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Session 21D
Are Medical Savings Accounts Keeping Their Promise?

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Recorder: THOMAS P. EDWALDS

Summary: This session will revisit the purpose and expectations for medical savings account plans at the time the Health Insurance Portability and Accountability Act was enacted. The presenters share their views on how well these have been achieved so far.

Mr. Thomas P. Edwalds: I'm the Research Actuary for Health and Pensions at the Society of Actuaries. We're going to look at the market for medical savings accounts (MSAs), the expectations for this market, and where it is going. I'm very pleased that we have two very distinguished, experienced, and knowledgeable presenters on the subject. Our first speaker is Rick Ruppel. Rick is the vice-president and actuary for Golden Rule Financial Corporation, where he has been for 31 years. I presume most of you know that Golden Rule was a pioneer in the MSA market and is still a market leader. Rick has some other perspectives that he's going to bring to this. He's a member of the Actuarial Advisory Committee for the Illinois Comprehensive Health Insurance Plan and a member of the board of directors for the Indiana Comprehensive Health Insurance Association. In addition, he's a part-time farmer. We'll start with Rick telling us what he thinks about where the MSA market is and where it's going.

Mr. Richard J. Ruppel: I've been involved with the MSA product since early 1992. Patrick Rooney called me up and said, "Rick, what can we do? Can we calculate the claim costs for a $2,000 deductible or a $3,000/20% coinsurance plan?" This led to the plan that is now offered, which is the $3,000 family deductible. In all my years in the actuarial profession, I feel that this is something that the country needs, and that it is the right thing to do.

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The right thing to do is to provide a product that's fair, and that gives the little guy a chance to participate in health care. A large employer can allow its employees to pay for their health care with pretax dollars. We don't have that choice now. I just had some dental work done with after-tax dollars. I want to get some new eyeglasses this year and that will be done after-tax. I want the same choice that Mr. Sutton has or anyone else has who is with a larger employer. We can accomplish part of that goal with MSAs. I hope we can accomplish more by expanding that.

I'd like to tell you a little bit about Golden Rule. MSAs represent 30% of new business. More than 75% of the people who have them are self-employed. More than 90% are in networks. Over 30,000 policies are sold with 80,000 lives, so that the average ratio is two-and-one-half additional enrollees over the insured or the policyholder. Over $13 million was leftover in MSAs at the end of 1997. There are going to be large amounts of money in MSAs, even though the sales may be a little bit slow, but they're picking up. We just entered into an agreement with Fifth Bank, and we have an agreement with Northern Trust. The banks are becoming interested because they see these kinds of numbers.

Some 17% of new purchasers indicate they previously had no insurance. I think that's wonderful. I had some farmer friends who can't afford the insurance, but they can afford this high deductible. The premium is small, and they hope that they can at least come up with the deductible for that given year, and then they will be insured above that $3,000. It's a great thing, and it's the right thing to do.

For 1997, Golden Rule distributed to its employees an average MSA refund equal to $925 from the funds contributed. I've already paid for my dental work with my contributions so far this year. Golden Rule puts in so much each month, and then, at the end of the year, it equals $2,000 for family coverage. When I went to pay for my dental work, I thought I'd just go ahead and ask them to reimburse me. Even though I had not built up enough contributions during the year, we set up a loan whereby they just borrow against that, at no charge, so I was able to get more than what my contributions were. I can't get over $2,000, but I can go up to that.

Table 1 shows some statistics of MSA policies by family status. This can give you some idea of what we have on our books. We hope that in another year it'll be doubled, and then tripled, and so forth. It's a good mixture. It's similar to what we had on our individual business. These MSAs are no different from our individual business. We already have over 100,000 policyholders. We hope legislators will change the law so that they can have this MSA. They already have the high deductible, because they can't afford the low-deductible policy. Our average deductible that being issued goes above $1,500 and it is probably getting close to $2,000. They need an MSA fund, if only the government would let them have it.

Most divorcees and retirees, the people who would buy these accounts, are not eligible. And I would hope that we'd make it so that they are eligible.

TABLE 1
MSA POLICIES BY FAMILY STATUS
(SOLD TO INDIVIDUALS)

Status	Primary Insured	Percentage
Single	Male	15.9%
	Female	10.3
Single-Parent Family	Male	5.1
	Female	3.2
Two-Parent Family	Male	43.3
	Female	4.8
Husband & Wife	Male	15.0
	Female	2.4
AVERAGE NUMBER OF CHILDREN = 2.23		

Table 1 showed individuals. Table 2 has individuals and groups together. We have approximately 10,000 small-group and large-group MSAs, and over 20,000 individuals.

TABLE 2
MSA POLICIES BY FAMILY STATUS
(INDIVIDUAL AND GROUP)

Status	Primary Insured	Percentage
Single	Male	21.0%
	Female	14.7
Single-Parent Family	Male	4.6
	Female	3.2
Two-Parent Family	Male	36.3
	Female	5.0
Husband & Wife	Male	12.7
	Female	5.0
AVERAGE NUMBER OF CHILDREN = 2.19		

The critics of the MSAs do not talk about fairness, and I want to put that on the table. They always mention the young, the wealthy, and the healthy. I have data on this large block of business (Table 3). The greatest portion of policies are sold to someone who is approximately 42 years old. That's not young. The young can't afford the high deductible if they don't have group coverage or anything. So the argument about the young is ridiculous.

