FEHB/MSA: ADDING MEDICAL SAVINGS ACCOUNTS—BROADENING EMPLOYEE OPTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON
CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

DECEMBER 13, 1995

Printed for the use of the Committee on Government Reform and Oversight

U.S. GOVERNMENT PRINTING OFFICE
36-622 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-054254-5

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

WILLIAM F. CLINGER, JR., Pennsylvania, *Chairman*

BENJAMIN A. GILMAN, New York
DAN BURTON, Indiana
J. DENNIS HASTERT, Illinois
CONSTANCE A. MORELLA, Maryland
CHRISTOPHER SHAYS, Connecticut
STEVEN SCHIFF, New Mexico
ILEANA ROS-LEHTINEN, Florida
WILLIAM H. ZELIFF, JR., New Hampshire
JOHN M. McHUGH, New York
STEPHEN HORN, California
JOHN L. MICA, Florida
PETER BLUTE, Massachusetts
THOMAS M. DAVIS, Virginia
DAVID M. McINTOSH, Indiana
JON D. FOX, Pennsylvania
RANDY TATE, Washington
DICK CHRYSLER, Michigan
GIL GUTKNECHT, Minnesota
MARK E. SOUDER, Indiana
WILLIAM J. MARTINI, New Jersey
JOE SCARBOROUGH, Florida
JOHN B. SHADEGG, Arizona
MICHAEL PATRICK FLANAGAN, Illinois
CHARLES F. BASS, New Hampshire
STEVEN C. LaTOURETTE, Ohio
MARSHALL "MARK" SANFORD, South Carolina
ROBERT L. EHRLICH, JR., Maryland
CARDISS COLLINS, Illinois
HENRY A. WAXMAN, California
TOM LANTOS, California
ROBERT E. WISE, JR., West Virginia
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
JOHN M. SPRATT, JR., South Carolina
LOUISE McINTOSH SLAUGHTER, New York
PAUL E. KANJORSKI, Pennsylvania
GARY A. CONDIT, California
COLLIN C. PETERSON, Minnesota
KAREN L. THURMAN, Florida
CAROLYN B. MALONEY, New York
THOMAS M. BARRETT, Wisconsin
GENE TAYLOR, Mississippi
BARBARA-ROSE COLLINS, Michigan
ELEANOR HOLMES NORTON, District of Columbia
JAMES P. MORAN, Virginia
GENE GREEN, Texas
CARRIE P. MEEK, Florida
CHAKA FATTAH, Pennsylvania
BILL BREWSTER, Oklahoma
TIM HOLDEN, Pennsylvania

BERNARD SANDERS, Vermont (Independent)

JAMES L. CLARKE, *Staff Director*
KEVIN SABO, *General Counsel*
JUDITH McCOY, *Chief Clerk*
BUD MYERS, *Minority Staff Director*

SUBCOMMITTEE ON CIVIL SERVICE

JOHN L. MICA, Florida, *Chairman*

CHARLES F. BASS, New Hampshire
BENJAMIN A. GILMAN, New York
DAN BURTON, Indiana
CONSTANCE A. MORELLA, Maryland
JAMES P. MORAN, Virginia
BERNARD SANDERS, Vermont (Ind.)
TIM HOLDEN, Pennsylvania

EX OFFICIO

WILLIAM F. CLINGER, JR., Pennsylvania
CARDISS COLLINS, Illinois

GEORGE NESTERCZUK, *Staff Director*
DANIEL R. MOLL, *Senior Policy Director*
CAROLINE FIEL, *Clerk*
CEDRIC HENDRICKS, *Minority Professional Staff*

CONTENTS

FEHB/MSA: ADDING MEDICAL SAVINGS ACCOUNTS—BROADENING EMPLOYEE OPTIONS

WEDNESDAY, DECEMBER 13, 1995

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2154, Rayburn House Office Building, Hon. John A. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Bass, and Moran.

Staff present: George Nesterczuk, staff director; Daniel R. Moll, senior policy director; Caroline Fiel, clerk; Cedric Hendricks, minority professional staff.

Mr. MICA. Good morning. I would like to welcome you to this meeting of the House Civil Service Subcommittee. Today we're going to have a hearing on medical savings accounts. We have Members who are involved in very weighty conferences on both sides of the aisle and several other mark-ups, but with the agreement of the minority side, we are going to begin.

I'll make my opening statement, and we'll get right to our first panel so we won't delay the hearing, but, in fact, your comments as witnesses today will be available to all of the Members, and we hope they can join us as the hearing this morning proceeds.

Today, we'll be gathering information on medical savings accounts, also known as MSA's, before we actually include them in the Federal Employee Health Benefit Program or any other program that deals with Federal employees. MSA's, I believe, give people more control over health care spending, and I think that taking a direction like that is very important today, especially when we're looking at costs and effectiveness of programs.

The FEHB program is a managed competition program that I believe is working extremely well. Overhead and administrative costs are relatively low, while employees can choose from a broad array of plans to meet their specific health care needs. Providing MSA's as an additional option for Federal employees can only reinforce one of the strongest tenets of the program, and that's freedom of choice for employees during what we call "open season." MSA's are, in fact, a positive, productive change, I believe, that will strengthen the program by adding a benefit for enrollees.

As one of the program's strongest supporters, I'm really only interested in improving the program. As I said, it's a program that

already works very well, and we wouldn't want to do anything that would harm our Federal Employees Health Benefit Program.

While providing personal choice, MSA's also foster individual responsibility for health care spending. I think that's an important factor to look at. MSA's are essentially savings accounts for uninsured medical expenses, which are coupled with a high deductible health insurance cover plan to cover catastrophic illnesses. An MSA allows the employer or an individual to contribute to the account and roll over the unused funds at the end of the year, much like an IRA, and it's pretty much incentive-driven.

MSA's provide a number of advantages over other health insurance plans. Economists across the political spectrum have concluded that one of the major factors driving health care costs is our third-party payment system. Because a third party, the insurance company, pays the bills, patients often are insulated from the cost. As a result, they do not choose doctors and hospitals on the basis of cost effectiveness, and they do not balance cost versus quality. Rather, they seek to maximize quality without regard to cost. The patient has no incentive to avoid unnecessary care or tests, nor to shop for the most reasonably priced care. Since consumers lack market incentives, which are so important to control costs, doctors and hospitals are not driven by competition to reduce costs.

MSA's address very specifically these problems by giving people greater control over their own health care dollars. With the realization that it is either their own money they are spending—and a very stark realization that in fact it is their own money—employees are much more careful and selective about the medical services they use. This increased price sensitivity results in more effective use of health care resources and in turn, we hope, will lower health care costs, and in fact do lower health care costs.

At a recent hearing before this subcommittee, the president of the American Federation of Government Employees, John Sturdivant, testified that "the FEHBP's relatively high premium costs for employees have left roughly 400,000 Federal employees uninsured." That number is undoubtedly high, but there are uninsured Federal employees, and MSA's in FEHB could, in fact, help eliminate this problem. The currently uninsured who select an MSA could use the government's contribution to health care to purchase a catastrophic coverage without to incur payroll deductions. The balance of the government's contribution would be deposited in the savings account of the MSA.

MSA's can be completely portable. Workers should be able to take their MSA's with them if they leave Federal employment, for example. MSA's, unlike traditional employer-provided health insurance, should follow the individual regardless of employment status. MSA's allow individuals to maintain designated savings accounts for health care expenditures and insurance, in fact, during temporary lapses in employment.

To help the subcommittee further explore these issues, we've convened two panels this morning. Our first panel includes Congressman Matt Salmon, who has been a leader in the Congress on this issue and really taken the forefront in bringing the benefits of MSA's to the attention of the Congress and the Nation, and he is

going to speak to us from his personal knowledge and experience of MSA's in Arizona.

He will be joined eventually by Congressman Dick Chrysler, and he is going to share with us the positive experiences his private company enjoyed with MSA's.

We also are privileged today to have one of the true leaders in municipal and local government, someone who is a star of innovation at the local government scene and who has made a tremendous impact on the thinking of how government should operate in the new environment that we find ourselves, with the new innovation, new approaches and cost consciousness, the very distinguished mayor of Jersey City, NJ, Mr. Bret Schundler. We're pleased to have him, and he can tell us specifically how MSA's were chosen as a health care option for employees of his very innovative city, again with his leadership.

Our second panel will be led by Gary Glenn, a county commissioner from Boise, ID. Despite firm opposition, Mr. Glenn was able to pass legislation allowing county employees access to MSA's. He will be followed by Peter Hendee, a consulting actuary with the Counsel for Affordable Health Insurance. The council is a trade association representing 40 insurance companies involved in the individual and small group market. Then we will hear from Mr. Merrill Matthews of the National Council for Policy Analysis of Dallas, TX, and, finally, from a distinguished representative of the medical community, Dr. Daniel P. Johnson, member of the Board of Trustees and president-elect from the American Medical Association.

I look forward to the testimony of our witnesses and hope that we can thoroughly examine the possibility of adding medical savings accounts to the Federal Employee Health Benefit Program, also institute MSA's in any other levels of government or government activities where, in fact, they can bring better health care, reduce costs, and provide another option to Federal employees or beneficiaries.

With that, again, I will welcome our two panelists. I think what we'll do is go ahead and start off. I know Mr. Salmon would like to go back to the conference, and then we'll hear from the mayor. So, with that, we'll recognize you again, Mr. Salmon.

STATEMENT OF HON. MATT SALMON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SALMON. Thank you, Mr. Chairman. I appreciate this opportunity. Medical savings accounts are definitely an idea whose time has come.

Three years ago, when I was a State senator in the State of Arizona and was working on legislation to provide medical savings accounts for our citizens at large in the State of Arizona, we realized very early on how meaningless it really is without the kinds of Federal assistance and benefits that we can provide and tax benefits that we can provide at the Federal level.

I guess maybe "meaningless" isn't the right word. It's a good start, in that some 3,000 companies across the country, as well as municipalities that have instituted medical savings accounts for their employees, have found tremendous savings and happier employees, as well.

It's based on the premise that made this country great. This country operates on a capitalistic economy. Would anybody out there really disagree or say that capitalism doesn't work?

If the free market works in every other industry in America, why should we say that it's not going to work in the health care industry? Why do we believe that incentives drive human behavior in virtually everything else that we do, but incentives won't drive human behavior when it comes to the health care dilemma? I think nothing could be further from the truth.

In fact, I think it's the same kind of arrogance that pervades this city, that Washington is the font of all knowledge, and it has the right answers for everything, and that individuals, left to their own devices, will harm themselves and other people. If we don't step in and mandate and tell people how to do things, that they won't get the job done.

That's typified in a lot of the arguments about adverse selection—which I'll talk about a little bit later—that if you give people that much control, almost total control over their own health care destiny and health care decision and the ultimate control in choosing their provider and making decisions regarding their family's health issues, that they will make wrong decisions, because, apparently, they aren't as smart as the bureaucrats in the insurance industry, or they aren't as smart as we here in Washington.

They don't care about themselves. They would rather be knocking on death's door than spend a couple of extra dollars out of their medical savings account for preventative care.

Now, I say this kind of tongue in cheek, and we all know that that's ludicrous. There's nobody out there that's going to skimp on their own health care so that they can save an extra few bucks for their medical savings account so they can buy that big-screen TV at the end of the year. That's just nonsense, and I think we all know it.

Last month, we passed legislation that will make medical savings accounts available to almost every American—almost every American. I'm here to say they should also be available to Federal employees, and I have a bill, H.R. 2341, that would do just that.

Under this plan, the Federal contribution to an employee's health benefits will be used to purchase a catastrophic plan and a contribution to an MSA. This MSA choice would be completely optional. I emphasize that again, optional. Nobody is forcing anybody.

The beauty of this kind of an idea is that most people, as Mayor Schundler will probably tell you in a few minutes, as most companies that offered MSA's to their employees, you will have probably well over 50 percent of the employee base that's going to opt toward medical savings accounts, because they kind of like freedom. They kind of believe that they can make the health decisions for their families, and they like the incentives that go along with the MSA option.

Federal employees could choose this plan, or they could continue with the other plans that are offered in the Federal employee health benefit plan. An MSA option for Federal employees would reduce health care cost inflation for the Federal Government and empower Federal employees to take control of their own health care decisions.

MSA's will not increase out-of-pocket costs for Federal employees. They actually limit out-of-pocket costs, because any funds spent out of the MSA's are applied simultaneously to the catastrophic deductible, and if the deductible is met, the catastrophic policy kicks in.

So, virtually, it's better than any other plan when it comes to out-of-pocket costs, because they can pay for prescription coverage or go to virtually any provider that they desire, and they have first-dollar coverage from their medical savings account.

Opponents of the MSA cite a few arguments—one, postponing preventative care. Simply put, that has not been borne out in the real world. The 3,000-some companies, like Quaker Oats, Fortune magazine, Dominion Resources, and Golden Rule Insurance Co., just to name a few, have not found that people skimp on preventative care.

Again, I think that the MSA's would encourage people to live healthier so they don't need expensive medical care, but there's absolutely no reason to think that anyone would jeopardize their entire MSA nest egg or their life just to save the cost of a doctor visit. I think we all recognize that that's pretty ludicrous.

In fact, private sector companies who offer MSA's have found no evidence, as I mentioned. Rather, middle and lower income workers are more likely to get preventative care, since they don't have those out-of-pocket costs or deductibles that they currently have.

Let's talk a little bit about the adverse selection process, the concerns that predominantly are being shared by the insurance industry. Adverse selection problems have never been found in the private sector.

MSA's are actually attractive to the very sick, as they will experience, again, much lower out-of-pocket costs, as compared to traditional plans. I don't understand the rationale that only healthy people would go to medical savings accounts. Again, they're operating under the assumption that you don't have a catastrophic care policy with your medical savings account, so that's just fallacious.

Mr. MICA. Mr. Salmon, I hate to interrupt. I want to give you this choice. There is a secret ballot going on in the conference. I would like to recess the hearing and accompany you over there immediately. So, if you don't mind, we will return within 10 minutes.

I will recess the hearing, and I apologize so much for the inconvenience to you, Mr. Mayor. Thank you.

[Recess.]

Mr. MICA. I will call the hearing of the House Civil Service Subcommittee to order and reconvene the meeting here after that quick run. We're testing whether Mr. Salmon will get to use his MSA or not. We are pleased to be back and also to have our colleague, Mr. Chrysler, join us.

We left off with Mr. Salmon, and you were finishing your statement. We apologize again to the mayor for his patience and understanding. Mr. Salmon.

Mr. SALMON. Thank you, Mr. Chairman. I'm just going to observe that, after having run across the street, run back, and walked in the cold and sweated and all that, I would like to have an MSA to cover my out-of-pocket expenses when I go see the doctor today.

Let me conclude that the adverse selection issue was where we kind of left off, that folks on the other side of this issue believe that

if we institute medical savings accounts, that only the healthy people will flock toward medical savings accounts, which the very sick would be stuck in the old system, and it would go broke. That's one allegation.

If that was borne out by a real-life example, they might have a point. Again, let me mention, there are about 3,000 companies that I know of throughout the country that have instituted medical savings accounts as an option. I know Mr. Chrysler will talk about his company as one of those examples. It simply hasn't been borne out by historical facts. They have not found the adverse selection to be true.

This argument is being promulgated chiefly by those in certain facets of the insurance industry that are deathly afraid that they're going to have to compete for a living and they're going to lose market share. So let's be very clear, as we understand who is making the arguments and why they're being made, the facts simply do not bear out the assertions that are made.

Again, if a person is very ill, they would want to go to a medical savings account with a catastrophic care policy, because they would have first-dollar coverage. By the time they expend, if they're a very ill person, their medical savings account dollars, then the catastrophic care policy kicks in, so there's really no reason that they wouldn't have to or they wouldn't want to pursue a medical savings account as others.

Now, your staffers and mine, they deserve an MSA option now, and the taxpayers deserve a break. Let's not discriminate against the Federal employees, and let's give them the same option that we believe is a viable option for all other Americans. I would urge the eventual passage of this bill, H.R. 2341, the Federal Employee Health Benefit Plan/Medical Savings Account Promotion Act of 1995. Thank you.

