assumptions and in this example we assumed the MSA was administered for 2%. Some of the scenarios Harry talked about would probably be close to that. Some of them would be much higher. Some plans are not going to charge anything, but instead will build it into the insurance plan. I think this would be most typical. Some will use an interest spread because you can make interest earnings on the MSA account. You have to consider all these things in ratings.

When I rate an MSA, the first thing I always try to figure out is where we are in the particular plan that we're measuring against. If I don't have one to measure against, it makes it much easier to just use a standard set of assumptions. Set the baseline and try to find out what the objectives are for measurement. Try to come up with a cost distribution to start with, and then recognize the changes.

Table 8 contains three types of plans to show you the analysis that we go through. The first line is the plan cost for an average adult, age 45, male and female combined. Obviously all your demographic, area factors, and so forth would already be built into these kinds of numbers. The next lines are factors that would change that value.

TABLE 8
PREMIUM ILLUSTRATION—FACTORS IN ESTIMATING COST

	Traditional	Deductible Plan with MSA	HMO
$0 Deductible	$2,500	$2,500	$2,500
Risk Selection	1.05	0.95	1.00
Discounts	0.95	0.95	0.70
Managed Care Utilization	1.00	1.00	0.85
Cost Sharing	0.87	0.71	0.97
Cost Sharing Utilization	0.95	0.83	0.99
Leverage	0.99	0.93	1.00
Rating Strategy	1.00	1.00	1.00
Loss Ratio	0.80	0.80	0.80
	$2,551	$1,546	$1,786

The risk selection is the type of thing that Guy was talking about. In an individual market with guarantee issue that number could be up in the range of 1.80–1.82. With an underwritten high-deductible plan in the individual market, that factor may be 0.6 or 0.7. That's a very important factor because the risk selection makes a big difference. One thing we had to do was explain to the government folks the

difference between selection and adverse selection. Selections are choices that people make. There's plan design and premium choices. Everything factors into them. Favorable selection, in that context, does not necessarily produce adverse selection from a health-care reform perspective. This is the mistake that we've made in almost every reform initiative.

In my opinion, every health-care reform that we've put in this country except perhaps MSAs, which even in this law may be very questionable, addresses a certain condition that one group has lobbied for in Washington. We pad the bill to solve this group's problem, although it punishes 99% of the population in the long term. We always worry about the short term, and many of these things create very bad adverse selection problems from a health-care reform perspective. For instance, if you put in guarantee issue, you may help the sick people, but you know the rates will increase. The healthy people will start to drop out or will start to reduce the level of coverage they have. So what is the aggregate impact? The cost goes up and then we have to raise rates and the cost goes up again. That's what happens with guaranteed issue. That's what happens when community rating is mandated.

That's why, in general, those things don't work. They may benefit a few sick people who can come into the system, but what is the impact on the whole population? That's what you have to think about. Those things go into the risk selection factor, and who better to decide those things than actuaries? That is our field. That is one of the main things we bring to this.

The third line of Table 8 adjusts for discounts. Those have to do with the charge level of providers, whether it's to the government or to Medicare, which is at about a 50% discount. These discounts are all relative to usual and customary, which is the starting assumption of $2,500 in the illustration. You will have to know what the starting assumption is relative to the cost level, underwriting, and everything else in that $2,500. Once the starting assumption is set, we can work off of those assumptions.

The HMO plan in the illustration is at a 30% discount. These are averages of the inpatient and outpatient provider discounts combined. The next line is an adjustment for managed care utilization. The illustration contains no adjustment for the traditional and MSA plans and a 15% cut for the HMO. Obviously, it will depend on the kind of management you have in your HMO. This is assuming 40% of the cost is inpatient and probably an average of about 35% or more reduction in utilization in the days per 1,000 on an HMO basis. The next line, the cost-sharing adjustment, is the value of the deductibles, coinsurance, or other copayments relative to your $0 cost. That's straight off your starting probability distribution.

The next line, cost-sharing utilization adjustment, is a key item. This factor shows what the impact is on utilization as a result of the aggregate inpatient/outpatient deductibles, coinsurance, and copayments. You can see the HMO adjustment is very small because this plan had only a $10 copayment on physician office visits and drugs. In the MSA plan, it's very large compared to the other plans. Why? The MSA plans, if they're designed properly, will generally generate 30% or 35% reductions in outpatient costs compared to your traditional type plan, which is why MSAs work. However, MSAs work primarily on the outpatient side. We do get some reductions on the inpatient side, but it's a much smaller number, maybe 5%. Of course, once you combine that with managed care, you have to worry about the cost shifts from inpatient to outpatient services.