TABLE 3
MSA POLICIES BY AGE/SEX (SOLD TO INDIVIDUALS)

Att. Age	Male	Female
Less than 25	0.9%	1.3%
25-29	3.4	4.7
30-34	8.7	9.5
35-39	16.8	15.3
40-44	22.4	19.4
45-49	19.9	18.3
50-54	13.8	14.1
55-59	9.1	10.6
60-64	4.8	6.6
65 or more	0.2	0.2
By sex	79.3	20.7
Average age	42.4	42.1

Table 4 shows individual and group. Notice the average age went down. The group pulls it down, because you have more young employees that have MSAs. That accounts for the argument about the young.

TABLE 4
MSA POLICIES BY AGE/SEX
(INDIVIDUAL AND GROUP)

Att. Age	Male	Female
Less than 25	2.7%	3.9%
25-29	6.4	9.6
30-34	10.6	12.1
35-39	16.7	15.3
40-44	20.4	17.1
45-49	17.7	15.3
50-54	12.3	11.8
55-59	8.2	8.5
60-64	4.5	5.5
65 or more	0.5	0.9
By sex	74.5	25.5
Average age	39.6	37.6

They say that only the wealthy will buy MSAs. However, look at Table 5, where the highest percentage, 22.4%, falls—it is highest for the $35,000–50,000 income bracket. It's not in the wealthy bracket. Even those who make less than $25,000 buy 10%. So, I think that blows that argument.

TABLE 5
MSA POLICIES BY INCOME
(SOLD TO INDIVIDUALS)

Income	Percentage
Less than $15,000	3.5%
15,000-24,999	10.1
25,000-34,999	13.8
35,000-49,999	22.4
50,000-74,999	19.8
75,000-99,999	10.2
100,000 or more	20.3

I didn't show the group because it was not statistically reliable. Less than 3% reported their income from the group business. This is based on over 85% that responded and put something down for their income. So I felt that was very reliable.

Mr. Edwalds: Our next presenter is Harry Sutton. Harry is currently senior actuary of health care in the Mass Marketing Division of Allianz Life Insurance Company of North America, which is a major reinsurer of catastrophic health care services for the HMO industry. Harry's career spans almost half a century. During the recent half, he has been a consultant. The first half of his career was with Prudential, and he helped develop Prudential's entry into the HMO field.

Mr. Harry L. Sutton: What are the purposes and expectations of MSAs under the Health Insurance Portability and Accountability Act of 1996? There are advocates and rationalists. Rick is an advocate, which is fine, but he doesn't represent some of the people who said we were going to sell two million of these in the first year; at least I don't think that was your expectation.

Mr. Ruppel: No.

Mr. Sutton: I talked to not only Rick, but a lot of other companies that are still in this business, and I think their business is growing. I'll get into some of the reasons why it didn't, and why it is now. I think there is a marketplace for this, so I won't be negative. But I would like to respond to some of Rick's comments. The advocates blew it out of proportion in Congress, by getting people to believe that everybody could buy this thing. We're in a limited market, and it will expand somewhat. We're in the individual and small-group market, forgetting Medicare. It was also advocated for large employers. Rick was talking about selection and things like that. Selection only applies if you're with a large employer and have multiple options.

I'll discuss how the data are outdated, and I'll talk about a couple of case studies with larger employers. I've called a lot of companies that are in this market besides Rick's, and the opinions have been somewhat similar to his.

There is the exaggerated advocates' expectations, not the rational advocate expectations. First, some of them said when we would get to two million, Congress would open it up to large employers and remove the limits within the first six months. As soon as they got the first report, they stopped worrying about it. So it did expand to Medicare. In 1997, with the Balanced Budget Act, in spite of the fact that the early reports were slow, Congress did put it in Medicare as a Medicare Plus choice.

The self-employed were a good market, and they're already a market for individual insurance. Many of those could be changed and transferred over, as long as they are self-employed. If they were just individuals who were unemployed, or their employers didn't offer insurance, you still can't cover them, although Congress is proposing to make their premiums fully tax deductible under the cigarette bill, but the cigarette bill is dead. So I'm not sure what will happen. They could have expanded MSAs to those people as well. NFIB was very gung-ho about it, and it's also pushing the Associations (Fawell) Bill, which has been reintroduced, but I'm not sure that it will pass either. I'm not sure anything else is going to pass in 1998, considering the failure of the cigarette bill.

There are some other expectations, some of which we don't know yet. There was a sharp reduction of 30% in medical costs for enrollees. There was lower administrative expenses. There was a long-term cumulative savings for a large majority of enrollees. Enrollees will negotiate low medical prices by going out and comparing. Rick is one of those who has tried that at least once. I don't know if he gave up or not. There was freedom from restrictive networks, and I think 70% of Rick's enrollees have a network where they do better. Those in Washington said, "We want to give the patient freedom of choice of doctor, and get away from the restrictive networks." So a fairly high percentage of companies have gone into preferred provider organizations (PP0s). There is no visible antiselection. There is no antiselection if the whole group enrolls out. I'll talk about the question of health risks.

We've accomplished a great deal in the area of tax equity. The fact is that Congress again was going to go to a 100% deductibility for everybody who is self-employed, as well as those others. If there is any question about whether they need the MSAs, they can just convert to low-deductible plans, because now it would be totally deductible, instead of only 40% being deductible. Another projected result is employees will save money.