[The prepared statement of Hon. Matt Salmon follows:]

MATT SALMON
MEMBER OF CONGRESS
FIRST DISTRICT, ARIZONA

COMMITTEES
INTERNATIONAL RELATIONS
SUBCOMMITTEE ON AFRICA
SUBCOMMITTEE ON INTERNATIONAL OPERATIONS AND HUMAN RIGHTS
SCIENCE
SUBCOMMITTEE ON ENERGY AND ENVIRONMENT
SUBCOMMITTEE ON SPACE AND AERONAUTICS
SMALL BUSINESS
SUBCOMMITTEE ON PROCUREMENT, EXPORTS, AND BUSINESS OPPORTUNITIES

Congress of the United States
House of Representatives
Washington, DC 20515–0301

115 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-2635

401 W. BASELINE ROAD SUITE 208
TEMPE, AZ 85283
(602) 831-2900

ASSISTANT MAJORITY WHIP
COMMISSION ON SECURITY AND COOPERATION IN EUROPE
(HELSINKI COMMISSION ON HUMAN RIGHTS)
REPUBLICAN EDUCATION TASK FORCE

TESTIMONY OF REP. MATT SALMON (R-AZ)

Committee on Government Reform and Oversight
Subcommittee on Civil Service
December 13, 1995

Last month we passed legislation that will make medical savings accounts available to almost all Americans. I am here today to say that they should also be available to federal employees, and my bill, H.R. 2341 will do just that.

H.R. 2341 would simply permit the federal contribution to an employee's health benefits to be used to purchase a catastrophic plan and make a contribution to an MSA. This MSA choice would be completely optional. Federal employees could choose an MSA plan, if offered by the private sector, or they could continue with any of the other plans offered in the FEHBP.

An MSA option for federal employees would reduce health care cost inflation for the federal government, and empower federal employees to take control of their own health care decisions.

MSA's will NOT increase out-of-pocket costs for federal employees. They actually limit out-of-pocket costs because any funds spent out of the MSA are applied simultaneously to the catastrophic deductible. And if the deductible is met, the catastrophic policy coverage kicks in.

The opponents of MSA's for federal employees fall into two camps. One camp is made up of advocates for federal employees who have heard some of the histrionics against MSA's and are naturally concerned for their constituencies. I am confident these folks will become enthusiastic supporters of MSA's once they hear the truth about them. Of course, even if they decide MSA's are not right for themselves, they will find in H.R. 2341 that the bill compels absolutely no one to choose an MSA. H.R. 2341 simply permits MSA's to be among the choices offered federal employees. No advocate for federal employees could oppose that!

The other critics of MSA's for federal employees have different motives. These are supporters of entrenched insurance interests who see their market shares threatened by MSA's. These opponents will never support MSA's and will appear wherever MSA's are offered to block any change from the status quo. These opponents may couch their rhetoric in terms of federal employees, but their true opposition is to competition in the market for health insurance. These opponents should be dismissed out of hand.

One claim cited by some opponents is that people with MSA's will choose to forego preventive care, to keep funds in their medical savings account. This is ridiculous. MSA's do encourage people to live healthier, so that they do not need expensive medical care. But there is absolutely no reason to think that anyone would jeopardize their entire MSA nest egg--or their life--just to save the costs of a test or doctor's visit.

In fact, private sector companies who offer MSA's have found no evidence that preventive care is being skipped. Rather, middle- and lower-income workers are MORE likely to get preventive care with an MSA, since they won't have out-of-pocket co-pays or deductibles like they currently have.

Adverse selection problems are also alleged at times. But they have never been found in the private sector experience with MSA's. MSA's are actually attractive to the very sick as they will experience much lower out-of-pocket costs as compared to traditional insurance plans. Moreover, the very sick will retain their choice of physician or specialist under an MSA, which is an attractive feature, particularly for those using an extensive amount of medical care. These individuals often find managed care too restrictive.

As federal workers find themselves stuck in the middle of a dispute between Congress and the President about whether to balance the budget, we should try to do something for them. One thing we can give them now is an MSA option for their health care. If action is taken in early 1996, federal employees can begin accruing savings in their Medical Savings Accounts in 1997. That would benefit the workers who choose them, would reduce health care expenses for the federal government, and would serve as a laboratory to prove in the federal public sector what Jersey City Mayor Bret Schundler and the private sector have already shown: MSA's work.

Your staffers, and mine, deserve an MSA option now, and the taxpayers deserve a break. MSA's for federal employees will save the entire health care system money. I urge the Subcommittee to support free market competition by supporting H.R. 2341, the FEHBP-Medical Savings Account Promotion Act of 1995.

Mr. MICA. I thank you, Mr. Salmon, for your testimony. I'm now going to call on Mayor Schundler.

Mayor Schundler, I should tell you that our subcommittee is part of a general oversight and investigations committee of the Congress, and it is customary that we do swear in our non-congressional witnesses, so if you wouldn't mind, would you stand, mayor, and raise your right hand.

[Witness sworn.]

Mr. MICA. Thank you. The record will reflect that I'm not only out of breath, but the mayor answered in a positive fashion.

We are again delighted to have you, for you to take time to come before a subcommittee. You, in fact, are one of the shining lights in the national municipal and local government arena. You've brought a breath of fresh air to some outdated and often clouded thinking and approaches in a city that has suffered a great deal of pain and setbacks and problems in the past.

Your innovative approaches to some of their problems, we think, can serve as an example here, too, to what we're attempting to do in Congress in trying to do a better job with less and redo some of the programs that just sort of chugged along, SOP, in the past.

But, again, we're delighted to have you. We look forward to your testimony, and I also apologize for the interruption. So, with that, you're recognized.

STATEMENT OF BRET SCHUNDLER, MAYOR, JERSEY CITY, NJ

Mr. SCHUNDLER. I very much appreciate the invitation and the opportunity to speak to the subcommittee. I do strongly recommend that you include medical savings accounts as an option for Federal employees. Last year, Jersey City was the first governmental entity to offer MSA's to its employees, although there have been thousands of private entities which have already done so, and the results have been extremely positive for us.

We offered the option to our management employees, and over 60 percent chose the option in its first year, and we expect a substantially greater percentage to opt in next year, after the checks go out on December 31, refunding what is, on average, going to be almost $1,000 for the employees participating.

Now, the city was able to achieve immediate budgetary savings while also allowing employees to reduce their out-of-pocket health care costs and continue choosing their own doctor. So this was a win/win for all of us.

Why has the program proved so successful? In the past, Jersey City covered its management employees through the New Jersey State Health Benefits Plan. Most chose the traditional indemnity or fee-for-service option, where employees had to pay a $200 up-front deductible, and then they had exposure for a 20 percent co-payment for the next $2,000 of medical expenses per family member.

That means if you have a four-person family and have a very bad year, where everyone gets sick, you could have, potentially, $400 worth of expense in co-payments per family member, plus that $200 deductible, which adds up to $1,800 of potential out-of-pocket expense.

Under the MSA plan that we've provided our employees, the city purchases a catastrophic insurance policy that covers 100 percent of a family's medical costs above a $2,000 deductible. The city then places an additional $1,800 in a medical savings account that the employee can draw upon for family medical expenses.

Added together, this means that the family of four enrolled in the family plan would, at most, have to pay $200. The $1,800 MSA would cover the first $1,800, then they would have a $200 back-end deductible that they pay after they've expended the money in the MSA, and after that, the catastrophic insurance plan kicks in and covers 100 percent of costs above that $2,000 deductible.

Now, if that same family's exposure under the old plan was $1,800, and now it's reduced to $200, if they have high medical costs, it's clearly a better plan for families which are at risk of suffering high medical costs.

And it's not hard to see why the MSA is attractive for families with low medical costs, because the way our plan works, if they have money left over in the MSA at the end of the year, money comes back to them. Again, for our participating employees, the average that will be coming back to them on December 31 is almost $1,000. That's a fairly sizable amount.

The critics of MSA's argue that employees will delay necessary medical procedures or refrain from preventative care to ensure that they receive a large refund at the year end, which I think is crazy.

We believe that Jersey City's MSA plan actually encourages our employees to access preventative care, because it offers first-dollar coverage for medical expenses, as opposed to traditional plans where the employee has to spend considerable deductible dollars before they get any coverage.

Again, it's the difference between having a front-end deductible, which is the traditional plan's approach, versus a back-end deductible, which you only have any out-of-pocket expense after the MSA is expended.

Further, we've also included wellness benefits as part of our MSA plan, which allows employees to use their MSA funds for routine medical expenses like doctor visits and immunizations. These services were not covered by our traditional indemnity plan, nor do they count toward an employee's deductible or co-payment requirements.

All of these basic preventative procedures had to be covered directly out of pocket without counting toward their insurance coverage whatsoever. Now, they're covered through the MSA, and they do count toward the deductible of that catastrophic plan.

Let me also share a personal experience about how MSA's save money, not by encouraging employees to defer necessary medical treatment, but by eliminating gratuitous medical spending. Two years ago, I had back surgery. After completing the necessary physical therapy regimen, my back felt absolutely fine, but I was told by the physical therapist I could continue coming for the various treatments, many of which felt very nice, actually, and they would waive all the co-payments.

Now, I responded that it was not proper for them to make that offer, and I declined the offer, but I could easily see someone else

saying, "Yes," because under most health benefits plans, there are no financial incentives to decline such an offer.

Medical savings accounts address this problem. As I mentioned previously, the MSA has provided immediate budgetary savings to the city. The cost of the family coverage that we had under the State health benefits plan was $6,775 per year, and it was rising every year. The premiums have doubled in just the last 5 years.

The cost of the MSA option is only $6,500—$4,700 for the catastrophic insurance policy and $1,800 for the cash contributions to the medical savings account. Therefore, in the first year alone, we're saving $275 for every management employee's family that chooses the MSA over the traditional indemnity plan.

I might add, obviously, that if we were able to restrain health care costs even to zero, that that would be an amazing feat for my State, in that we've actually reduced our costs, even while reducing the out-of-pocket exposure of our employees.

That's a great deal—better coverage for our employees, maintaining their ability to choose their own doctor, and lowering the potential out-of-pocket expenses for our employees, combined with lower cost to the taxpayers of Jersey City.

Because of the MSA's rebate potential, we expect even larger budgetary savings in the future, as our employees are incentivized to avoid gratuitous expenses and the reduced claims experience by the insurance company results in lower premiums going forward.

For example, Forbes, Inc., has been able to reduce its health insurance premium by close to 10 percent per year in its first 3 years by offering MSA's to its employees, while employers with traditional fee-for-service insurance plans have continued to see their premiums increase.

Our employees aren't afraid to make informed decisions about their own health care needs—as consumers, we make thousands of decisions each and every year—but our employees are afraid of losing the right to make choices for themselves through third-party rationing.

They don't believe government or any employer should have the power to determine what level of health care they're eligible to receive or which physician they can see. They want and deserve the right to make those decisions for themselves.

That's why MSA's are so popular with our employees. They keep the power to choose in the hands of the patient, instead of putting it into the hands of government, employers, insurance companies, or health care providers.

I just want to add one last point. Congress should pass legislation that will end the foolish practice of treating funds that an employer deposits into medical savings accounts as taxable income. Only the unspent funds an employee is rebated at year's end should be treated as taxable income.

Further, individuals enrolled in an MSA should be given the opportunity to start a medical IRA, whereby funds that are left unspent can accumulate in the MSA, tax free, for future medical expenses.

In June, I testified in favor or H.R. 1818, the Family Medical Savings and Investment Act of 1995, before the House Ways and Means Subcommittee on Health, which would change the tax sta-

tus of MSA contributions. I hope that this crucial piece of legislation sponsored by Chairman Archer, which has received bipartisan support, will be part of this year's budget reconciliation package.

The choice is clear. Adding MSA's to the FEHB program will improve the coverage that Federal employees receive. It will preserve their choice of their own doctor. It will slow down the rate of cost growth to the government and to the taxpayers who pay that bill, and it will do all of this, not by third-party rationing, but by giving individuals an incentive to take an active interest in the quality and cost of the medical care they receive.

I encourage you to lead us in the direction of higher quality and expanded consumer choice and lower costs by offering the Federal employees the MSA option. Thank you very much.

[The prepared statement of Mr. Schundler follows:]

CITY OF
JERSEY CITY

BRET SCHUNDLER
MAYOR

CITY HALL
JERSEY CITY, NJ 07302
(201) 547-5200

Chairman Mica and Members of the Subcommittee on Civil Service:

Good morning. I am appearing before you today to strongly recommend that you include Medical Savings Accounts (MSAs) as an option of the Federal Employees Health Benefit (FEHB) Program, which is responsible for providing health insurance to over nine million federal employees, retirees, and their families.

Last year Jersey City, New Jersey was the first governmental entity to offer MSAs to its employees. Thus far, the results have been extremely positive. We offered the option to our management employees, and approximately 60% of them chose the MSA over their previous coverage -- and we expect that percentage to increase substantially next year. Meanwhile, the City was able to achieve immediate budgetary savings while also allowing employees to reduce their out of pocket health care costs and continue choosing their own doctor.

Why has this program proved so successful?

In the past, Jersey City covered its management employees through the New Jersey State Health Benefits Plan. Most chose the traditional indemnity or "fee-for-service" option, where employees had to pay a $200 front-end deductible and a 20% co-payment on the next $2,000 of medical expenses for each covered family member. That means a

family of four had to pay up to $1,800 in out-of pocket expenses annually.

Under the MSA plan, the city purchases a catastrophic insurance policy that covers 100% of a family's medical costs above a $2,000 deductible. The city then places an additional $1,800 in a medical savings account that the employee can draw upon for family medical expenses. Added together, this means that a family of four enrolled in the family plan would, at most, have to pay a $200 back-end deductible. And if that same family's total health care costs fall below $1,800, the money remaining in the MSA account will be refunded to the employee at year's end.

It's not hard to see why the MSA plan is more attractive. If family health care costs are high, family out-of-pocket expenses will be less under the MSA. If family health care costs are low, the family will actually get the money left in the MSA rebated back to them, which doesn't happen under the State Plan.

The critics of MSAs will argue that employees will delay necessary medical procedures or refrain from preventive care to insure that they receive a large refund at year-end. I disagree. We believe that Jersey City's MSA plan actually encourages our employees to access preventive care because it offers first dollar coverage for medical expenses, as opposed to the traditional indemnity plan, which requires employees to spend considerable deductible dollars before their insurance is activated.

Further, we have included a "wellness benefit" as part of our MSA plan, which allows employees to use their MSA funds for routine medical expenses, like doctor visits

and immunizations. These services were not covered by our traditional indemnity plan, nor did they count toward an employee's deductible or co-payment requirements. So, under the MSA, we have actually increased our employees' access to preventive care.

Let me share a personal experience about how MSAs save money, not by encouraging employees to defer necessary medical treatment, but by eliminating gratuitous medical spending. Two years ago, I had back surgery. After completing the necessary physical therapy regimen, my back felt fine. But I was told by the physical therapist that I could continue coming for the various treatments -- which were quite pleasant -- and they would wave all co-payments. I responded that it was not proper for them to make such an offer, and I declined. But I could easily see someone else saying "yes," and running up unnecessary bills, because under most health care plans, there is no financial incentive to decline such an offer. Medical savings accounts would address this problem.

As I mentioned previously, the MSA has provided immediate budgetary savings to the city. The cost of family coverage under the State Health Benefits Plan is $6,775 per year and rising (premiums have doubled in just the last five years). The cost of the MSA option is only $6,500 -- $4,700 for the catastrophic insurance policy and $1,800 for the cash contribution to the Medical Savings Account. Therefore, in the first year alone we save about $275 for every management employee that chose the MSA over the traditional indemnity plan.

That's a great deal: better coverage for our employees, which maintains their ability to choose their own doctor and lowers their potential out-of-pocket expenses, combined with lower cost to the taxpayers of Jersey City!

Because of the MSA's rebate potential, we expect even larger budgetary savings in the future as our employees are incentivized to avoid gratuitous expenses, and the reduced claims experience that results is translated into lower premiums. For example, Forbes, Inc. has been able to reduce its health insurance premiums by close to 10% per year by offering MSAs to its employees, while employers with traditional fee-for-service insurance plans have continued to see their premiums increase.