The next adjustment in the illustration is for leverage. Most of you know what leverage is. If I have a $2,000 deductible and a 10% increase on all the claim amounts in my distribution, that would mean the cost to the plan would increase by more than 10%. So I have to increase my deductible by 10% to bring it to $2,200 to have no change there. It also works in reverse; it's what I call reverse leverage. If we start reducing costs through behavior or through discounts, we will start getting cost reductions because we have the deductible. MSAs bring to the table those two items. I will not be discussing rating strategy, such as durational rating and so forth, but you could make adjustments to reflect the impact.

Multiply all those numbers, divide by the loss ratio (expense) assumption, and that results in a premium. That's essentially the types of things that we go through in rating MSAs. Some of those values can get fairly difficult to estimate.

MSAs are very sensitive to the cost-risk relationship, just like you'll find in individual plans. If you don't properly design your MSA to fit the group you're looking at, you're not going to get much cost savings. For example, be careful to not set the deductible too low or too high. If you're in New York City, a very high-cost area, you would not want to put in an MSA plan with a $2,000 deductible. When you go back and you look at your utilization, you will not get much reduction because even an outpatient case will blow through the $2,000. If you took a blind or disabled Medicare population, a low deductible wouldn't make any sense. The key with an MSA is to put the deductible where there's discretionary spending by the consumer.

In terms of ways of looking at your options, such as under Medicare, you have to consider all those things. Plans can be designed to bring in healthy people only. I think that is going to happen in the small group individual market. Carriers will start using MSAs to get the healthiest people. You say, "That's no good." In my opinion, that's very good because if we don't have the healthy people in the system,

we will have the sick people in it in a guaranteed issue environment. If we don't bring the healthy people in, the costs will go through the roof. Carriers in those markets will have to use MSAs to attract the healthy people. That's not bad, and it's not good. If we don't keep those people in, those markets will just go under and essentially we'll get some other reform to fix it. That's what we're talking about with adverse selection.

Remember, MSAs can relate only to certain types of services. For instance, you can throw money into an MSA if you want people to have mammograms. Don't look at MSAs as just one type of plan. You can do many things with it as long as the law allows you to do it, of course. At this point I want to open it up to questions for the panelists.

Mr. Sutton: You were just talking about limiting what you could take out of the MSA. Now, would it be legal to say that you could only take out benefits that are covered by the health plan? I mean, that's a restriction that's different from what's in the law, which has no restriction as long as it's deductible.

Mr. Litow: Yes, the law right now says that if you take it out, you will be taxed as ordinary income with a 15% penalty on top of that.

Mr. Sutton: Can you say you could only take out medical expenses that are covered under the health plan with a high deductible?

Mr. Litow: I think you can do that. I don't know whether there's any prohibition against that.

Mr. Stephen C. Carlson: My question has to do with the law and the out-of-pocket limitations. I'm wondering what any of the panelists think about usual and customary rules with regard to determining what the benefit levels are that will be paid. Also, what about penalties under managed care plans?

Mr. Litow: I'll respond first. That has been a question that's been asked a number of times regarding in-network versus out-of-network benefits. The limit is $3,000 out of pocket for individual and $5,500 for a family, and there is no statement in the law that gives any indication as to whether that's to be viewed any differently. I think there will be people that will put in plans where that is essentially an in-network out-of-pocket maximum cost. If there's a penalty for going out of network, that will be extra. I'm not sure whether that'll comply or not. I think if you view that rule as being applicable to both in and out of network, which I thought was your question, that obviously will create a great deal of problems. I'm not sure how people will interpret that. There are a large number of questions like

that. I don't think those things were ever thought of. I really can't give you much guidance. I believe that some carriers will look at it that way and if there's a penalty, that will just be viewed as an excess. There's a risk that could disqualify the plan. I mean, that's really a legal question.

Mr. Sutton: Many of the advocates of MSAs argue that this gets back to the patient and his own physician. If the physician wants to charge more than reasonable and customary (R&C), the MSA can pay that. That doesn't mean that the carrier has to allow that full charge as eligible to meet the deductible under the high-deductible plan. At least one plan has a PPO where if it's in network, the plan will credit 100% of the fee towards the deductible. If it's outside of the network the plan will credit only 75% of the payment as going towards the MSA deductible. I don't know if they disallow in total, if it's somewhere in excess of that. Part of the problem is it has been viewed that the MSA permits the individual to pick any doctor he or she wants and negotiate his or her own deal with that doctor.

I happen to think that in many areas the discounts prevailing in the HMOs and other plans are so high that no individual can negotiate a deal as good as the HMO. Look at California where the discounts exceed 50% of fee-for-service retail prices. In fact, we don't have an R&C anymore, because they don't count what they get from HMOs as part of R&C. It's only retail transactions, which may only be 10% of the total. They're not representative fees for anything. That was the same question I asked just a minute ago, and I think we talked of HMOs having restrictions that you have to buy your medical services from the HMO, even if you have an MSA. The services would be eligible, but you will be restricted as to where you can get them. That would apparently defeat the purpose of the people who want to pick a physician outside of the HMO or buy prescription drugs that are not covered by the HMO or something like that.