Let's discuss some of the market-related projections. There was slow growth in 1997. It was at 200,000 but we're in a limited, small-group market, which unfortunately has shrunk as a percentage of the total. We have more who are unemployed, even though the unemployment rate is really at rock bottom. We have more uncovered people who work for small employers. So there's something about health care costs with small employers. If they don't get anywhere near 750,000 or 500,000 enrollment the first year, there won't be any pressure in Congress to push for expansion. I didn't think they will because Senator Edward Kennedy (D-MA) was fighting so hard against Medicare. I didn't think they'd ever pass a Medicare MSA, but they did; however, I don't think they can install it. The self-employed market is the most attractive immediate market.

It is also projected that there will be no major effect on the uninsured because 15% (30–40 million people) of the U.S. population is uninsured. The 200,000 figure is a drop in the bucket, and 17% of that is a smaller drop in the bucket. It's not going to affect the 200,000, and it won't affect the total national health care costs much either. Representative Harris Fawell's (R-IL) bill failed in 1997, but it's still hanging in there in 1998. Many insurance commissioners and carriers are opposed to it, which means there must be something good about it, so maybe it'll pass.

There were other projected general results. There was a savings in the medical costs, but it was more like 10% and not 30%. At least that's my view of what was shown. Administrative expenses would drop, particularly in the small group and individual markets, because the retention ranges from 25–40%. If you remove the claims, you don't have to process claims, and you don't have the premium or some of the rest of the expenses. You could save money on expenses. Long-term savings depend on the emergence of the market and what happens in the market.

We thought freedom from network restrictions was a major point of the advocates. They didn't want HMOs, PPOs, or networks. There could be antiselection if large groups were offered choices. Tax equity would be improved. We didn't think MSAs would be attractive to high-risk individuals because they see a large gap between the deductible and the MSA amount. That's not to say whether it's more or less than what they would have had to pay in their low-deductible plan with coinsurance up to a fairly high limit. I still think it was designed so that the employers could not save much money. Almost all the examples showed a reduction in the medical premium because of the high deductible and the employer putting the savings into the MSA. By definition, the employer has the same costs that he would have had before. The argument that employers save a lot of money never seemed to hold too much water.

Table 6 shows what happened in 1997. This is what was reported. People who were uninsured and came in for the first time do not count against the limit. So when you subtract all of them out, and spouses and so on, each might have a separate MSA. As of June 1997, 17,000 individuals were sold coverage. This represents MSAs. This is what was reported by the banks and holding companies, or Merrill Lynch, or whoever is managing the accounts. When you set this thing up, unless you have control of the payroll deduction or something, you're not absolutely positive that the person starts his MSA. He or she might wait a few months. At least one of the people I've talked to says it's just like an individual retirement account (IRA). They're going to wait until April 15 to put the money in. We might see a big inflow of cash into these accounts on April 15 just like we did with IRAs for individuals. So you're not too sure whether you have a good fix on how many people are going to put the money in. The anecdotal evidence was that these are MSAs, but the high-deductible insurance sold to go with MSAs was much higher than this.

TABLE 6
CURRENT STATUS IRS REPORTS
THROUGH SEPTEMBER '97

	Total MSAs (Cumulative)	
	As of April 30	**As of June 30**
MSAs	9,720	22,051
Dep/Spouse	-550	-1,236
Net	9,710	20,815
Uninsured	-1,768	-3,670
Net	7,384	17,145
Count toward 750,000 limit		

I'd like to give a summary of the General Accounting Office (GAO) study. Qualified plans were available in all states, and almost all states had more than one carrier writing them. The GAO searched the industry and asked who else was writing. Fifty-four insurers and three HMOs, including 18 Blue Cross plans, were in the market. Eighty percent were in the individual market, and 90% went to small groups, so there was some overlap. Half of the states had six or more plans available in their states. The major commercial carriers are now mostly HMOs. Companies like Prudential and Aetna were never in the small-group market. They had dropped out years ago. They also weren't in the individual market; they'd dropped out in the 1980s. So since they weren't in that market that was permitted by law, they also weren't in the general market.

Essentially, the small-group carriers, like Employers Health Insurance, which is Humana, are in it. No one knows what they'll do when they're part of United Health Care. United Health Care is now the American Association of Retired Persons (AARP) insurer. It expects to have $3 billion or $4 billion in premium in

Medigap supplements. About one-third of the plans that the carriers said they had were enrolled in a PPO or some kind of a network. This is less than Rick talked about. A number of the carriers have centers of excellence for organ transplants and things like that.

Sales have not met expectations. Right now, there doesn't seem to be a lot of new carriers coming in. Many carriers, like Rick's, say that the sales actually went down. Part of the reason was the definition of the deductible for family was not understood. Forrest started issuing multiple deductibles and out-of-pocket limits, which was like your own employer plan before you switched. Then they had to backtrack and reissue all those plans. It was very difficult to explain to employers why they'd issued an illegal plan. Some of the employers weren't so sure they wanted to stay in.

From the Floor: That plan, incidentally, wasn't illegal; it was legal up until November.

Mr. Sutton: Yes, but it took them that long to make up their mind what they meant by a $3,000 family deductible. Was it two $1,500 deductibles or one $3,000 deductible? They were permitted to issue it, but then they had to change it by the end of the year or on renewal. So many of the companies think there was a misinterpretation of the law. Whatever it was, it disrupted the market at some point when they knew they couldn't sell it.