Our employees aren't afraid to make informed judgements about their own health care needs. As consumers, they make thousands of purchasing decisions each and every year. However, they are afraid of losing the right to make choices for themselves through third-party rationing. They don't believe government, or any employer, should have the power to determine what level of health care they are eligible to receive, or which physicians they can see. They want, and deserve, the right to make those decisions for themselves.

That's why MSAs are so popular with our employees -- they keep the power to choose in the hands of the patient, instead of putting it into the hands of government, employers, insurance companies, or health care providers.

I do want to add one last, very important point. Congress should pass legislation that will end the foolish practice of treating funds that an employer deposits into an MSA as taxable income. Only the unspent funds that an employee is rebated at year's end should be treated as taxable income.

Further, individuals enrolled in an MSA should be given the option of starting a "medical IRA," whereby unspent funds accumulated from their MSAs could be saved, tax-free, for future medical expenses.

In June, I testified in favor of HR 1818, the "Family and Medical Savings and Investment Act of 1995," before the House Ways and Means Subcommittee on Health, which would change the tax status of MSA contributions. I hope that this crucial piece of legislation, which was sponsored by Chairman Archer and received strong bi-partisan support, will be part of the this year's budget reconciliation package.

The choice before you today is clear. Adding MSAs to the FEHB Program will improve the coverage your beneficiaries receive, preserve employee choice, and slow down the rate of future cost growth -- again, not by third-party rationing, but by giving individuals an incentive to take an active interest in the quality and cost of the medical care they receive.

As the trustees of the FEHB Program, the largest employee-sponsored health insurance program in the nation, you have an opportunity to be a leader in national health care reform. I encourage you to lead us in the direction of higher quality,

expanded consumer choice, and lower cost, by offering federal employees the opportunity to enroll in MSAs. Thank you!

Bret Schundler
Mayor, Jersey City, New Jersey

# # # # #

A Health Benefits Presentation

for the employees of

City of Jersey City

BlueCross BlueShield
of New Jersey

January 1995

BCBSNJ offers a variety of products

From full managed care to traditional indemnity

Jersey City employees can choose from:

- HMO Blue, our health maintenance organization
- Blue Choice, our point of service product
- Traditional, a standard indemnity plan
- MSA, the Medical Savings Account Plan

Medical Savings Account Plan

- A Medical Savings Account reimburses subscribers for eligible medical expenses. Funds are deposited into an account managed by BCBSNJ.
- When subscribers have an expense in any of their eligible benefit categories, the plan reimburses them for that expense. BCBSNJ becomes, in one sense, a bank allowing withdrawals on their individual accounts.
- At the end of the benefit period, subscribers are reimbursed the balance in their individual account.

The Medical Savings Account Advantage

- $ First dollar coverage for eligible medical expenses from MSA up to $1,400/$1,800
- $ Out-of-pocket expense:
  - $100/single
  - $200/family
- $ First dollar coverage continues after deductible has been met

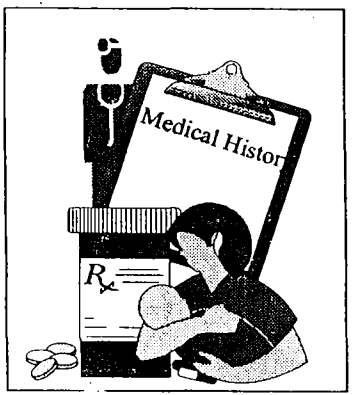
*** All money not used in the MSA is returned to the subscriber**

Blue Cross and Blue Shield of New Jersey

More MSA Plan Advantages

First Dollar Coverage for eligible medical expenses

Such as:



- Well visits ($100 per individual per year)
- Ob/Gyn visits
- Immunizations
- Chiropractic care
- Prescription drugs (City offers a free-standing prescription drug card program - employee will submit reimbursements for co-pays and drugs that are not covered under program)

Some of these are not covered with Traditional plans

Medical Savings Account Profile

$1,400 in MSA account
- 200 in medical expenses

$1,200 reimbursement

- Mary Jones has $1,400 in her medical savings account
- At the end of the benefit period, she used $200 from her MSA plan
- She is now eligible for a $1,200 reimbursement

THE MSA ADVANTAGE

- Employees are incentive driven to control their purchasing of health care
- City taxpayers save through reduced health insurance premiums
- Unlimited choice of health care providers
- First dollar coverage for medical expenses

MEDICAL SAVINGS ACCOUNT
HOW IT WORKS

EMPLOYEE ELECTS THE MSA AS THEIR BENEFIT OPTION

BASED ON THEIR ENROLLMENT STATUS EMPLOYEES RECEIVE

$ 1,400 SINGLE
$ 1,800 FAMILY

MONEY IS THE EMPLOYEES' TO BE UTILIZED FOR HEALTHCARE CLAIMS

ANY MONEY LEFT IN THE EMPLOYEES' ACCOUNT AT THE END OF THE BENEFIT YEAR IS PAID TO THE EMPLOYEE

THIS WILL BE TAXED AS INCOME (TAX RATE IS AT PERSONAL INCOME LEVEL)

Exhibit "C"

MSA RATE PROPOSAL FROM BLUE CROSS AND BLUE SHIELD OF NEW JERSEY
TO
JERSEY CITY, NEW JERSEY
$1500/$2000 DEDUCTIBLE

	Current Annual Indemnity Rates	Proposed Annual MSA Rates	Proposed Annual MSA Contribution	Total Annual MSA Plan
SINGLE EMPLOYEE	$2,657.76	$1,140.40	$1,400.00	$2,540.39
EMPLOYEE & SPOUSE	$5,797.32	$3,740.36	$1,800.00	$5,540.36
EMPLOYEE & CHILD(REN)	$3,878.04	$1,849.87	$1,800.00	$3,649.87
EMPLOYEE AND FAMILY	$6,776.76	4,705.11	$1,800.00	$6,505.11

Mr. MICA. I thank you again, mayor, for both your testimony and your patience this morning.

I'll turn now to our distinguished colleague from Michigan, someone who comes from the private sector and offered his expertise, not only on this issue but on the important reorganization issues, provided tremendous leadership as a new Member of Congress, again bringing new ideas to the new Congress. So welcome, Dick Chrysler, and you're recognized.

STATEMENT OF HON. DICK CHRYSLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. CHRYSLER. Thank you, Mr. Chairman. It is a pleasure to be with you today, and thank you for taking the time to learn about medical savings accounts for Federal employees.

As the Nation's largest employer—as the world's largest employer—the Federal Government should prove itself as a leader in innovative, cost-effective health care management. I believe it is imperative that Congress approve MSA's as a health care insurance alternative, and, in my opinion, should be the only option for Federal employees. That eliminates all the adverse selection problems.

I have a long personal experience with medical savings accounts. My company in Brighton, MI, has enjoyed tremendous success with MSA's. RCI is an automotive specialty manufacturing company which has had a traditional health insurance program until 2 years ago, when we replaced the traditional plan with MSA's.

In the plan, employees are free to choose where they want to go for their medical care. They make choices based on the quality of care, while negotiating a reasonable price. Even though employees have a higher level of benefits with the MSA's, a higher level than with our previous health care insurance program, the company's annual health care costs were reduced from $4,800 per family to $4,200 per family, a 14.3 percent savings.

At the end of the first year, RCI did not even receive a premium increase for the high deductible policies used in conjunction with the account. This kind of cost cutting means real savings for businesses, let alone the potential savings for a huge employer like the Federal Government.

Bringing MSA's to RCI was not an easy process, because MSA arrangements do not share the same tax benefits as traditional health insurance plans. Therefore, I look forward to the passage of H.R. 1818, the Archer-Jacobs bill, to bring tax equity to MSA's. I can guarantee that MSA's will quickly develop a strong presence in the marketplace.

Employees need to have a direct role in seeing their health care dollars spent wisely. Personal involvement provides an incentive to be conscientious consumers of health care and utilize preventive health care to avoid costlier medical procedures. MSA's are an extremely cost-effective way to offer health care benefits to employees, because they put the consumer back in the decisionmaking process.

At RCI, employees use an MSA health ID card to pay for all of their medical, prescription, dental, and vision expenses. We find that employees shop around for their health care needs, and what

better way to control the costs than through competitive free enterprise? Remember that no system of free enterprise works without a participating consumer.

RCI employees are proud to point out that they have saved money by comparing costs, a relatively new experience for employees used to blindly handing over their insurance cards. They often save hundreds of dollars for routine procedures, several dollars on prescription drugs by finding the lowest price. A managed care system provides an added feature to our employees. They may choose to utilize the PPOM to lower their medical expenditures. However, the preferred providers are only an option. Employees are free to go to any health care provider they wish.

Employees are enthused and excited about MSA's because they have the freedom to go to any doctor, hospital, or pharmacy they like. They control how their health care dollars are spent, and they can buildup a pool of money in their MSA to pay for health care later on in their lives or when they are out of work. MSA's provide employees a financial incentive to stay healthy.

RCI is pleased with MSA's because we increased the level of benefits to the employees while reducing our health benefits expense by over 14 percent. Putting the consumer back in the loop keeps health care expenses to a minimum. Paperwork is significantly reduced. Since 75 percent of our employees don't spend more than the amount in their MSA's, these payments are not subject to the scrutiny of reasonable and customary determinations, pre-existing conditions, and other administratively cumbersome and expensive reviews. The expenses are simply paid out of the MSA's. Future premium levels have already proved to be stable.

I know of no health plan that is such a win/win for both employers and employees.

Based on my first-hand experience with medical savings accounts at RCI and research on health care alternatives, I know that MSA's work. I strongly believe there is no other health care program that compares to the MSA concept when it comes to providing a high level of employee benefits, employee satisfaction, cost control, and freedom of choice and administrative efficiency.

In allowing the individual, not a third-party insurance company, to choose a physician, plan, treatment, and range of services, competition will increase in the health care marketplace while simultaneously increasing consumer access. MSA's allow individuals to become educated consumers of health care, practice preventive health care, and improve the quality of health care while forcing the market to react to their choices.

MSA's can and should play a major role in reducing health care costs and improving health delivery nationally. Now is the time to expand MSA's as the choice for all Americans, starting with Federal employees.

Mr. MICA. I thank you for your testimony and thank all of our panel witnesses this morning for their insight.

Let me turn first, if I may, to the mayor.

You said that you dealt first with management.

Mr. SCHUNDLER. Right.

Mr. MICA. Are MSA's now offered both to management and other employees?

Mr. SCHUNDLER. The reason we offered them to management, Jersey City has become a two-party city recently. That is an unusual experience in Jersey City, so a lot of things have become politicized that before weren't quite as political.

The result is, we felt there was—rather than enter this into unionized contracts, which would require opening all the contracts and so forth, and that would become very political, we could do it with management employees, and it would be, practically, much easier.

Mr. MICA. So it was first done there. But has it expanded to other employees yet?

Mr. SCHUNDLER. So we're going to be offering it to our unionized employees this coming year, because we feel, now that we've got the year to demonstrate—we have a year's worth of experience which we can demonstrate for unionized employed that this is working, and you've got 250, if you will, people who can witness directly to the fact that it is working, and that will take some of the politics, if you will, out of the debate.

Mr. MICA. Well, we had sort of a similar problem here, mayor. This place was run by the same folks for 40 years, and they didn't get any option other than what was offered, and sometimes the unions would block any—or employee groups would block any new approach. How did you—I guess you did this first with management?

Mr. SCHUNDLER. Right.

Mr. MICA. And then—I mean it looks pretty attractive.

Mr. SCHUNDLER. Yes.

Mr. MICA. It looks like you reduced some of the cost.

Mr. SCHUNDLER. Yes.

Mr. MICA. It came down about $200. Now, that $200 had to go somewhere, so it would actually either reduce your expenditures somewhere else?

Mr. SCHUNDLER. Right.

Mr. MICA. Or it could have been put back into what you could provide for medical costs for other employees.

Mr. SCHUNDLER. We could have reduced the costs far more if we wanted to keep, let's say, the exposure for the employees at the same level, or if we had wanted, for instance, not to cover things like preventative care.

What we've done is we've actually given them an enhanced coverage package, again, where things that previously were not covered at all are now covered, both by the MSA and also count toward the deductible and the catastrophic policy. We took some money out, but from our perspective, the long-term interest of the city is having more employees participate in this, again, having people who use health care intelligently and not gratuitously, with the belief that that will reduce our premium growth for the catastrophic policy, and that's where the big savings is to be found. It's nice when you can get long-term savings, but you don't have to have short-term costs. So here, what we've been able to do is actually take out some cash today, but leave such a nice package for our employees that it's almost impossible to say it's not better for you. The result is, we expect very high participation, and we expect the result of that will be significant savings, very significant sav-

ings, through claims experience reductions, translating into premium reductions on the catastrophic part of the package.

Mr. MICA. So your radical approach has actually worked.

Mr. SCHUNDLER. Yes.

Mr. MICA. And you've caught the attention of the employee groups.

Mr. SCHUNDLER. Right.

Mr. MICA. So they want to be dealt in.

Mr. SCHUNDLER. Right.

Mr. MICA. Are they going willingly now?

Mr. SCHUNDLER. Yeah. I think, over the course of the next year, we'll be able to have all of the different employees' unions. We have, I believe, 16 different unions. I think we'll be able to have them all.

Mr. MICA. I'm sure we could match you.

Mr. SCHUNDLER. True.

Mr. MICA. The other group that I have to be concerned about is our Federal retirees.

Mr. SCHUNDLER. Right.

Mr. MICA. When this was first unveiled by Mr. Salmon, myself, and others, the sky immediately began to fall for Federal retirees. At least their representatives felt that there would be cherry picking, this adverse selection, that their people, who would be the most likely to use the services, would be somehow denied, and that, in fact, their premiums would go up.

Now, you only have a short-term experience with this. How do you respond to those people, who may indeed have very legitimate concerns?

Mr. SCHUNDLER. I think the—again, the way we've tried to respond is by holding all other things constant so other variables don't get into the equation. For instance, we offered them the same three options—we offer our employees the same three options they had before, plus a fourth.

We didn't require that they take the fourth. They didn't lose any of the options they had. They just got a new option. We used Blue Cross-Blue Shield as the provider, who was the administrator of the State plan. So the people they deal with are actually the same people as they were dealing with before.

Our management employees are no longer in the State plan at all. You know, they're now under a plan directly from Blue Cross-Blue Shield, but that's the person who was administering the State plan for them before. So they don't change the person they're dealing with on the health insurance side.

So, by doing all of these things, the only issue becomes, since you are guaranteed the same benefits plus a few extra, since you've reduced your costs if you have high expenses, since you get cash back if you have low expenses, don't you think this is a pretty good deal? And again, 60 percent in the first year already said, "Yes," and I think we'll be over 90 percent in the second year.

The only reason why some people, I can imagine, might not choose to go this route is because—let's say you're part of an HMO right now. You can make an HMO fit into a medical savings account type of approach. But the way we—again, we just offered

them the same HMO, basically, that they had before, or they could choose the MSA plan with a fee-for-service provider.

Now, you can make an HMO fit within an MSA structure, but for those who actually have a personal relationship with an HMO now, where they've been going, they continue to go where they're going. There were some others who choose to stay where they are, too, because of a pre-existing condition, and so they want to stay under the relationship that they have.

But we have not suffered adverse selection. The reality is, our experience is that, again, if you have high costs, this is going to lower your out-of-pocket expenses.

Mr. MICA. But what about now that folks that are left in the other systems or choose to stay in those other plans?

Mr. SCHUNDLER. Right.

Mr. MICA. Have you in fact seen that they've had to pay more?

Mr. SCHUNDLER. Not at all.

Mr. MICA. Their premiums have not been increased?

Mr. SCHUNDLER. Not at all.

Mr. MICA. I didn't really understand whether this has been expanded or will be expanded to retirees. Do you have city retiree folks that are eligible?

Mr. SCHUNDLER. Yeah, we do. Again, this first year, we put it in with management employees. Next year, we believe we'll be able to, without having a big political fight, have the unions want to get involved, because they will have been able to see, by through watching the experience of their own direct unit bosses, that it's working well.