Mr. Ruppel: Harry, you made a remark that sales were down a little bit, or flat. Was that on small groups or individuals?

Mr. Sutton: The individual was never quite the same problem as the small group.

Mr. Ruppel: It's increasing every month.

Mr. Sutton: Yes, right. I meant that there was a dip near the last part of 1997 when they knew they had to change all the policies, reissue them, and then come out with new policies. In other words, it is going back up this year.

There are some comments in the GAO study. Hay Associates did the interviewing of the companies. Some carriers opted to protect and some opted to expand their market share. Much of the business was set up. Some of it was easy to convert and some of it you couldn't convert, which is unfortunate. They spent a lot of money in some cases, but they never did much market analysis to know how big the market would be. Insurers view high-deductible plan enrollees as lower risks than those in low-deductible plans, maybe because they wouldn't take it otherwise. The market

is dominated by agents and brokers, whereas large employers have consultants, but they do their own thing. About 75% of qualified plans were sold to individuals, and existing policyholders were rolled over frequently, which was part of the enrollment. Only 18% of the carriers required opening an MSA, and I'll talk about a couple of ones that I interviewed.

So why aren't MSAs selling? I think it's the traditional difficulty of marketing a new product. A few companies, like Rick's, were marketing a product that they knew fairly well, except for the changes required because of the federal law. However, at other companies, agents and brokers didn't know anything about it. It was a complex product. You have insurance, you have an MSA with a bank, or somebody, and you have an administrator, and you're not sure which is which. Sometimes you have all three. Some process the MSA like a flexible spending account (FSA); others don't care what it is. You just have to document what your claims are and send them in, and nobody worries about the MSA part of it. Different carriers do it differently.

In many cases, the high-deductible premiums were too high. Now, it may be a method of setting rates. If you're using your group insurance experience, which has a mix of new and old lives, you might come up with a higher rate than if you looked at your rate for marketing individual, high-deductible insurance, depending on how you rewrite that business, and whether you have low rates in the first year or aggregate rates over all of your years. Employers didn't save much, with some exceptions, which I'll mention. The potential for out-of-pocket expenses causes some people to shy away from it, so you need some aggressive selling, and you have to understand the complexities of the tax laws and everything else that affects this. Many of the agents just weren't that knowledgeable.

One of the things that happened is the premium may be cut by 50% when people switch to a high deductible from some other plan that they have. If they're being paid a 10% commission, 10% of half the premium is half the commission. Some of the agents were worried about this thing standing on its own, but I think, as I'll explain in a minute, they're more interested in it now than they were because of follow-on products that they can sell. Regardless of Rick's table by incomes, I think the population that gets in this is those with higher-than-average income. Even the owner of a small corporation or the self-employed professional individuals have higher-than-average incomes. Someone mentioned that agents can sell people a $1 million life insurance policy since they were getting in to talk to these people in connection with the MSA.

The multiple contractors, the change in the family deductible, legal issues, and benefit mandates have thrown a couple of states out, like Wisconsin. There are

community rates in New York and Vermont. In some states, there really are very few carriers interested in it because of the nature of health care reform efforts, which this runs into. If the employer doesn't put most of the money in the MSA, but he puts some in, then the employee cannot put any money in. In some cases, employees are prevented from putting much money in a MSA. Some knowledgeable people have found ways around it. They switch the premium to the employee, if it's an employer case, and let the employee use an FSA to pay the premium. Then the employer can put the full amount in the MSA. Small employers normally aren't going to be that knowledgeable to do it, but a larger employer could figure that out, because it already has funding standard accounts and flexible benefits. It sounds funny, because the employee essentially pays the whole premium, but it's tax deductible under an FSA. The employer puts money that's deductible into the MSA, and then the employee has both. That way employees may be able to put more money in the MSA. It is ingenious. There's a way around almost everything.

So what seems to be the MSA niche? There are the self-employed, partners and professionals. Many of these are in association groups, where the employer size is one or two people—an individual and a secretary or an individual and his wife. They tend to be high-income earners, and they can understand the deductible. Some of them may be using it purely as a tax shelter, just as one would use an individual retirement account. They pay their medical expenses out of their own pocket, until they get into the insurance, but they use this as a mechanism of savings. It is hard to say how many do what, but if the IRS looked at it, we'd have some idea. As Rick said, there is $13 million left in the MSAs at this point. They already have high deductibles, so they don't have to change the concept much. The premiums will become 100% deductible. Whether that will change the interest in MSAs and cause people to go back to, more or less, full coverage, since it's fully deductible, you lose some of the tax advantages.

So that's the way we looked at the situation. I had some discussions with Rick, and I called a number of the other carriers where I know the actuaries, and they talked to me informally. We didn't talk about rates or anything like that. It was just a discussion about how they're doing in business. An Eastern Blue Cross plan that was really gung-ho sold about 4,000 individual policies so far, and it doesn't manage the MSA. Its application is a questionnaire about whether they're going to open an MSA or not. Sixty percent of them said they were not going to open an MSA. They were people with higher incomes and high-deductible policies, and they were just changing it to fit. They could put the money in the MSA later if they wanted to.

Another Blues plan on the West Coast has sold about the same amount, give or take 4,000. They are selling to about 80% individuals. They're just having a hard time selling it, but I don't know why. In California, of course, there's so much prevalence with HMOs. They use a PPO.

Maybe this would be a good time to mention the question of health status. When we're talking about health status and things like age, sex, or whatever, we're talking about large employer groups where they have choices. I asked someone at one plan if they underwrite every individual, even if they're just changing the deductible on an in-force policy. What I'm saying is, the market that we have does not take anybody without underwriting, generally speaking. I asked this person about small groups because this person's state has great limits for small groups. This person thought the plus or minus 10% or 20% in the rate basis they can use for small groups in their state is sufficient to underwrite one or two bad risks in a group. It's guaranteed issue, but they could jack the rate up, maybe 20% higher than their lowest rate. They underwrite that if it's in a state that typically has community rates, although I think New York has maybe Blue Cross selling something. I'm not sure who else is selling there with a community rate, but that might be a very difficult step for people selling to individuals, if you can't rate by age. Or, in some states, you can't rate by sex, but you can rate by age.

Another company I talked to, which is probably the second-biggest writer after Golden Rule, is enthusiastic right now. It had a holdback because of the change in the definition of the family deductible and had to re-gear. There's a big learning curve in training the salespeople. They have a wide range of brokers. The commissions were part of the problem, but they've learned that this gets them access. I talked to one field force person, and found out that they go after individuals or small groups that are getting big rate increases in the market. In some of these, the broker normally would go out and try to get a competing bid. Some of these have switched to the high deductible in the MSAs, and in many cases, the employer has put most of the money in an MSA. As long as it's combined, it is a lot lower than the rate increase in premium that they would have had. They're looking at the market to grab on to that segment that's getting big indemnity or even HMO rate increases.

They think it's gradually growing, and there are the by-products of selling disability insurance or selling life insurance to these clients. Most of them think there is higher-than-average income in the self-employed market, and that there are other chances for products. They think that it's worth using it as a door opener. They looked at it as a solo product and didn't feel that way. They weren't sure who was going to buy it.

I'm convinced that the selection we're talking about is in larger employers where they have a low option and a high option. Flexible benefits have shown large selection in that. There were two MSA-type plans sold, neither of which qualified. Ada County in Boise, Idaho, had 2,000 employees. It set up an MSA, and it got about 15% or 20% enrollment in the MSAs, but that group had very few claims. Blue Cross threatened to raise its premium rates on the rest of the employees by 35% because it thought another 20% would shift over and projected it that way. Blue Cross dropped it after the first year. Another one was in Jersey City, and Bret Shundler wrote a very positive article in *The Wall Street Journal* a year or two ago, and only the 200 managers of Jersey City got in the MSA. The union wouldn't let the employees go into it. After about a year-and-a-half, when they'd seen the claim run out, they jacked the premium rates up 30% or 40%. There were complaints and threats to go back and fight it. Then Mr. Shundler just gave up and went back to the state benefit plan the city managers had been in before where the rates were set by the state with Blue Cross.

I have a study from DuPont from a couple of years ago. It offers a $1,000 deductible plan to employees. It has a network HMO-type plan. A point-of-service (POS) plan is in the middle, which gives the employee back $500. He or she can put it in an FSA, buy company stock with it, or whatever he wants. Only 4% took the $1,000 deductible, and they were all males under the age of 30. So I think we do have some indication of selection, but I'm not talking about an individual, or even a small group. One of the companies is a big marketer and will allow people to buy either the low-deductible plan or the MSA high-deductible plan without any rating variance.

Most of these companies do not have enough claims experience on their high-deductible insurance written since early 1997 to really know what the long-term experience of the rates is going to be. So, I think we have a limited market. A lot of the people I talked to want to go up to 100 lives, but when they get over 100 lives, I think they're going to have to consider whether they're going to force everybody into an MSA or offer choices.

One other thing that we need to consider is the fact that premium-rate increases for indemnity and HMOs are very large around the country now because of the competitive bidding in the last few years, where the real rates have been underpriced. If we do see 5–15% rate increases for two or three years, which some of us think is going to happen, many large employers might try to switch to a defined-contribution plan for their health benefits. They have been reluctant to do it because they're worried about their employees having a lot of out-of-pocket expenses, and they're worried about the reaction to shifting premium costs back to the employees. One of the ways they could do it, but they don't have the nerve to

do it, is to switch to a high-deductible plan. You'd have a real difficult problem with unions, though.

One of the ways they could do that is switch to a high-deductible plan, and put enough money in the MSA to spend a certain percentage of payroll and fix it. If costs kept going up they could lower the MSA contribution. Now that's going to cause a problem if the employees can't put any more money in to it. A few consultants think that the big employers will be forced to use something like the MSAs to be able to do this. However, they also are probably not going to stop offering choices. They have to estimate the kind of selection they're going to get. Are the young people going to take it?

In flexible compensation, with multiple benefit options, let alone with HMOs and other options, there has been a rather extreme amount of selection. There's no reason to think, in my view at least, that people within a corporation, who are buying MSAs with a sizeable contribution into a fund, won't be as selective as they are with the other options. I think Rick and I both believe that, in the limited markets we're talking about, we should possibly expand up to 100, and we should pick up people who don't have any option for insurance. I really had big hopes for the small-employer market, but something else is holding that back. I think it's their fear of starting a plan and then having to give it up if they get big rate increases. There are still signs that, after this business is in force two or three years, there may be some fairly sizeable increases in the high-deductible rate. With high deductibles, you would expect the leverage from the deductible to cause it to inflate faster, particularly since we're underwriting the large majority of these entrants in the beginning, we also have the wearing off of the underwriting effect.