We think retirees tend to be the most conservative, in the sense that anything new, they're suspicious of. They like what they have, and they're perfectly happy to stay with that. Our belief is that when we have, again, a full work force filled with people who are saying, "This is great," you won't notice any change in your doctor relationship, because you just go to the same doctor you've been going to, and that's fine.

The only thing you'll notice is that your bills will go down. Once we have all of those people speaking up for the program, I think we'll be able to get the retirees in, as well, but we have not tried to force this on anybody at all. We've really done this in a way where we—with management employees, we offered it to them; they took it.

Now, we're going to go to the unions again and not force it on anybody, but simply say, "This is what's happening, and look at how great the success, the experience is." We think they'll take it. Then, when we go to the retirees—again, who may be the most suspicious of change—we can say, "Look at how well this is working," and make it a very nonpolitical evolution into MSA coverage.

Mr. MICA. Now, just to make sure that we've got the record clear, you stated before the committee before, the cost was—what?—$6,775?

Mr. SCHUNDLER. Exactly.

Mr. MICA. It went down to $6,500.

Mr. SCHUNDLER. Right.

Mr. MICA. And that only dealt with management. So even if they cherry-picked, there still was no additional cost.

Mr. SCHUNDLER. That's right.

Mr. MICA. You're telling me that the premiums did not, in fact, go up for the retirees or for the full-time employees?

Mr. SCHUNDLER. That's right. What you have here is you've got—again, Blue Cross-Blue Shield, which was administering the State plan, is also administering our MSA plan with mirror image plans. We've gone from the State health benefits plan now, and we've offered our employees an HMO option, a PPO option, and a standard indemnity offered by Blue Cross-Blue Shield which mirrors the plan that the State offered them and Blue Shield administered before.

So they have the exact same coverage being administered by the exact same administrator, simply a different pool of cash, if you will, standing behind those policies with, now, a fourth option.

Blue Cross-Blue Shield had all of the claims experience before, because they were administering the plan, so you have someone who, right away, knows whether or not they're suffering any adverse selection and whether or not they're going to have to adjust the premiums for the different plans. The reality is they are not suffering adverse selection. We are not going to see costs going up on those other three options that the employees are able to choose from.

Mr. MICA. Well, I only graduated from a State university, and I didn't do well in math, but according to my calculations, about $275, I think you said, per person that got in this. So it obviously could have been used somewhere else.

Mr. SCHUNDLER. Right.

Mr. MICA. It was available to reduce your cost of government or something.

Mr. SCHUNDLER. And I have to say that our deficit was never as great as yours.

Mr. MICA. It's hard to match.

Mr. SCHUNDLER. But it was bad enough. And, all too often, we get into this situation where we are looking to have to cut services because have to begin to live within our means. It's nice when you can actually expand services and cut spending at the same time.

Mr. MICA. I thank you. Mr. Chrysler, now you cited, again, before the subcommittee the same type of experience with the private sector. Did this—was it RCA?

Mr. CHRYSLER. RCI.

Mr. MICA. RCI. I'm sorry. Trying to get you bigger than you were. Was that offered to all employees, this MSA, or was it to management or a select group, and were there retirees that could also choose from this? How expensive was your coverage?

Mr. CHRYSLER. It's very simple. You know, most companies offer a health insurance plan. We had a Blue Cross plan prior to this, and when we looked at MSA's, we offered a plan—MSA's—to all employees, salaried, hourly, retirees, same plan to everyone.

That's the reason why I guess I don't understand the adverse selection issue, is because most companies offer an insurance plan to their employees. This is a benefit. You should only offer one plan. And the thing about MSA's is you will have, when the Federal Government finally gets around to passing MSA's this year, you will have the market that will respond to MSA's.

And the private sector—this MSA is very good for private sector insurance companies, because they can offer the MSA, which means they have control of this pool of money that the employer and/or the government puts into it, and that's a pool of money that the private sector insurance companies will control.

They will be able to offer IMA's—Individual Medical Accounts—to their employees, which is another product they can offer, plus they will be selling the high deductible health care insurance policies, which is another product that they will earn profit on, plus it has very, very low administration costs. When we understand that 30 cents out of every dollar we spend in health care is spent on paperwork, this can eliminate 80 percent of those costs.

Mr. MICA. Now, Mr. Chrysler, we're going to have a vote. I'm going to give the next 5 minutes to the vice chairman. But you have to tell me and the subcommittee, was there any cost-shifting? In fact, this was offered to everyone?

Mr. CHRYSLER. Yes.

Mr. MICA. The management, employees, and retirees?

Mr. CHRYSLER. Yes.

Mr. MICA. Was there any cost-shifting?

Mr. CHRYSLER. Absolutely not.

Mr. MICA. Were the premiums increased? Say, after introduction of MSA, was there any—I mean could you cite—there may have been some normal increases, but was there anything that showed that one group versus another group were penalized by the introduction of MSA's in your private sector experience?

Mr. CHRYSLER. No, our health care premiums went down by over 14 percent when we went to medical savings accounts, and after the first year, when we started the second year, there were no increase in premiums for the medical savings accounts for the second.

Mr. MICA. You're not under oath, but you're telling us the truth about this radical idea, right? Thank you.

Mr. CHRYSLER. Only real-life experience.

Mr. MICA. I want to yield to our vice chairman, and we'll go until it's time for the vote.

Mr. BASS. Sure. Thank you very much, Mr. Chairman, for yielding. My question will be short, and we'll make our vote.

One question to Congressman Salmon. I understand that, in a prior life in Arizona, that you were responsible for or participated in the passage of legislation which provided for MSA's for Arizona State employees. Could you give this subcommittee some observations about the type of program that you proposed and that was accepted, and how has it worked in Arizona?

Mr. SALMON. Thank you, Mr. Bass. The bill that we passed actually opened MSA's up as an option with a State tax incentive, like a State-based IRA, to basically all citizens at large. It was not designated just for the State employees. Let me say, if I had everything to do all over again, it would have been the logical next step, or maybe even first step, because, frankly, here we are as stewards of the taxpayer dollars.

I believe, as Mr. Schundler said, we have an opportunity to expand the employees' opportunities when it comes to the health care arena, to give them more options, give them the ability to take

their own health care destiny in their hands and save taxpayer dollars at the same time. It's a total win/win situation. We ought to pursue this as vigorously as we pursue any kind of legislation this year.

There are several companies in Arizona, as I believe either Mr. Chrysler or Mr. Schundler mentioned that there are insurance companies that craft policies where they couple a catastrophic care policy with an MSA, and that has happened in Arizona.

Insurance companies have seen this as a wonderful opportunity, and they will manage, then, and they do manage the medical savings account, itself. They take care of the fiduciary responsibilities for that, and then they also provide the catastrophic care policy, which kicks in when your medical savings account has been expended.

Mr. BASS. Thank you very much, Mr. Chairman.

Mr. MICA. Well, we have just a minute here, and we're going to recess for a vote, but could any of the panelists cite any instances where they've seen MSA's institute—Mr. Chrysler in the private sector, Mayor Schundler in the municipal sector, Mr. Salmon in the State sector—where you've seen the introduction of MSA's in balance or increasing costs as a result of that, or some deprivation of service, either quality or availability at the level of service? Mr. Salmon.

Mr. SALMON. Can I just make a comment? I know that I've pored over, time and time again, results from private sector companies that have offered medical savings accounts to employees, and they've all had the same results. They have all lowered their costs and increased employee satisfaction.

Let's walk through this just 1 minute, because I think we've mentioned a lot of positive benefits or attributes of a medical savings account. But let's talk about within the medical industry, itself.

About 40 percent of the costs of hospitals and doctors are pushing paper, whether it's paper to satisfy the Federal requirements for Medicaid or Medicare or whether it's pushing paper through the insurance companies. About 40 percent are costs of pushing paper, and if you deal on a cash basis with a doctor, they cut you breaks. They give you discounts.

In my life, the last child that we had, Matthew, was born 7 years ago. We were covered by a traditional third-party payer policy, and, basically, the costs for delivery of my child, with hospital and doctor, was $3,500. Two months later, my sister-in-law had a baby, same doctor, same hospital, only she wasn't insured, so she paid cash, $1,500—$2,000 savings just on a delivery of a baby.

You shop around, and you look at procedures for everything from gallstones to heart surgery, and you will find prices all over the maps. If individuals are empowered to deal on a cash basis with their doctors, they can negotiate. They can drive costs down. Doctors benefit, patients benefit, the taxpayers benefit, and the economy benefits.

There is no real argument against this, other than those entities that are scared to death of the competition that they will be thrown into if medical savings account into the arena and we're going to

do away with some of the bureaucratic we've seen in the insurance industry heretofore.

Mr. MICA. Mayor, did you think up this radical approach yourself, or did you use some other model, private or municipal?

Mr. SCHUNDLER. Actually, I read a book called Patient Power, which was published by John Goodman of the National Center for Policy Analysis. That's how I came upon the idea. Then, what we did was contact the insurance providers and, again, ask them if they would offer us such a plan. Then we went to the State, itself, and went through the process of removing ourselves from the State health benefits plan. So it was step by step, just working with the insurers, working with the State to set this up.

Mr. MICA. Do you know any State or municipal activities that have resulted in more cost or lower benefits?

Mr. SCHUNDLER. You know, I've—we actually have been able to do other things to—I want to make sure I understand the question. Is it easy to find places where you can do more and spend less?

Mr. MICA. No. You know, maybe this panel is prejudiced. What I'm trying to do is say, is there some place out there lurking, some place where they did MSA's, where they had a bad experience, and where it drove costs up or people were denied services or access? Because I want to know about those, and I'm asking you if you know of any.

Mr. SCHUNDLER. No, I think the ultimate issue with regard to insurance plans is the insurance providers themselves, how easy are they to work with? So we have the same administrator that we had before, and, again, there has just been no change in experience.

If the Federal Employee Health Benefits Plan offers this as an additional option, it will be the same person, it will be the same entity that's now offering the other options available to Federal employees. So I don't think anybody will experience any difference in, let's say, the ease with which claims are settled, when you have the same provider.

Now, ideally, it's nice if individuals can take the cash value that the city of Jersey City is putting into that plan and, if they want to, be able to buy a different insurance policy altogether, because it has a whole different set of coverages which may conform to their particular situation more.

You could end up with an adverse selection under that scenario, potentially, because someone could decide that they want a much higher MSA contribution and a much, if you will, higher deductible, because they just figure that they're going to have very low medical costs, and they want more cash back at the end of the year.

Now, it's conceivable that you can design a program if you want to where you have adverse selection as a problem, and there might be reasons to do that. There might be reasons where, in the end, it justifies doing so, because the overall cost to the system could be less. That's not the system we've designed, per se, which I'm not saying is the end-all of all systems, but it's certainly one which, without having any change in experience whatsoever on the part of the employees, lowers our costs and give them better coverage.

Mr. SALMON. Mr. Mica, just one point. There are about 3,000 private sector corporations and limited partnerships that have offered MSA's to their employees throughout the country. Do you not think

that if the other side, those who oppose medical savings accounts vociferously, who probably are the same ones that got to the retirees to stir up some fervor against it, do you really think that they wouldn't have paraded them forward or gotten some kind of a Dear Colleague letter, talking about their horror story? Three thousand companies across the United States—if the other side could find one example of where they haven't worked, they would be trumpeting that to the nth degree right now, and everybody knows that. But they can't find it.

Mr. MICA. Mr. Chrysler, a last word. We've got about 1 minute.

Mr. CHRYSLER. Yes. Just to answer your original question, the answer is no with our employees. I had over 1,200 employees, and MSA's for them was just an outgrowth of a program that we started, where we had monthly caps on our premiums. You know, we paid, as a company, the first $20,000 in medical costs, and then the insurance company kicked in after that. I can say that our 1,200 employees, they were extremely delighted with our health care benefits.

Mr. MICA. I would like to pursue this, but what we will do is ask additional written questions of the panel. I want to thank the panel for coming down, for your patience, for your contribution, leadership, and innovative approaches at the municipal level.

We do have a vote, so we will recess the hearing and reconvene in 15 minutes.

[Recess.]

Mr. MICA. I would like to call the Subcommittee on Civil Service to order and turn to our second panel and call them forward. We've got Gary Glenn, who's the county commissioner of Ada County, Boise, ID; Peter Hendee, consulting actuary of the Council for Affordable Health Insurance; Merrill Matthews, director of Health Policy Studies, National Center for Policy Analysis; and Dr. Daniel Johnson, member of the American Medical Association Board of Trustees.

I welcome our panelists, and I want to tell you again that this is an investigations and oversight subcommittee of the Congress and of the full committee, and it's customary to swear in our witnesses.

[Witnesses sworn.]

Mr. MICA. Thank you. The witnesses answered in the affirmative. We will call first on the Honorable Gary Glenn, who is the county commissioner in Boise, ID. We'll call on you, sir, and you're recognized for 5 minutes. It's the custom of the subcommittee, if you have a lengthy statement, without objection, it will be made part of the full record, and we ask you to try to summarize in 5 minutes so that we can have questions and exchange. So welcome, and you're recognized.

STATEMENTS OF GARY GLENN, COUNTY COMMISSIONER, ADA COUNTY, BOISE, ID; PETER HENDEE, CONSULTING ACTUARY, COUNCIL FOR AFFORDABLE HEALTH INSURANCE; MERRILL MATTHEWS, DIRECTOR OF HEALTH POLICY STUDIES, NATIONAL CENTER FOR POLICY ANALYSIS; DANIEL P. JOHNSON, JR., PRESIDENT-ELECT, THE AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES

Mr. GLENN. Yes, sir. Thank you, Mr. Chairman. Mr. Chairman, Ada County, ID, is the first county in the Nation and, as incredible as it is to me, only the second public employer in the Nation to adopt an MSA plan, second to Mayor Schundler's Jersey City.

Mr. Chairman, the bottom line I can offer you and the members of your panel today is that if Ada County and Jersey City, having proven that a government employer can design an MSA plan that will reduce costs to the taxpayers to insure public employees, if Mayor Schundler and I can do it, certainly the esteemed Members of this body can do it.

The only difference is that if you do it, you will immediately save American taxpayers millions of dollars a year, rather than the tens and then hundreds of thousands of savings we'll experience at the local level.

Based on Ada County's experience, Mr. Chairman, I feel confident in predicting the following regarding your inclusion of an MSA option in the FEHB. Tens of thousands of Federal Government employees will enroll in a well-designed MSA option the first year.

The main reason for those who don't will be the simple fear of change—any change, at least based on the focus groups that we did with our own employees, which we believe will evaporate after the first year's tens of thousands of enrollees brag to their coworkers about all the cash they've got left over at the end of the first year.

Eventually, a majority of Federal employees will choose the option, I would predict. The bottom line will be immediate savings in the millions of dollars, with long-term savings of much more to the American taxpayers.

By introducing tens of thousands of cost-conscious health care consumers into the local markets across the Nation, you will overnight force health care providers to become more price conscious, which will help restore market forces to bring the cost of health care down for all Americans.

Under Ada County's MSA plan, the taxpayers save money, which was the first motivation that I had in proposing the plan. But please note, Mr. Chairman, the taxpayers would not have saved a dime if no employee had enrolled. Therefore, by definition, the employees who enrolled did so only because they judged it to be in the best interests of themselves and their families. This is, as described earlier, a win/win situation. In fact, they win/win/win, because it's good for the taxpayers; it's good for the employees, themselves; and good for our health care economy.

Our medical savings account offers three major benefits to employees, and I would offer as evidence of the fact that it is a benefit to our employees the endorsement of this plan by our AFL–CIO affiliate and the Service Employees International Union member, the Ada County Sheriff's Employees Association. You have a letter to

that effect that I've submitted as part of the record. Those benefits are as follows.

The opportunity to receive up to $2,100 in cash per year from the county, any portion of which not spent on health care is the employee's to keep and spend as he or she sees fit.

Because money they can otherwise keep is now at stake, we expect the county's MSA enrollees to become cost-conscious shoppers for health care services, just like they are for everything else, to file substantially fewer claims for nonessential health care, resulting in even lower premiums long-term, and helping force providers to become more price conscious in order to compete.