You might have noticed, as we've talked here, that there has been almost no discussion of whether we've reduced medical costs or medical care expenditures under this thing. We haven't even found any way to measure that yet. Part of the reduction could be due to underwriting, and you can't tell if it's due to a naturally lower use of health care. So the effect of the MSAs on the underwriting is that the high-deductible insurance by itself could lower costs. But whether the MSA makes it the same, or whether having that money to spend would increase the utilization of lower-level expenditures, is unanswered yet.

Mr. Ronald E. Bachman: Harry and Rick, maybe you can comment on the idea that one of the problems with the MSAs is that it is more of a plan design than it is a financing opportunity. Congressionally legislating how much the deductibles or out-of-pocket expenditures should be is irrelevant to what the individuals might need in terms of having pretax money set aside that can accumulate. They could go from a lower-deductible plan to a higher-deductible plan over time. This is just a lot

of bureaucratic mumbo-jumbo that's unnecessary, and nobody's going to want to get into this because of those kinds of unnecessary complexities. What would be the difference between taking what the MSA is today and removing the use-it-or-lose-it type of provisions on employee savings accounts?

Mr. Sutton: The proponents of this look at the Rand study and say that if people have to spend money out of pocket, they're going to spend a lot less. That has been the hope—of constraining health care expenditures. It doesn't relate to the method of financing, necessarily. I think the deductibles should be higher than they are, in the federal law, because too many routine claims would hit the $1,500 limit for the individual deductible. Anybody who has to go into the hospital would hit $3,000 in two days. It isn't exactly catastrophic. I think there needs to be more of a spread between the MSAs and the deductible in order to really inhibit people's spending on medical care. I think it's a question of taxes. When we had the FSAs, without the use-it-or-lose-it factor, people figured out how to just subtract whatever their medical expenses were from their salary. I did. If you put it in in December, you could get a deduction for all your medical expenses after taxes. As it is proposed, we would be destroying, the 7.5% if we expand it the way Congress was proposing. I would not have worried so much about insurance if I could deduct it or deduct my out-of-pocket medical expenses from my income taxes. It's a complex mixture of the federal revenue projections. They estimate that the tax exemption for employer insurance premiums is somewhere between $50 billion and $150 billion a year. That's a lot of money they could use. The FSA was merely a way of lowering the cost of medical care. The tax deduction for the MSA is similar because of the tax deduction. I think the advocates are stressing the equalization of tax advantages, and Congress is buying it to some degree. The medical cost goes up because insurance pays for all the cost with no controls. So it leaves the patient at risk in a meaningful way, and theoretically, you could lower the utilization. Whether the MSA or FSA really does that is not too clear. The FSA originally did not do that. Only 20% of the people use the FSA because of the use-it-or-lose-it provision, and they put in relatively small amounts of money.

Mr. Bachman: If they didn't have the use-it-or-lose-it provision, wouldn't that make an entirely different potential list of product designs and encourage the savings that would encourage going to higher deductibles, where individuals had more say over their expenses? Now, with the very high deductible plan, they're going to have the MSA, but they will be very careful about what services they use because the rest is coming out of their own pockets.

Mr. Sutton: Right.

Mr. Buchman: I just think Congress voted on it entirely incorrectly by trying to create a plan design and specifying deductibles. All they ought to do is set aside money in a medical IRA that doesn't have the use-it-or-lose-it provision.

Mr. Sutton: I think they were spoiled by the FSAs back in the late 1970s that greatly increased the tax deductions for medical expenditures and destroyed the limit and the IRS rules. It's not as simple as saying the employee should have the right to accumulate the money, which would make it a lot simpler for you; it's a question of how much money the government is going to lose in tax revenue.

Mr. Bachman: That's an entirely different question of whether the government ought to be worried about that, as opposed to a product for the marketplace that makes it productive.

Mr. Sutton: You could cover every person 100%. Why doesn't your employer do that?

Mr. Ruppel: I'd like to give you a different style of answer. H.G. Wells said it best. "Leaders should lead us as far as they can, and then vanish. Their ashes should not choke out the fire they have lit." I feel that they are, in a sense, doing that by limiting the plan design. I think the government should get out.

Mr. Bachman: Let me ask one more follow-up question. The Speaker of the House, Newt Gingrich is in my area, and I talked to him about it. He's very concerned and has asked specifically what would need to be done. He was one of the big proponents, and he used exaggerations as to what might or might not happen, but that's the political realm of trying to get something passed. I don't think that it's appropriate to look at all sides of the political arguments to see the extremes of what might or might not happen. But I think it's a legitimate question. If it has some value, what would you say needs to be done to correct the legislation to make this a marketable, viable product that might get more benefits to more people? The individual market in the entire United States comprises only 4.5% of the population, so if everybody bought a MSA, it would have a relatively small impact. If everybody under 100 lives had the coverage, you're probably still only talking about 30–40% of the population, which is still a large number of people. But what would you suggest if Speaker Gingrich were here today asking what needs to get changed to make this a viable piece of legislation? As much as you're proud of what's happened, in general, I think it's considered a bust right now. Golden Rule is the only one really doing a lot. Rudy was out there fighting for this thing, and his reputation is on the line, in some ways, to do as much as he can. We're arguing about why it failed, as opposed to trying to find ways to accommodate more of this. What would you suggest?

Mr. Ruppel: First I would say, on the individual market, expand it and take off the limits of the plan design. In other words, expand it to everyone—the uninsured and the uninsurable. Let them buy a high-deductible plan. They can buy high or low, but take the limits off.

Second, let me pay my dental care with pre-tax money out of my MSA. I can't do that now because it's taxed. I don't know why we want to put a limit on group lives, because group is a very tough sell. I don't think it will have the impact that the critics think that it would. It would dilute the pool that's left. Let the water seek its own level. I've been in the health business, re-rating rates since 1967. Let the market decide what's going to happen.

Mr. Sutton: I don't think large employers are going to offer it if they feel they're going to get selected against. I think they do at the moment. On the other hand, I think it's ingenuous to try to sell MSAs to the totally disabled and sick people because I don't think you would sell to them.

Mr. Ruppel: I didn't mean to imply that we could sell it to them. I meant why take that choice away?

Mr. Sutton: Do you mean the government will sell them an MSA for Medicaid, or something like that? I know some have advocated that.

Mr. Ruppel: For the high-risk groups, we have MSAs. That group has the highest morbidity around.

Mr. Sutton: What high-risk groups?

Mr. Ruppel: The state high-risk pools.

Mr. Sutton: They have a $500 or a $1,000 deductible. If a Medicaid person doesn't have any money, what's he going to do with the MSA? Is he going to spend it on food? I still have hard time with making this available to all segments of the population. I probably won't mind if they expanded it to larger employers because I think the larger employers are going to get the expertise that will explain what will happen to them, and all the big consulting firms have selection tables that they use for flexible benefits now, which they never used before. It remains to be seen, I've called many of the big consulting firms, and they don't see any big push for MSAs in very large employers. That doesn't mean that some of their employees might not like it, but they don't see it in the framework of things, particularly after years of setting up HMO networks and stuff like that. If they can't control costs with the

HMOs, they may try something else. I don't think we've quite reached that point yet. I think the deductibles should and could be higher, but the government is going to measure exactly how much tax deductible money you're going to allow the person to put in there. It's still only $2,000 a year for an IRA. If they liberalize that, there's no reason they couldn't liberalize the MSAs. I hope small employers would buy the high-deductible insurance, at least to have catastrophic coverage, and then the owner could put his own money in to the MSA. The younger employees don't get much tax advantage. If they don't pay any income taxes, they don't save any money on it.

Mr. Ruppel: I know one of the groups that did buy an MSA. It is the place where I get my tires changed in Lawrenceville, Illinois. I asked the owner, "What made you decide to purchase this MSA?" He said, "I couldn't provide my employees with an insurance plan unless I went with a very high deductible." The MSA gave the employees the chance to contribute. Either the employer or the employee could put money in, but not both. He was very happy that his employees had a high-deductible insurance plan, and if they could find enough MSA money to put into that fund, they could build up a fund that would be used to meet the deductible. They recognized that you might have, on a family basis, a $3,000 deductible, but they can live with that. After meeting the deductible, they are 100% insured. That sure is a lot better than nothing.

Mr. Sutton: I was hoping that the small employer market would take off that way, but you'd have to explain to the owner that he can get a deduction for the whole thing. His employees would at least have catastrophic coverage, and if they wanted to save money that way, they could. It doesn't seem to me to have been sold that way very often.

Mr. Eric L. Smithback: It always seemed to me that MSAs were a combination of two things. First, there was a tax advantage. Clearly a tax advantage is going to make people buy more insurance. If you give me a 40% discount, through taxes, I'm going to be more likely to buy insurance, so that can be more fair and equitable. However, it is a tax issue, and we can debate the merits of tax policy with the government. I don't understand how it views equity.

The other side of the MSA issue was always kind of mixed in the public debate. Are MSAs vehicles that are capable of saving money? That was really the rationale for allowing people to accumulate side funds. Without that rationale, you might as well just give them the tax break and treat them like everybody else, or give them an IRA. Harry said that there was no evidence that MSAs really reduce cost. It was always a little hard for me to believe that a truck driver could walk into his cardiologist, or be carried in on a gurney, and say, "Well, doc, I can't pay $12,950.

How's $4,332? That kind of negotiation never seemed to work in practice among the people that I knew. Anecdotally, I couldn't really find too much evidence of it. The management of care clearly affects it, as Ron said. That person is more careful about spending his own money.

It seemed to me that the whole rationale for the side fund and allowing the buildup was predicated on this ability of MSAs to manage care. It sounds like we don't have much evidence of that. I thought that Golden Rule had started an MSA, and not a tax-deductible one a couple years ago. I thought that I had seen experience from year one. But I never saw year two, even though the study was done long after year two would have finished. I was curious about whether there was something we could learn from that. Rick, can you elaborate a little bit on how the loss ratios were the same on this product. Does that mean that there really aren't medical savings here, or were you just saying it's not different enough to tell yet?

Mr. Ruppel: I think I read that same article. I don't pay too much attention to the marketing area in our company. I worry about the claims costs and rate increases and the reserves. The reserve examiners are after me hot and heavy now on our five-year examination. I had to spend so much time on that recently, I didn't get a chance then to go into that study, so I don't know. In 1997, there was $927 left in the account, which shows me that people are saving. They get a $2,000 contribution to their account, and they've spent part of that, but they still saved $927. So, they've spent their deduction dollars wisely and gotten breaks because then they could save $927. In my case, I'm not going to make it this year, because I had a root canal and the purchase of glasses. Those things don't meet the deductible in the first place, so I have to come up with $3,000. The critics brought that in as a disadvantage. It's not a disadvantage as far as I'm concerned. It's still a deductible; when you buy a high deductible, and you know what's covered.