These funds are also extremely portable, which would address the people who are uninsured solely because they are between jobs, between employers who offered health care insurance.

Based on the size of their families, it also offers the chance to dramatically reduce the maximum amount of money they face having to pay out of their own pockets in the worst-case scenario.

In my family's case, with a wife and four children, I have an 82 percent reduction in my maximum worst-case out-of-pocket risk by enrolling in the medical savings account, and when I enrolled in the medical savings account, I save the taxpayers of my county, on my family alone, $1,100 a year, even if I'm taxed by the Federal Government, and if the Archer-Jacobs bill passes, then my family alone will save the taxpayers of my county $1,500 per year.

Even the sickest individual is better off with our MSA, because they will end up spending less, or in the worst case, if you're single, no more out of their own pockets than they do with the old low deductible 80/20 copay plan.

Finally, and most important, the MSA plan financially empowers individuals with cash over which they have absolute control, and MSA thereby provides our employees maximum freedom of choice regarding their family's health care. Our MSA plan is based on faith in the ability of adult Americans to make rational choices in the best interests of themselves and their families.

Mr. Chairman, I've included specific information in the packet I've submitted as to the design of Ada County's plan. I know that you know how these things are designed and work. I would briefly describe ours as follows.

If you are a two-party family or a larger family, you have a $2,000 per-individual with a $3,000 maximum per family deductible, and the county will give you $2,100 a year in cash. If you're single, you have a $2,000 per-individual deductible, and the county gives you $1,100 in cash.

Mr. Chairman, I'll be happy to address that in questioning in more detail if you like, but let me speak for a moment as a taxpayer, instead of an elected official. I urge you to support Representative Salmon's bill.

But speaking as a taxpayer, I urge you, as stewards of the taxpayers' money, to decide that an MSA-based health insurance plan, as Representative Chrysler indicated earlier in his opinion, that that should be the only plan you offer Federal employees at some point in the future, perhaps after a phase-out for other plans and retirees.

You would eliminate all concerns about so-called adverse selection. You would immediately save taxpayers tens of millions of dollars in premiums. If I had a second vote on the Ada County Commission, it would be the only plan we would offer our county employees. With 900 employees, we would save nearly a quarter million dollars a year in premiums, if that was all we offered.

By injecting 9 million Federal employees, retirees, and dependents with MSA's into the health care market, you will force an even more dramatic price consciousness and competition incentive on health care providers, pressuring them to reduce health care prices in order to compete, thereby saving not only American taxpayers considerable amounts, but resulting in lower health care costs for all Americans.

It is my view that it is unquestionably in the best interests of the American taxpayer, who has to pay the bill, to do so, but it clearly indicates, Mr. Chairman, why the simple notion of just offering Federal employees the freedom to choose an MSA option if they desire is a modest step with which any reasonable person should agree.

Mr. Chairman, if I can just close by indicating that, in my opinion, it's inconceivable that a single eastern city and a small county in the west are leaders on this issue. We are, to my knowledge, the only two public employers in the Nation, and we don't have to pay some of the Federal taxes that the thousands of private sector employers have to pay to enlist in these plans.

I hope Congress will take its rightful leadership role in restoring the principles of free market economics to the health care market of this Nation. By so doing, you will address the single largest obstacle to a balanced Federal budget, the cost of health care, and thereby address perhaps the single largest determinant of the kind of economy in which my children and yours will have to raise their families.

I strongly urge you to follow the lead of Ada County and Jersey City, save American taxpayers millions of dollars, and help restore cost-conscious consumption and price-conscious competition to American health care, all by offering employees of the Federal Government at least the option of a medical savings account health insurance plan. Thank you, Mr. Chairman, for this opportunity.

[The prepared statement of Mr. Glenn follows:]

ADA COUNTY

COMMISSIONERS
OFFICE
650 Main Street
Boise, Idaho 83702
364-2333

Gary Glenn
Commissioner, First District

November 30, 1995

COMMISSIONER GARY GLENN
ADA COUNTY, IDAHO

TESTIMONY BEFORE THE U.S. HOUSE SUBCOMMITTEE ON CIVIL SERVICE

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I SUBMIT THE FOLLOWING INFORMATION ON ADA COUNTY'S "MEDICAL SAVINGS ACCOUNT" PLAN FOR THE OFFICIAL RECORD:

ADA COUNTY IS THE FIRST COUNTY AND THE SECOND PUBLIC EMPLOYER IN THE NATION TO ADOPT AN MSA PLAN.

MR. CHAIRMAN, HERE'S THE BOTTOM LINE I CAN OFFER YOU TODAY. ADA COUNTY AND JERSEY CITY HAVE PROVEN THAT A GOVERNMENT EMPLOYER CAN DESIGN AN MSA PLAN THAT WILL RESULT IN LOWER COST TO THE TAXPAYERS TO INSURE PUBLIC EMPLOYEES.

AND IF MAYOR SCHUNDLER AND I CAN DO IT, SO CAN THE FEDERAL GOVERNMENT. THE ONLY DIFFERENCE IS THAT YOU WILL IMMEDIATELY SAVE AMERICAN TAXPAYERS MILLIONS OF DOLLARS PER YEAR, RATHER THAN THE TENS AND THEN HUNDREDS OF THOUSANDS IN SAVINGS WE'LL EXPERIENCE AT THE LOCAL LEVEL.

IF I HAVE READ CORRECTLY REGARDING SOMEWHAT RELATED LEGISLATION, THE C.B.O. PREDICTS ONLY ONE PERCENT OF MEDICARE RECIPIENTS WOULD SELECT AN MSA OPTION IF OFFERED. HOW ABSURD...

BASED ON ADA COUNTY'S EXPERIENCE, I FEEL CONFIDENT IN PREDICTING THE FOLLOWING REGARDING FEHB:

* TENS OF THOUSANDS OF FEDERAL GOVERNMENT EMPLOYEES WILL ENROLL IN A WELL-DESIGNED MSA OPTION THE FIRST YEAR.

* THE MAIN REASON FOR THOSE WHO DON'T WILL BE THE SIMPLE FEAR OF CHANGE -- ANY CHANGE -- WHICH WILL EVAPORATE AFTER THE FIRST YEAR'S TENS OF THOUSANDS OF ENROLLEES BRAG TO CO-WORKERS ABOUT THE CASH THEY HAVE LEFT IN THEIR ACCOUNTS.

* EVENTUALLY, A MAJORITY OF FEDERAL EMPLOYEES WILL CHOOSE THE OPTION. THE BOTTOM LINE WILL BE IMMEDIATE SAVINGS IN THE MILLIONS OF DOLLARS, WITH LONG-TERM SAVINGS OF MUCH MORE.

BY INTRODUCING TENS OF THOUSANDS OF COST-CONSCIOUS HEALTHCARE CONSUMERS INTO LOCAL MARKETS ACROSS THE NATION, YOU WILL OVERNIGHT FORCE HEALTHCARE PROVIDERS TO BECOME MORE PRICE-CONSCIOUS, WHICH WILL RESTORE MARKET FORCES TO BRING THE COST OF HEALTHCARE DOWN.

UNDER ADA COUNTY'S MSA PLAN, THE TAXPAYERS SAVE MONEY -- WHICH WAS MY FIRST MOTIVATION IN PROPOSING THE PLAN -- BUT PLEASE NOTE THAT THE TAXPAYERS WOULDN'T SAVE A DIME IF NO EMPLOYEE ENROLLED IN THE PLAN.....AND OF COURSE, THE EMPLOYEES WHO ENROLLED DID SO ONLY BECAUSE THEY JUDGED IT TO BE IN THE BEST INTERESTS OF THEMSELVES AND THEIR FAMILIES.

OUR MSA OFFERS THREE MAJOR BENEFITS TO EMPLOYEES:

1. THE OPPORTUNITY TO RECEIVE UP TO $2,100 IN CASH PER YEAR FROM THE COUNTY, ANY PORTION OF WHICH NOT SPENT ON HEALTHCARE EXPENSES IS THE EMPLOYEE'S TO KEEP AND SPEND AS HE OR SHE SEES FIT.

BECAUSE MONEY THEY CAN OTHERWISE KEEP IS NOW AT STAKE, WE EXPECT THE COUNTY'S MSA ENROLLEES TO BECOME COST-CONSCIOUS SHOPPERS FOR HEALTHCARE SERVICES -- FILING SUBSTANTIALLY FEWER CLAIMS FOR NON-ESSENTIAL HEALTHCARE, RESULTING IN EVEN LOWER PREMIUMS LONG-TERM, AND FORCING PROVIDERS TO BECOME MORE PRICE-CONSCIOUS IN ORDER TO COMPETE.

2. BASED ON THE SIZE OF THEIR FAMILIES, THE OPPORTUNITY TO DRAMATICALLY REDUCE THE MAXIMUM AMOUNT OF MONEY THEY FACE HAVING TO PAY OUT OF THEIR OWN POCKETS IN THE WORST-CASE SCENARIO...(IN MY FAMILY'S CASE, AN 82 PERCENT REDUCTION IN MAXIMUM OUT-OF-POCKET RISK).

EVEN THE SICKEST INDIVIDUAL IS BETTER OFF WITH OUR MSA, BECAUSE THEY WILL END UP SPENDING LESS -- OR IN THE WORST CASE, NO MORE -- OUT OF THEIR OWN POCKETS THAN THEY DO IN THEIR OLD LOW-DEDUCTIBLE, 80/20 CO-PAY PLAN.

#3. FINALLY, AND MOST IMPORTANT OF ALL --- BECAUSE IT FINANCIALLY EMPOWERS INDIVIDUALS WITH CASH OVER WHICH THEY HAVE ABSOLUTE CONTROL, OUR MSA PLAN PROVIDES OUR EMPLOYEES MAXIMUM FREEDOM OF CHOICE REGARDING THEIR FAMILIES HEALTHCARE. OUR MSA PLAN IS BASED ON FAITH IN THE ABILITY OF ADULT AMERICANS TO MAKE RATIONAL CHOICES IN THE BEST INTERESTS OF THEMSELVES AND THEIR FAMILIES.

THIS IS EXACTLY THE OPPOSITE OF THE DICTATES AND FINANCIAL INCENTIVES OF THE MANAGED CARE SYSTEM AT THE HEART OF THE CLINTON ADMINISTRATION'S SOCIALIZED MEDICINE SCHEME, WHICH WOULD DENY INDIVIDUALS FREEDOM OF CHOICE AND PAY DOCTORS NOT TO PROVIDE HEALTHCARE.

MR. CHAIRMAN, I HAVE INCLUDED SPECIFIC INFORMATION IN MY WRITTEN TESTIMONY AS TO THE DESIGN OF ADA COUNTY'S PLAN, WHICH -- BECAUSE I KNOW YOU KNOW GENERALLY HOW MSA's WORK -- I WILL DISCUSS IN DETAIL ONLY IF YOU SO DIRECT ME DURING QUESTIONING.

HOWEVER, GIVEN THE FACTS I'VE DESCRIBED, MR. CHAIRMAN, PLEASE ALLOW ME TO SPEAK FOR A MOMENT AS A TAXPAYER MORE THAN AS AN ELECTED OFFICIAL.

BECAUSE, THANKFULLY, YOU AND YOUR COLLEAGUES REJECTED THE SOCIALIZED MEDICINE SCHEME PUT FORTH BY THE WHITE HOUSE LAST YEAR, THERE IS NOTHING IN FEDERAL LAW WHICH REQUIRES YOU OR ANY OTHER EMPLOYER TO PROVIDE HEALTH INSURANCE TO YOUR EMPLOYEES, MUCH LESS THAT YOU MUST PROVIDE A MENU OF OPTIONS.

IF I HAD A SECOND VOTE ON THE ADA COUNTY COMMISSION, THE MSA PLAN WOULD BE THE ONLY PLAN WE OFFER.

LET ME STAKE OUT THE MOST FAR-REACHING STEP YOU HAVE IT WITHIN YOUR AUTHORITY TO TAKE, COMPARED TO WHICH A DECISION TO SIMPLY OFFER MSA'S AS AN OPTION TO FEDERAL EMPLOYEES PALES IN SIGNIFICANCE AND SCOPE.

I URGE YOU, AS STEWARDS OF THE TAXPAYERS' MONEY, TO DECIDE THAT AN MSA-BASED HEALTH INSURANCE PLAN WILL BE THE ONLY PLAN YOU OFFER FEDERAL EMPLOYEES AT SOME POINT IN THE FUTURE -- (PERHAPS AFTER A PHASE-OUT PERIOD FOR OTHER PLANS) --

* YOU WOULD ELIMINATE ALL CONCERNS ABOUT SO-CALLED "ADVERSE SELECTION," SINCE ALL FEDERAL EMPLOYEES WOULD BE ON THE PLAN.

* WITH A WELL-DESIGNED PLAN, YOU WOULD IMMEDIATELY SAVE TAXPAYERS TENS OF MILLIONS OF DOLLARS ON PREMIUMS.

* BY INJECTING 9 MILLION FEDERAL EMPLOYEES, RETIREES, AND DEPENDENTS WITH MSA'S INTO THE HEALTHCARE MARKET, YOU WILL FORCE AN EVEN MORE DRAMATIC PRICE-CONSCIOUSNESS AND COMPETITION INCENTIVE ON HEALTHCARE PROVIDERS, PRESSURING THEM TO REDUCE HEALTHCARE PRICES IN ORDER TO COMPETE, THEREBY NOT ONLY SAVING AMERICAN TAXPAYERS CONSIDERABLE AMOUNTS, BUT RESULTING IN LOWER HEALTHCARE COSTS FOR ALL AMERICANS.

THE DIFFICULTY OF SUCH A DECISION ASIDE, IT IS IN MY VIEW UNQUESTIONABLY IN THE BEST INTERESTS OF THE AMERICAN TAXPAYER.

AND IT CLEARLY INDICATES, MR. CHAIRMAN, WHY THE SIMPLE NOTION OF OFFERING FEDERAL EMPLOYEES THE FREEDOM TO CHOOSE AN MSA OPTION IF THEY SO DESIRE IS A MODEST STEP WITH WHICH ANY REASONABLE PERSON SHOULD AGREE.

IT IS INCONCEIVABLE THAT A SINGLE EASTERN CITY AND ONE RELATIVELY SMALL COUNTY IN THE WEST ARE LEADERS ON THIS ISSUE.

I HOPE CONGRESS WILL TAKE ITS RIGHTFUL LEADERSHIP ROLE IN RESTORING THE PRINCIPLES OF FREE MARKET ECONOMICS TO THE HEALTHCARE MARKET OF THIS NATION. BY SO DOING, YOU ADDRESS THE SINGLE LARGEST OBSTACLE TO A BALANCED FEDERAL BUDGET -- THE COST OF HEALTHCARE -- AND THEREBY ADDRESS PERHAPS THE SINGLE LARGEST DETERMINANT OF THE KIND OF ECONOMY IN WHICH MY CHILDREN AND YOURS WILL HAVE TO SUPPORT THEIR FAMILIES.

I STRONGLY URGE YOU TO FOLLOW THE LEAD OF ADA COUNTY AND JERSEY CITY, SAVE AMERICAN TAXPAYERS MILLIONS OF DOLLARS, AND HELP RESTORE COST-CONSCIOUS CONSUMPTION AND PRICE-CONSCIOUS COMPETITION TO AMERICAN HEALTHCARE, ALL BY OFFERING EMPLOYEES OF THE FEDERAL GOVERNMENT THE OPTION OF A MEDICAL SAVINGS ACCOUNT HEALTH INSURANCE PLAN.

# # #

Mr. MICA. I thank the gentleman, and we'll turn now to Mr. Peter Hendee, consulting actuary of the Council for Affordable Health Insurance. You're recognized, sir.

Mr. HENDEE. Thank you, Mr. Chairman. I am a consulting actuary, and I'm a member of the American Academy of Actuaries and was part of its work group on medical savings accounts.

The Council is an association of small and mid-sized insurance companies that was formed to fight for free market solutions to our country's health care problems. We also represent several hundred individuals, including actuaries such as myself, physicians, insurance agents, and other Americans that are interested in free market solutions.

I thank you for conducting these hearings on creating a medical savings account option for Federal employees. I agree with many positive things that have been said about MSA's. Rather than repeat them, I'm going to address the concern that MSA's will cause adverse selection.