I can give you the two-foot high stack of letters from all the policyholders who write in and say they've saved money by wisely buying their medical care. As an ex-mathematics professor, I know that all the examples in the world will not prove something, so I'm not even going to try to prove the answer to that statement.

Mr. Sutton: Could I ask you a leading question? I think more than 90% of your employees take the MSA plan, and they get the $925. What about the other 10%? Is their cost higher than average?

Mr. Ruppel: I'll tell you about my secretary. She was very hesitant. She did a lot of the typing and the work on it, but she said she was not going to sign up. For two years, she did not sign up. Finally, in the third year, she signed up for the program because she had a lot of claims and high morbidity. She said, "Even though I have

high claims and the traditional plan really took care of me well, if I can just save a little bit extra in that MSA in one or two years, I'm going to be ahead of the game. So she is very happy with it today. That doesn't prove anything. That's just one little example.

From the Floor: Access to and timing of the care in much of the HMO market is a major problem for membership. Many times patients feel like they have to beg for care. It has always seemed to me that the MSA approach was the way to defeat much of that problem with the HMO industry; however, 70% of your members are in some sort of a network. There are networks and then there are networks. I'm wondering what kind of approval or referral processes are required under your program. I have a non-MSA high-deductible plan, and I find I can get an appointment with the doctor the next day. I would have had to wait a week or more in an old HMO plan. I can get testing or treatment done the next day that I otherwise would have had to wait in line for. It seems that the MSAs were supposed to defeat much of the negative aspects of the HMOs. What do you find?

Mr. Ruppel: Networks help to keep the premiums down. That's the only purpose of going to networks. We try to set up a network where patients can then get a lower premium with a 10%, 15%, or 20% discount, depending upon what you negotiate with the providers. I feel that that does not deter from what you were saying. The availability is there.

From the Floor: So your network is not one that has some sort of a referral or approval process. It's a discounted rate. If you get somebody in your network, they're willing to take a lower or fixed rate, so there's no balance billing or whatever. Just talk about the managed care aspects of that network.

Mr. Ruppel: Yes, I would classify it as managed care. We have some old blocks where you had to have pre-certification and so forth with small groups. If you are in a certain network, you go to a certain hospital, and then you get this discount. These networks would compete with each other on who's going to give the biggest discount.

Mr. Sutton: If somebody goes outside of the network, is that full claim allowed against the deductible, or do you limit it so that 75% or 80% of the expenditure counts towards the deductible?

Mr. Ruppel: To answer that, I'd have to see the contracts.

Mr. Sutton: Do you have some where a differential of a certain amount can be used towards the deductible? Suppose it's $3,000. If you go to Dr. A., he charges

$100 and he's in the network, and you allow that. If you got to Dr. B., who is not in your network, it's $150. Do you allow the $50 to count towards the deductible? Is it like a PPO with diminished benefits if you go out of network?

Mr. Ruppel: You may be reimbursed for only a certain percentage of that claim before the 100% kicks in.

Mr. Sutton: Do you do that with yours, too?

Mr. Ruppel: I really would rather not answer that, because I don't remember, and I don't want to give a false impression.

Mr. Gregory Daniel†: Are you getting any resistance from any of the networks of providers in terms of getting into these plans because of fears of increased un-collectibles on their own books because the MSAs won't or don't cover the amounts that these people end up with?

Mr. Ruppel: If I understand the question, on the individual business, you don't get paid from that policy. The claim does not get paid at 100% until you meet the deductible.

Mr. Daniel: Right.

Mr. Ruppel: And so, if you have an MSA that can pay that full $3,000 deductible, everything's fine. If you have zero in that MSA because you've depleted it already, you have to come up with $3,000.

Mr. Sutton: The hospital is worried about collecting the $3,000.

Mr. Ruppel: I've not come across a situation where that was expressed as a worry.

Mr. William V. Dwyer: We've had poor results with individual sales of MSAs for many of the reasons you listed, plus one more that I didn't catch, which I'd like to throw out to you for your comment. The popular option on most of our sales now are copayments for office visits and prescription drugs. Our company viewpoint was that we could not guarantee a policyholder that that option would qualify as an eligible plan for the MSA. So our field force and our customers, primarily families, would rather choose the copayments, if they can't have both. We're not getting the MSA sales. Are you aware of how other companies are dealing with that?

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†Mr. Daniel, not a member of the sponsoring organizations, is Supervisor of Actuarial Finance at LHC Health plans, Inc. in Salt Lake City, UT.

Mr. Sutton: Yes, I am, with the possible exception of Medicare, because it indicate you could add benefits to it. I think you're right. You can't have a copayment except on certain defined wellness benefits, and so you can't pay anything below the deductible. You can't have a $10 copayment on prescriptions or something, as far as I know. That's another thing that Congress could fix up. So many people have card benefits with copayments. It would be much easier to continue using them.

Mr. Ruppel: We just have the 100% coinsurance after the deductible.

Mr. Sutton: There are assumptions that a $10 or $20 copayment on office visits could restrain those visits. I suppose paying totally out of your own pocket would restrain them as well. I think there is a lack of knowledge of what would attract the marketplace, like you were talking about.