Selection is the process of each person choosing what's in his or her own best interest, and there's concern that all the young and healthy people will want an MSA, and all the aged and sick will be left behind in the other health plans.

Certainly, MSA's will appeal to the young and the healthy. It offers them a financial gain. They can keep the funds if they don't use health care that year. But MSA's can be financially beneficial to high-risk individuals, also. Catastrophic coverage may have a $2,000 or a $3,000 deductible and all expenses above that paid in full. This is similar to the maximum out-of-pocket amounts under several of the Federal employee plan options.

But with an MSA arrangement, the funds from the account can be applied toward those maximums, so a high-risk person with an MSA could actually pay less out-of-pocket in a year of high medical expenses than under a traditional plan.

Also an MSA could be more attractive than managed care options to high-risk individuals who want to preserve their choice of provider, rather than disrupting their existing provider relationships.

Another reason someone may want an MSA is because funds are available for the first dollar of primary care. Other arrangements require some type of out-of-pocket, either the deductible or a copayment when services are received. But under an MSA, the first dollar of health care expense can be paid out of the account, and this can be important for a low-income worker.

Now, one last thought on selection. The Academy of Actuaries work group suggests that there's not going to be an Oklahoma land rush into MSA's. People are cautious in their response to change, and the pace of the shift into MSA's is likely to be slow, and it will give HMO's, insurers, and employers time to adjust to the new environment.

One other point for your attention is some research by the Health Care Financing Administration's Office of the Actuary. This research shows that health care inflation is accelerated when the

proportion of expenses paid by third-party payers increases. So a financing arrangement like MSA's, that decreases the proportion of health care costs paid by third parties, could help reduce health care inflation.

Thank you again, and I'll be happy to take any questions.

[The prepared statement of Mr. Hendee follows:]

Statement by Peter Hendee, Consulting Actuary, Odell & Associates, Inc.
for
The Council for Affordable Health Insurance

Mr. Chairman, my name is Peter Hendee and I am the consulting actuary for Odell & Associates, Inc., of Winston-Salem, North Carolina, and a member of the Council for Affordable Health Insurance. I am also a member of the American Academy of Actuaries and was part of the Academy's Medical Savings Accounts Work Group.

The Council, also known as CAHI, is an association of 40 small to mid-sized insurance companies that was formed in March 1992 to fight for free market solutions to the problems in the health care system. We also represent several hundred individual members including actuaries, physicians, insurance agents and other Americans interested in free market solutions to the nation's health care problems.

Mr. Chairman, I would like to take this opportunity to thank you for conducting these hearings on creating Medical Savings Accounts as an option for federal employees under the Federal Employees Health Benefits Program.

Included in the 1995 Balanced Budget Act, now under negotiation, are changes in the U.S. Tax Code that will provide the same tax treatment for Medical Savings Accounts now available to other health care financing mechanisms. Once enacted, federal employees will want, and should have access to, the same health care options and incentives available to other Americans.

The MSA concept is a popular one both in this Congress and in the state legislatures. Since the Council was founded in 1992, 13 states have enacted medical savings account laws including Arizona, Colorado, Idaho, Illinois, Indiana, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah, and West Virginia.

Two additional states, Washington and Virginia, have recently enacted MSA laws that rely on further federal action to make them effective. Medical Savings Account legislation is also pending in an additional 16 states. Medical Savings Accounts are proving to be a popular approach in the states.

Medical Savings Accounts, coupled with high deductible health insurance plans would offer the nation's federal employees the security of funds to pay for the first dollar of health care expenses. Unlike other first dollar programs, however, this coverage has a built-in financial incentive not to over-utilize health care. By switching to an MSA, federal employees could use the MSA as a source of funds for primary and preventive care and have the opportunity to save unspent MSA funds for future health care needs.

Private employees with regular deductibles or copayments may not have sufficient out-of-pocket funds to access primary or preventive services. MSAs provide them with a source of funds to pay for these services, and this is particularly important for low income workers.

During the past three years, several dozen versions of medical savings accounts have been introduced in the U.S. Congress. Until the dawn of the 104th Congress, most of the beltway interest groups did not pay much attention to the concept, but in recent months, CAHI has been flooded by requests from hundreds of organizations trying to get up-to-speed on the issue. We have been working overtime to educate these interest groups, but I am afraid there are still some misconceptions out there.

The biggest concern we are currently hearing is that Medical Savings Accounts may lead to adverse selection, meaning that only the young and healthy would want an MSA, leaving the sick and aged behind in traditional health care plans and managed care settings such as HMO's. This concern must be clearly addressed and understood because it is so misleading.

Selection is the process of each person choosing what is in his or her own best interests. For example, high users of health care services prefer traditional plans over managed care plans. Why? Because it is important to hem to preserve their personal network of providers and their ability to choose their own provider. Some observers attribute the savings generated by managed care to this very process --- the younger and healthier do not mind going into an HMO because they do not have ties to any particular physician. Therefore the cost of care for a typical HMO patient is lower.

To the extent MSAs help preserve their choice of provider, MSAs will be more attractive than managed care options to high risk individuals in the federal employee pool.

Under an MSA with catastrophic coverage, the maximum payable out-of-pocket can be similar to or even less than under a traditional indemnity plan. Therefore, a high risk person could actually pay less out-of-pocket in a year of high medical expenses than under a traditional plan.

MSAs will be attractive to a cross section of people, some low cost and some high risk. Both groups could benefit financially from this choice and high risk individuals may also place a high value on the ability to choose their provider.

Foster Higgins surveyed nearly 1,000 mid-sized firms in 1993. The average cost for a traditional indemnity plan by itself or for an HMO plan by itself were both just over $3,000 per employee and were within 1% of each other. Allowing employees a choice between an indemnity plan and an HMO increased the average cost by $1,000 per employee. Their conclusion was that "healthier employees choose HMOs, and the indemnity plan is left with the poorer risks." (*Highlights*, September, 1994).

The healthier employees receive more benefits from the HMO than they would from their traditional plan, such as full maternity benefits. The freedom of provider choice for the poorer risks cost more than if they were restricted to the HMO's providers. Each employee chooses in his or her own best interest and the average plan cost increases.

Employers who allow employees to make a choice are providing a more desirable and more expensive benefit. The reason for the higher cost is the choice available to the employees.

The addition of Medical Savings Accounts to the Federal Employees Health Benefits Program will help return our health care system to individuals by allowing them to do the following:

1. Choose their own physicians, facilities and services;

2. Choose and pay for their primary and preventive services; and

3. Save for future health care expenses.

This will have the following benefits:

1. Reduce administrative costs;

2. Help Restore the doctor-patient relationship; and

3. Reduce the upward pressure on the cost of health care and health insurance, thus saving federal dollars by bringing free market forces to the health care market.

The U.S. health care system has been harmed by tax incentives to spend money rather than to save it. This same situation applies to the Federal Employees Health Benefits Program.

Medical Savings Accounts will not solve all our nation's health care problems, but they could certainly go a long way in improving choice and quality of care for all Americans, giving them proper incentives to stay healthy, get preventive care, and save for the future.

Thank you, Mr. Chairman. I would be happy to take any questions.

Council for Affordable Health Insurance
Addendum to Mr. Hendee's Testimony

This addendum to Mr. Hendee's testimony provides additional information on specific issues the Subcommittee on Civil Service requested regarding Medical Savings Accounts currently in the market and their impact on health care cost and access.

Question #1: How have employers offering MSAs structured this health care option?

Answer: Medical Savings Accounts, as currently envisioned, have not been possible because of their tax status. Contributions to an MSA are currently treated as wages subject to withholding and payroll taxes. This is very different from employer paid health benefits which are received tax free by the employee. Consequently a variety of MSA type arrangements are currently being used to provide employees with a financial incentive to consume health care economically. If MSAs are given the same tax treatment as other health care financing mechanisms then the structure of MSA programs is likely to be tailored to meet the requirements of the law.

Question #2: What is the average cost of the catastrophic insurance policy that accompanies the MSA and what is the deductible?

Answer: The cost for an employer to provide comprehensive coverage and the savings from shifting to catastrophic coverage will vary dramatically depending on many factors such as: geographic area, age, sex, income, etc., and health characteristics of the work force, managed care features in the coverage provided, discounts negotiated with providers, any health care choices or options available to t he employees, program expenses other than claims, types of services covered under the program, and, the difference in exposure to out-of-pocket costs under the comprehensive versus the catastrophic coverage. The American Academy of Actuaries' Medical Savings Accounts work Group report provides examples of the cost of various deductibles based on 1995 medical cost levels.

There is little information in the public domain about experience with MSA type programs. The following are based on the information that has been reported.

Question #3: Has the introduction of MSAs been viewed by employees as a benefit?

Answer: The percentage of employees who have selected MSA type benefits when another option was available has varied from a very high percentage to a very low percentage. Factors that can affect this decision include requirements for voluntary contributions, the level of benefits in the available plans, the degree of satisfaction with existing plans, and how new options are communicated.

Question #4: Have MSAs helped to constrain the rate of growth in health care costs?

Answer: Significant reductions in the annual rate of health care programs cost increases have been reported.

Question #5: Are you aware of employees delaying necessary or preventive care to save money in their Medical Savings Account?

Answer: There has been no indication that participants in MSA type arrangements have delayed or skipped any needed care or have less favorable health outcomes than participants in other health care programs. Anecdotal evidence indicates that primary care is more accessible. Other plans typically require some type of out-of-pocket payment (a deductible or copayment) the first time services are received in a year, but under an MSA, the first dollar of health care expense comes out of the account.

Mr. MICA. Thank you, Mr. Hendee. We'll get back for questions. I want to first recognize the balance of our panelists. Mr. Merrill Matthews, director, Center for Health Policy Studies, the National Center for Policy Analysis. You're recognized and welcome.

Mr. MATTHEWS. Thank you, Mr. Chairman, for the opportunity to address this committee on this important subject. The NCPA has been supporting the idea of medical savings accounts for about 11 years now. We were one of the first organizations to come forward with that idea and promote it.

Established in Congress in 1960, the Federal Employee Health Benefits Program provides health insurance coverage to about 9 million Federal employees and their families. The program provides employees with a wide range of choices, from fee-for-service policies to health maintenance organizations.

However, there is recognition among FEHBP administrators and Federal employees that the program could be made even more competitive. For example, some of the departments have been considering implementing flexible spending accounts, which give employees the opportunity to set aside pre-tax dollars for health care and health insurance, and the Postal Service has had these flexible spending accounts, or FSA's, for years.

But while adopting FSA's would be a positive reform for the FEHBP, they do have a problem. That's the "use it or lose it" provision.

We have a flexible spending account at the NCPA, where I work, and at the end of the year, you always look at your account to try to determine how much money you have left in it because of that "use it or lose it" provision. You begin to ask yourself, "Do I need to get a physical?" or "Do I need to get some glasses? Do I need to go get dental work? What can I do to spend the rest of that money?"

What Congress has done in creating the flexible spending account is created a program that encourages me to spend money now when I don't need it, rather than save it for a time when I do need it. The medical savings account is simply this flexible spending account without that "use it or lose it" provision. It permits me to save the money for a time when I do need it.

Mr. Chairman, Congress needs to consider this. Like the flexible spending accounts, the medical savings accounts would provide Federal employees with the option of setting aside pre-tax dollars to pay for health care and health insurance while avoiding the inefficiencies inherent in these flex accounts. As a result, those departments of the Federal Government considering FSA's would likely switch to MSA's instead.

We have medical savings accounts at the NCPA, where I work. Many people have talked about how their plans work. Last year, we had a policy in which you had a $500 deductible, 80/20 copay for the next $5,000 of expenses or $1,000 out of your own pocket.

Under the new plan, the single individual gets $1,125 deposited in their medical savings account at the beginning of the year—that's after-tax dollars so that it's considered compatible with current law—and you get a $1,500 deductible that pays for everything above the deductible.

The family policy, you get $1,500, as the chart shows over here. You get a $1,500 contribution to your medical savings account, and a $2,000 deductible policy, and that is not per person in the family, that's a one-time deductible.

As a result, under our old plan, you were at risk for $1,500 per individual in the family, for a total of three individuals, $4,500. Under our plan now, the single individual is at risk for $375 after the MSA is spent or $500 total for the family after the $1,500 in the MSA is spent.

The existence of these plans like the NCPA's refutes most of the criticisms against MSA's. Some actuaries have argued that MSA's are not actuarially feasible. The fact is, as has already been testified today, some 3,000 businesses already have them in place. They are working today.

Others argue, as you know, that they would result in adverse selection, that healthy people would chose them, sick people would not. Again, as most of the testimony has indicated and the NCPA's plan testifies, people are better off financially, whether you're sick or healthy, by moving into the MSA plan.

And finally, there has been some criticism that MSA's would destroy the foundation of managed care, that managed care has been making great gains in saving health care money, and that the implementation of MSA's would destroy that progress made by managed care.

But, in fact, many of the MSA plans out there actually have a managed care element. Ours has at the NCPA. That is there is a network of physicians that you can go to. There is a network of hospitals. There is an encouragement to try to go to certain providers, but you have the freedom of access to go to others if you want to.

When you're in the insurance part, after you've met the deductible and you're in the insurance, you may have to pay more out-of-pocket to do that, but you can use the MSA money to make those expenditures.

In conclusion, what is important to realize is that businesses are responding quickly and efficiently to the perceived changes in the health care marketplace by providing more options that lower costs to patients, employers, and society as a whole.

Over 35 years of existence, Congress has ensured that Federal employees also had a choice. Indeed, most Federal employees have more options than their counterparts in the private sector. However, Congress is on the verge of making tax-free medical savings accounts available to the general public. If Congress wants to retain the FEHBP's historic commitment to choice and quality, it should be leading the fight to make MSA's available for Federal employees, as well.

I want to thank you for giving me this opportunity to state why Federal employees should have access to medical savings accounts. You are to be commended for holding this hearing to look into this exciting option, and I would be glad to try and answer any questions at the appropriate time. Thank you.

[The prepared statement of Mr. Matthews follows:]

Medical Savings Accounts and the Federal Employees Health Benefits Program

Merrill Matthews, Jr., Ph.D.
Director, Center for Health Policy Studies
National Center for Policy Analysis

Thank you, Mr. Chairman, for the opportunity to address the committee on this important subject.

Established by Congress in 1960, the Federal Employees Health Benefits Program (FEHBP) provides health insurance coverage to about 9 million federal employees and their families. The FEHBP has a number of positive elements that have made it a very attractive health insurance program for federal employees.[1] The program provides employees with a wide range of choices, from fee-for-service policies to health maintenance organizations (HMOs). And by imposing a maximum amount the government will contribute to each employee's policy (in essence, a defined benefit), the program forces employees to be value conscious in choosing a plan. As a result, competition is enhanced in a way that benefits the government, federal employees and American taxpayers.

However, there is recognition among FEHBP administrators and federal employees that the program could be made even more competitive. For example, some of the departments have been considering implementing Flexible Spending Accounts (FSAs), which give employees the opportunity to set aside pretax dollars to pay for health care and health insurance. And the Postal service has had FSAs for years. But while adopting

[1] See, for example, Walton Francis, "The Political Economy of the Federal Employees Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, DC: American Enterprise Institute, 1993), pp. 269-307.

FSAs would be a positive reform for the FEHBP, they do have a problem: the "use it or lose it" provision.

We have a Flexible Spending Account at the National Center for Policy Analysis (NCPA). Every December I have to look at my account to see if I have money left over. If so, I must figure out a way to spend that money before December 31 or I will lose every unspent penny. I begin to think about a getting physical, eye glasses or dental care — whether I really need these services or not — just so I will not lose the money.

Mr. Chairman, what Congress has done is create a law that encourages me to spend money on health care at a time when I don't need it rather than save for a time when I do. The idea of setting aside pretax dollars in a Flexible Spending Account is good, but it can be made better: by moving to a Medical Savings Account (MSA). Like FSAs, Medical Savings Accounts would provide federal employees the option of setting aside pretax dollars to pay for health care and health insurance, while avoiding the inefficiencies inherent in Flex Accounts. As a result, those departments of the federal government considering FSAs would likely switch their attention to MSAs instead.

The National Center for Policy Analysis believes that federal employees would appreciate having that option and that they and the federal government would benefit from it significantly.

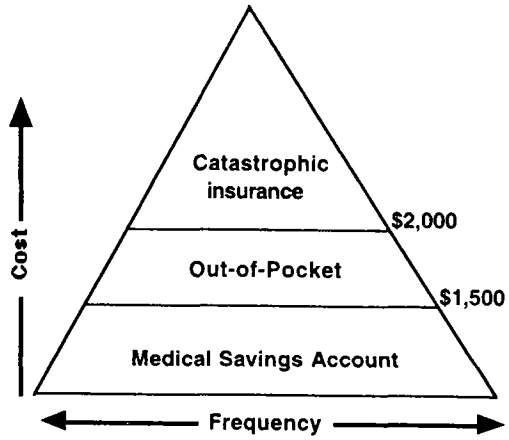
The Future of Health Insurance. The traditional, low-deductible fee-for-service health insurance policy — one that lets people choose any doctor or select any diagnostic test and send the bill to someone else — is being priced out of the market. Most people can no longer afford it, and most employers won't offer it. As a result, in the future most people will have to settle for one of two options: (1) they will enroll in a health maintenance organization that restricts their choice of physicians and limits their access to

medical services; or (2) if they want to make these choices for themselves they will have to manage their own health care dollars through Medical Savings Accounts.

Currently, the Internal Revenue Service taxes MSA deposits, although employer payments for third-party insurance are tax free. However, that may change soon since a version of Congressman Bill Archer's bill to create MSAs is currently in the House Budget Reconciliation Bill.

How Medical Savings Accounts Work. Medical Savings Accounts give people the opportunity to move from a conventional, low-deductible health insurance plan to one with a high deductible (say $2,000 to $3,000) and to put the premium savings in a personal savings account. These accounts are used to pay for routine and preventive medical care, and are combined with a high-deductible health insurance policy that pays for major expenses. Employees and their families pay all medical bills up to the deductible from their MSAs and out-of-pocket funds. Catastrophic insurance pays all expenses above the deductible.

FIGURE I



Some employers and their employees are turning to MSAs for the same reason others are turning to managed care: to control rising health care costs. Since employees get to keep any MSA money they do not spend, they have a financial incentive to shop prudently in the medical marketplace. In general, they won't spend a dollar on health care unless they get a dollar's worth of value. Employer experiences with MSA plans show that the incentives work: employees curtail health care spending significantly.

The NCPA's Employee Health Plan. In 1994 the employees of the National Center for Policy Analysis had a conventional fee-for-service health plan with a $500 deductible and a 20 percent copayment. Under this policy, an employee was at risk for up to $1,500 out of pocket. If three members of the same family all became seriously ill, the family was at risk for $4,500 in medical bills.

This year the NCPA adopted an MSA plan that limits the exposure of the employees and at the same time gives them more control over their health care dollars. *At no extra cost to the employer*, the plan creates a $1,500 deductible and deposits $1,125 to an MSA for individual employees. For family coverage, the deductible is $2,000 and the MSA deposit is $1,500. [See Figure I] The total out-of-pocket exposure is $375 under the individual policy and $500 under the family policy. [See Figure II.]

NCPA employees may use their MSA funds to see any doctor, enter any hospital or pay any medical bill. However, spending counts toward satisfying the deductible only if the service or procedure is covered under the health plan. For example, employees can pay for dental care or eye glasses with their MSAs, but those expenses do not apply toward the deductible. Furthermore, after they have exceeded the deductible, if they go outside the Preferred Provider Organization (PPO) affiliated with the plan, only 75 percent of "usual and customary" fees are counted.

FIGURE II

Options for NCPA Employees

	Family	
	Conventional Policy[1]	Medical Savings Account Policy
Deductible	$500	$2,000
Maximum copayment	$1,000[2]	- 0 -
MSA deposit	- 0 -	$1,500
Total out-of-pocket exposure	$1,500	$500

[1] The figures in this column are per family member up to a maximum of three people.

[2] 20 percent of the first $5,000 of expenses above the deductible.

In the future, the buildup of MSA funds will give the employees important options with respect to expensive medical procedures. For example, as mentioned, the health plan will pay the full costs above the deductible only if the procedure is done by a network doctor in a network hospital. But employees will be able to go outside the network and use their MSA funds to pay that portion of the bill not covered by insurance.

Benefits of Medical Savings Accounts. Widespread use of MSAs would create the following benefits.

- People would have first-dollar coverage for primary or preventive care, using their MSA funds; this would be particularly beneficial for lower-income workers who may be short on funds and may be tempted to avoid basic care.

- MSAs would restore the doctor/patient relationship, making doctors agents of patients, rather than agents of third-party payer bureaucracies.

- MSAs would allow patients rather than third-party payers to make the sometimes tough choices between health care and other uses of money.

- Paperwork and administrative costs would be greatly reduced; since patients would be paying most bills directly out of their MSAs, primary care physicians would rarely be burdened by insurance forms.

- Those who live healthy lives and avoid risky behavior would benefit financially from those choices.

- MSAs would put the consumer, rather than an insurance company or the government, in charge of the health care system.

Answering the Critics of Medical Savings Accounts. The existence of plans like the NCPA's refutes most of the major criticisms against MSAs. It is ridiculous to argue, as some have, that the plan isn't actuarially feasible since the very existence of the NCPA employee benefit plan and 1,000 similar private plans proves the opposite. The argument that MSAs benefit the healthy but not the sick is also easily refuted. A person with high expected health care costs benefits by choosing the new NCPA plan because his total financial exposure is $375, rather than $1,500 under the NCPA's old plan. For families, the exposure is $500 rather than $4,500.

Finally, the criticism that MSAs are incompatible with managed care is clearly untrue, since the NCPA's MSA plan has a managed care component. Although the NCPA has never been a proponent of managed care and MSAs probably are inconsistent with the traditional philosophy of HMOs, efforts to make medicine cost-effective are natural allies of Medical Savings Accounts.

Under the NCPA plan, for example, the insurance company has established the PPO and has negotiated discounted rates with hospitals and other providers. But the employee is free to use that MSA money for the purchase of any type of medical care. Patients who go outside the network can pay for the full cost of the service from their MSAs.

Business Experience with MSAs. The NCPA is not the only organization to adopt Medical Savings Accounts. As I have mentioned, more than 1,000 businesses have adopted some form of the MSA concept, with positive results. Recent studies by the Heritage Foundation, the Evergreen Freedom Foundation and Dr. Steve Barchet have been looking into the companies that have implemented an MSA concept. Ron Thompson of Thompson and Associates created an MSA-type plan ten years ago which experienced an average increase in health care expenditures of about 4 percent, with no managed care.

Tax Fairness. If MSAs have all of these benefits, why haven't they become more widespread? The reason is the tax system. When an employer spends a dollar on health insurance, the employee escapes federal and state income taxes. But if the employer puts that dollar in an MSA to pay medical bills directly, it is taxed as income.

Because of this distortion, 15 states have passed MSA legislation under their state income tax systems to create a level playing field between self-insurance and third-party insurance. Those states are letting people avoid the state income tax on money they set aside in a Medical Savings Account.

However, states have no control over federal tax law, which is why America needs the tax changes proposed in the Medical Savings Account legislation before Congress.

Health Care in the Information Age. The direction of health care reform is changing — from imposing a large bureaucratically-controlled system to one in which

patients are in control — and it will be exciting to observe how the health care system will adapt in the future.

Around the country businesses are already gearing up to meet the needs of consumers in a health care market that permits them to control part of their health care dollars. Considering these changes we can assert that *the future is here.*

- West One Bank in Idaho has created a Medical Savings Account product for its customers, using a special money market fund that will allow employers or employees to make deposits to the account and permits the owners of the account to draft on it to pay health care expenses.
- Eclipse Consulting Group of Indiana has designed a computer system to provide electronic banking using "Smart Card" technology that would permit patients to pay providers directly from their MSAs.

Conclusion

What is important to realize is that businesses are responding quickly and efficiently to the perceived changes in the health care marketplace by providing more options that lower costs to patients, employers and society as a whole. Over its 35 years of existence, Congress has ensured that federal employees also had choice. Indeed, most federal employees have had more options than their counterparts in the private sector. However, Congress is on the verge of making tax-free MSAs available to the general public. If Congress wants to retain the FEHBP's historic commitment to choice and quality, it should be leading the fight to make MSAs available for federal employees as well.

I want to thank you for giving me the opportunity to state why federal employees should have access to Medical Savings Accounts. You are to be commended for holding this hearing to look into this exciting option, and I will be glad to try and answer any questions at the appropriate time.

Mr. MICA. Thank you, Mr. Matthews, and we'll recognize Dr. Daniel Johnson, who's a member of the American Medical Association Board of Trustees.

Welcome, and you're recognized, sir.

Dr. JOHNSON. Thank you very much, Mr. Chairman. My name is Daniel H. Johnson, Jr., M.D. I am a practicing diagnostic radiologist from Metairie, LA, and, as you've pointed out, I also serve as the president-elect of the American Medical Association. We commend you, Mr. Chairman, for holding this important hearing.

For more than a decade, the AMA has supported the adoption of MSA's as an option in all segments of our Nation's health care system. We believe MSA's not only represent a cost-effective approach to financing health care, but also would strengthen the market for medical care by assuring patients more freedom of choice.

Empowering individuals with the responsibility to choose the type of health care they will purchase has continued to remain at the center of the health system reform debate. Should we favor more bureaucratic control over our health care dollars or more freedom for all of us as consumers of health care to make our own decisions? The answer from the American people, we think, is quite clear, and MSA's would help to provide Federal employees with that freedom.

With FEHBP enrollees making cost-conscious decisions in choosing among competing health plans, it's no wonder that the program has had a positive track record to date for cost-effectiveness. The AMA believes that the FEHBP could be further enhanced by allowing participants the opportunity to choose an MSA option if they choose to do so.

There are many advantages to an MSA option. For instance, one might ask a simple question. Is it more desirable to link the patient to the cost of health care or to insulate the person from the cost? Unfortunately, the lack of this direct linkage has led to overuse by consumers, who have had little incentive to limit spending or thoughtfully weigh the costs or benefits of services.

Numerous studies provide evidence, as has already been pointed out, that third-party payment for health care shields patients from cost awareness and the responsible consumption of health care dollars.

But a second question might also be asked. Is it better to reward individuals for using the system in a cost-effective way or to punish them for not doing so? Companies searching for more innovative and cost effective ways to provide health care benefits for their employees have learned first-hand the benefits of putting employees in control of their health care dollars through the use of MSA's, despite the fact that individuals who choose MSA's are discriminated against by current Federal laws.

By giving consumers the opportunity and the responsibility to make their own decisions about the value of the health care they will purchase, we believe an MSA option has the potential for substantially improving the physician-patient relationship, a relationship which has been eroded by the increasing intrusion of third-party payers. Unlike some traditional health benefit plans which manage care by limiting access through plan restrictions, MSA's would eliminate the need for bureaucratic restraints that interfere

with patient choice and with the patient-physician relationship. MSA's would allow the individual, not a third party, to choose the physician, treatment, and range of health care services that best meet his or her needs.

Now, as has been already pointed out, there are several criticisms of MSA's, and many of those have been addressed. But let me, from the perspective of a physician, address a couple of those, if I may, Mr. Chairman.

It has been argued that MSA's are likely to reduce incentives to seek preventive medical care. We disagree. The American Medical Association has long advocated the importance of preventive medicine, from routine checkups for kids to mammograms and prostate screenings for adults. We are aware of no long-term studies to support the contention that MSA's are likely to discourage individuals from seeking preventive medical care. In fact, as has already been pointed out, from existing experiences, medical savings accounts could be a source of funds for services such as preventive care not always covered by traditional health insurance.

It has also been argued that MSA's are not likely to reduce costs because consumers are not in the position to bargain for reductions in cost, as are managed care plans and insurance companies. Again, Mr. Chairman, we disagree. An MSA option in the FEHBP would empower patients to make prudent and sensible treatment choices and to reap the reward of their savings—savings realized by more cost-conscious purchasing of health care would accrue to the patient, not to some other third-party payer. Consumers can and will make prudent decisions about their health care, just as they decide the type of mortgage to purchase, the kind of car to buy, or the amount of life insurance to carry.

As Thomas Sowell of the Hoover Institution wrote during the health system reform debate last year, "No freedom can be more personal than to decide for yourself what should be done to preserve your health and your life." While the private sector health care market and the Medicare program may soon be touting MSA's among their plan offerings, the FEHBP will not unless we act now.

We believe this is ironic, considering that many have praised the FEHBP as a model for other health care delivery systems and have advocated opening the program to non-Federal workers. In the interest of furthering consumer choice and competition in the FEHBP and enhancing a proven program, Federal employees should likewise have access to an MSA option.

Thank you very much, Mr. Chairman, for the opportunity to participate in your hearing, and we, as well, look forward to any question you may have for us. Thank you.

[The prepared statement of Dr. Johnson follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Government Reform and Oversight
Subcommittee on Civil Service
United States House of Representatives

Medical Savings Accounts: A Viable Option for Federal Employees?

Presented by: Daniel H. Johnson, Jr., MD

December 13, 1995

Mr. Chairman and Members of the Subcommittee:

My name is Daniel H. Johnson, Jr., M.D, and I am a diagnostic radiologist from Metairie, Louisiana. I also serve as President-Elect of the American Medical Association (AMA). On behalf of the 300,000 physicians and medical students of the AMA, I am pleased to have this opportunity to testify before you today to express our overwhelming support for including a Medical Savings Account (MSA) option in the Federal Employee Health Benefit Program (FEHBP). We commend Subcommittee Chairman John Mica for holding this important hearing.

An MSA option, combined with a high deductible catastrophic insurance plan, represents a refreshing and rational reform of our health delivery system. Empowering individuals with the responsibility to choose the type of health care they will purchase and from whom has continued

to remain at the center of the health reform debate: Should we favor more bureaucratic control over our health care dollars or more freedom for all of us as consumers of health care to make our own decisions? The answer from the American people is clear, and an MSA option in the FEHBP will help to provide enrollees with that freedom.

For more than a decade, the AMA has been on record as supporting the adoption of MSAs as a choice among various types of health plans in our health care system. In fact, a longtime AMA health policy economist, Jesse Hixson, PhD, is credited by the National Center for Policy Analysis (NCPA) with the original concept of medical savings accounts. We believe an MSA option not only represents a cost effective approach to providing health care, but also strengthens the market for medical care by assuring patients more freedom of choice.

The FEHBP provides health insurance coverage for over 9 million Federal Government employees and their families. Participants choose from roughly 400 competing health plans nationwide in the FEHBP, with anywhere from ten to thirty health plan options available in any particular area. Such choices range from traditional health insurance plans to managed care plans with varying benefit packages and premium costs. With the fixed dollar amount contributed by the Government, FEHBP enrollees decide what health plan is best for them and their families. With enrollees making cost conscious decisions in choosing among competing health plans, it is no wonder that the FEHBP has had a positive track record of cost effectiveness.

The AMA believes that the FEHBP can be further enhanced by expanding the array of choices in the FEHBP and allowing enrollees the opportunity to choose an MSA option combined with a high deductible catastrophic policy.

There are many advantages to using MSAs and I would like to touch on several reasons we believe an MSA option in the FEHBP would be beneficial to federal employees and their families.

The Advantages of MSAs

MSAs are cost-effective. A fundamental problem exists today in the way we finance our health care. Because many of us receive our health care insurance from an employer-provided plan, we do not personally experience the need or the desire to pay attention to the cost of a medical procedure. With traditional insurance, consumers are insulated from prices and do not perceive the full cost of consuming health care resources. Numerous studies provide evidence that third party payment for health care shields patients from cost awareness and the responsible consumption of health care dollars. In fact, a Rand Corporation study found that individuals who had access to "free care" consumed at least 30 percent more than those who had to pay a substantial portion of the bills up to a maximum amount out-of-pocket.

One might ask a simple question: Is it more desirable to link the patient to the cost of health care or insulate the patient from the cost? Unfortunately, the lack of this direct linkage has led to systematic overuse by consumers who have had little incentive to limit spending or thoughtfully weigh the cost/benefits of services. Consumers are not exerting as much pressure

on providers for economic efficiencies as they would if they were paying the full cost of medical care directly out of their own pockets. The result is that many prices may be higher than they otherwise would be and many providers are less efficient than they could be.

Companies searching for more innovative and cost-effective ways to provide health care benefits for their employees have learned first-hand the benefits of putting employees in control of their health care dollars through the use of MSAs. It has been reported that *Forbes* magazine health costs fell 17 percent in 1992 and 12 percent in 1993. Likewise, in the first year of an MSA plan for its employees, health costs for Golden Rule Insurance Company were 40 percent lower than they would otherwise have been. Dominion Resources and Knox Semiconductors have had virtually the same experience with their MSAs -- the cost of the premiums for their employee's health insurance fell significantly. In short, it is estimated that more than 1000 businesses have adopted some form of the MSA concept. But, federal tax law changes are needed to achieve even greater and more effective use of MSAs.

We believe tax-advantaged MSAs will spur even more competition in the FEHBP and in the health care marketplace as a whole. MSAs represent a market approach, rather than a regulatory approach, to reducing health care costs by encouraging prudent health care buying and saving. Rather than achieving cost containment through global budgeting or price controls, which usually leads to gaming or other distortions in the health care system, MSAs would create incentives to wisely use one's own health care dollars, rather than continue the present perverse incentives to freely consume someone else's.

Further, by allowing unspent balances in MSAs to be carried over tax-free to subsequent years, consumers will be rewarded for practicing responsible consumption. We believe it is more desirable to reward health care consumers for using the system cost effectively rather than punishing them for not using the system in a cost effective manner. By encouraging appropriate use of our nation's health care dollars, while preserving individuals' access to the physicians and other providers of their choices, MSAs represent one of the best approaches to achieving cost savings in the FEHBP.

We believe MSAs have the capacity to increase portability of health care policies, a goal which has broad bipartisan support. The portability aspect of MSAs will enhance job mobility by eliminating "job-lock" that forces many employees, especially those with pre-existing conditions, to stay in jobs in order to continue receiving needed coverage. Indeed, recent public opinion surveys conducted by the Employee Benefit Research Institute in conjunction with The Gallup Organization found that one in five Americans surveyed indicated they or a family member passed up a job opportunity based solely on health benefits.

In addition, MSA funds could provide financial resources for workers who become temporarily unemployed, allowing them to purchase bridge health insurance while they are between jobs. While the greater availability of MSAs will not completely solve the portability problem, they could result in greater access to our health delivery system.

Improving the Physician-Patient Relationship

By giving consumers the ability to make their own decisions about the value of the health care they will purchase, we believe the MSA option has the potential for substantially improving the physician-patient relationship, a relationship which has eroded by the increasing intrusion of third party payors. Unlike some traditional health benefit plans which "manage" care by limiting access through plan restrictions, MSAs would eliminate the need for bureaucratic restraints that interfere with patient choice and the patient-physician relationship. In addition, savings made by more cost conscious purchasing of health care would accrue to the patient, not to the HMO or some other third party payor. Most important, MSAs would allow the individual -- not a third party -- to choose the physician, treatment, and range of services that best meet his/her needs.

MSAs -- Unlimited Potential

MSAs have unlimited potential in our health care system. From the private sector to FEHBP to Medicare and Medicaid, MSAs should be a viable option in the health care marketplace as well as an important savings mechanism for future undetermined medical expenses, including long term care costs.

MSAs, Medicare Transformation and the Private Sector

The AMA fervently believes that the Medicare program must be transformed and applauds those efforts as set forth in the Balanced Budget Act Conference Report accompanying the Medicare Preservation Act of 1995 (H.R. 2491), which unfortunately was vetoed by President Clinton. The AMA is pleased that an important component of this transformation would be the

availability of an expanded array of plan choices for Medicare beneficiaries that range from the restructured traditional Medicare program to various health plans, such as Provider Service Organizations, to tax-advantaged MSAs.

The AMA strongly favors Medicare MSAs because of their potential to enhance the operation of the medical care market, to promote competition between health care providers, and to temper the rates of price inflation of medical services. Exercising greater choice may increase the complexity of the beneficiary's decision-making about medical care, but it will undoubtedly provide enhanced opportunities for more prudent use of medical care resources.

Likewise, the AMA supports the provision in the Balanced Budget Act Conference Report which would allow individuals and families to establish tax-favored MSAs for unreimbursed medical expenses. We believe this legislation holds much promise in creating the proper incentives to wisely use one's health care dollars by promoting cost conscious purchasing of health care.

Criticisms of MSAs

There have been several criticisms of an MSA option, a few which the AMA would be pleased to address from a physician's viewpoint. It has been argued that MSAs are likely to reduce incentives to seek preventive medical care. We disagree.

The AMA has long advocated the importance of preventive medicine, from routine checkups for kids to mammograms and prostate screenings for adults. We are aware of no long-term studies to support the contention that MSAs are likely to discourage individuals from seeking preventive

medical care. In fact, MSAs could be a source of funds for services such as preventive care not always covered by traditional health insurance. Moreover, anecdotal evidence from employers suggests that employees are most interested in seeking preventive care including wellness programs to avoid greater health risks and costs down the road.

It has also been argued that an MSA option is not likely to reduce costs because consumers are not in a position to bargain for reductions in costs as are managed care plans and insurance companies. Again, we disagree. An MSA option would provide the opportunity and the responsibility for patients to make wise treatment choices and to reap the rewards of their savings for future unreimbursed medical expenses. Patients, in consultation with their doctors, would manage the patient's care -- not a third-party payor. Consumers can and will make prudent decisions about their health care just as they decide the type of mortgage to purchase, the kind of car to buy or the amount of life insurance to carry. As Thomas Sowell, an economist and a senior fellow at the Hoover Institution, wrote during the health care reform debate last year, "No freedom can be more personal than to decide for yourself what should be done to preserve your health and your life."

Recognizing the importance of preserving patient choice in health care, a number of states have recently passed measures authorizing the use of tax-free MSAs for medical expenditures. As a result, there is now an increased availability of MSAs, usually combined with high deductible, catastrophic health plans. To date, over ten states have enacted MSA laws, including Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi, Missouri, New Mexico, Utah, Virginia and

West Virginia. Although such action demonstrates the continued enthusiasm for MSAs in the health care marketplace, federal tax changes are needed to measure their true worth.

While the private sector health care market and the Medicare program may soon be touting tax-free MSAs among their array of plan offerings, the FEHBP will not. This is ironic considering many have praised the FEHBP as a model for other health care delivery systems and have advocated opening the program to non-federal workers. In the interest of furthering consumer choice and competition in the FEHBP and enhancing a proven program, Federal employees should have access to an MSA option now, and we stand ready to help this Subcommittee achieve this sensible reform.

Mr. Chairman, we are grateful for the opportunity to share our thoughts with you and look forward to working with you as this important issue moves forward.

Mr. MICA. Thank you, Dr. Johnson. I can't help but start with you, because first I want to ask you, are you testifying on behalf of the American Medical Association and not personally?

Dr. JOHNSON. Yes, I am.

Mr. MICA. You are? So you've just testified that these MSA-type plans, in which, I understand from the studies I've seen, there would actually be less utilization of doctors, because under some of the other plans there is more incentive to go to the doctor, to utilize medical services, that actually they would be using doctors less.

Dr. JOHNSON. There is certainly the potential for that, Mr. Chairman, and there is also the potential, which is equally important, for individuals to use the system in a more cost-effective way.

Mr. MICA. So their visits would be more valuable, more directed, but possibly less frequent.

Dr. JOHNSON. If I may give you just an example of what we're talking about here, from my own practice, Mr. Chairman. As I indicated at the outset, I'm a practicing diagnostic radiologist. I work in an outpatient facility that does very expensive high-tech procedures—MRI's, CT scans, and so forth.

We have been a cost-effective provider of those services for years, but most people in our community don't care about that. Now, keep in mind, the quality issues are determined by whoever refers them to us. They wouldn't refer to us unless they're satisfied that we can do the job well.

But the referring physicians typically don't care about the cost, and the reason is, someone else is paying for this. It's very unusual to have anyone care. On the contrary, physicians hear over and over again, "Why are you worried about the cost, doctor? My insurance will pay for this." It's exactly the mindset we've heard.

And so the cost-effective provider of services is not rewarded in the current environment we have. And so, from my own personal experience, I suggest to you that we can maintain—through the quality of the service that we provide, we can see to it that people get the services they require, but we can do so in a more cost-effective way, which we consider to be one of the major objectives here.

Mr. MICA. Well, the other thing that has been charged against MSA's—and it was interesting to hear your testimony—is the question or comment that people say, because folks wouldn't want to expend the money, they would not seek preventive care. And you're saying that there's no study, no evidence, that this would be true, that there would be any endangerment to preventive care. Was that a correct assessment?

Dr. JOHNSON. Yes, Mr. Chairman. That's our understanding of the current experience, and our view is that, given the opportunity to realize long-term savings by cost-effective utilization of the system today, by doing the preventive things that make sense in order to reduce the amount of money that will be taken out of their savings account at a later time, that people should respond.

But suppose we're wrong. Suppose that this assertion that we've made in our testimony today is wrong. It's very easy to adjust for that. It's very easy to incorporate the various costs of preventive services which are deemed to be desirable into the insurance, into the catastrophic side of that, have those benefits paid for.

We don't think we're wrong, and there's no evidence to suggest we're wrong, but if we are, the fix is quite simple.

Mr. MICA. Well it seems to run contrary. Usually you hear, "See your physician annually," or as often as you can get down there to the physician, and the other thing is to always encourage preventive care. Some folks say that MSA's may lead folks in the opposite direction, but you're saying there's no evidence to this and, in fact, support the MSA concept strongly. Is that the correct assessment?

Dr. JOHNSON. Yes, Mr. Chairman. If I might go to the example. It covers both of the issues you raised, I think. Look at the AMA's long-standing proposal to have a tobacco-free society by the year 2000. If it was in the best interests of physicians to increase our income, we would have free cigarettes in our reception rooms. We don't do that.

What we want is for people to take better care of themselves, and, increasingly, people understand that doing so will save them money over the long run, and that's what we advocate for the public health, for the kind of preventive measures that will make a difference to individuals, that will enable them to lead a longer and healthier and happier lives.

And so it has been an ongoing part of our advocacy and, hopefully, it would be no surprise that we are anxious to see the system used in a more cost-effective way.

Mr. MICA. Thank you. It's interesting, very interesting testimony, and your observations, I think, will be important to action this committee may take in the near future.

Dr. JOHNSON. Thank you.

Mr. MICA. Commissioner Glenn, how long has your experience been with the MSA's?

Mr. GLENN. Mr. Chairman, our experience is brand new. We had open enrollment in September, and the first deposits will be made into the medical savings accounts on February 1.

Mr. MICA. Is this open to a select group or to all employees, and what about retirees?

Mr. GLENN. Mr. Chairman, we don't have retirees covered.

Mr. MICA. You don't?

Mr. GLENN. It was offered to all—well, it was technically offered to all 900 employees. The truth of the matter is, in our experience, 20 percent of our work force voluntarily enrolled, but that is, in fact, about almost 80 or 90 percent of those that we know knew we offered it.

We had a peculiar political situation, in which I'm confident that there are hundreds of our county employees who aren't even really aware that we offer the program, and many more who may have been vaguely aware that we offered it and who don't have a lot of information about it.

We had about 250 employees—actually 10 briefings by the county that gave in-depth information about the medical savings account program. Our plan was intentionally designed the first year so as not to be attractive to those currently enrolled in the option of an HMO, and so we have just about 90—maybe even close to 100 percent of those who were in the old indemnity plan, who actually attended the briefings.

It's our anticipation that, now, we have 170 salesmen—170 enrollees—90 percent of whom we expect will have money left over by the end of the first year and who will brag to their coworkers about that money left over. So we are already preparing to double the number of enrollees next year. I think by the third year we'll have more than half the county's employees.

Mr. MICA. So this is presented as an option.

Mr. GLENN. Yes, sir.

Mr. MICA. It has less than a year track record.

Mr. GLENN. Yes.

Mr. MICA. What kind of savings do you anticipate from 170 employees?

Mr. GLENN. From 170 employees, the calculation is that we will immediately save just over $37,000 per year in up-front premiums. That will be the reduction in the premiums that we enjoy.

If we were to be exempt from Federal FICA, being exempt from Federal taxation would automatically exempt us from the State of Idaho's Public Employee Retirement System, and we would just about triple our savings to over $90,000 per year on premiums just on 170 enrollees.

Because it appears that the likelihood of congressional approval of Archer-Jacobs is delayed a bit, we are going to be introducing, the very first week of the legislature in January, a bill to take care of separately the State Public Employee Retirement Exemption, so that will put us up in the $60,000-per-year range.

And that's really not even the savings. The bulk of the savings will be in the comparative reduction in premiums over the long term, we anticipate, because fewer claims will be filed by individuals who are having to spend their own money. So we anticipate hundreds of thousands of dollars in savings, even if it remains just an option, even if as small as 20 percent of our work force was all that ever enrolled, which we're confident will grow year by year.

Mr. MICA. Did you say there was an 86 percent reduction? Was that in out-of-pocket costs for those participating?

Mr. GLENN. Mr. Chairman, I specifically said that there was an 82 percent reduction for my family, and that differs depending on the size of family.

Mr. MICA. OK.

Mr. GLENN. Now, all this concern about adverse selection, the way our plan is designed—and I think that everybody is aware that you can design these things any number of ways. The way that ours is designed, the young and healthy have an incentive to enroll in our plan. That is they get a shot at $1,100 in cash per year, which, if they are in fact healthy and don't spend, is theirs. They have a good Christmas, they make a down payment on a new car, or they go to Hawaii.

But the older and the odds-on sicker members of our employee population, those with families of at least two members or more, have two incentives to enroll. They get the shot at the cash—in fact, they get a shot at $2,100 in cash per year.

But, even more significant—and I can just use my own family as an example—with a wife and four children, under the old $100 deductible, $300 maximum per family, and an 80/20 copay plan that we had, where we were subject to $800 per person on the copay ob-

ligation, if all six of my family members were in a car wreck or we all six got sick at the same time, I would be looking at having to pay $5,100 out-of-pocket after taxes in my copay and deductible obligation.

Under the MSA, I will have a $3,000 deductible for my family, no copay, and the county will give me $2,100 in cash per year. The worst-case scenario I would ever face out of my own pocket under that plan is $900, State income tax-free, because Idaho is one of the States that has already made these deductibles against State income tax. And that's just the first year.

If I'm smart enough to have money left over at the end of the year, and I am smart enough not to go to Hawaii with it but to leave it in my account and roll it over—let's say I leave $900 in my account after the first year—the second year, the county gives me $2,100 again.

Now I've got $3,000 in my account, and my deductible is $3,000. My maximum out-of-pocket risk that year is $0, and it can only get better as each year goes by for those who are responsible and prudent consumers, as we expect most of our employees will be.

Mr. MICA. These sound like horrible alternatives—cost less to the government, less out-of-pocket potential for the beneficiary, fewer choices.

Mr. GLENN. Yes, Mr. Chairman.

Mr. MICA. I mean the parade of horribles goes on. It sounds like even in the proposal stage there were people opposed to this. What kind of opposition did you have and how did you overcome it?

Mr. GLENN. Mr. Chairman, there was little, if any, opposition based on merit or arguments against the medical savings account. In fact, that passed unanimously.

Mr. MICA. Was it just fear of the unknown?

Mr. GLENN. Well, we did focus groups of our employees afterwards and asked them, "Why didn't you enroll?" and it was fear of the unknown. I can't remember a single employee who said it sounded like a bad plan. The litany was, "It sounds good, but we're going to let somebody else be the guinea pig for the first year."

But now we figure we've got 170 salesmen who, as I said, will brag about the money left over. But there was no philosophical opposition to the plan. It was all more something unique to the politics of my little county, in which we are a dysfunctional little family, politically.

But we actually had the circumstance where one member of the Commission's immediate reaction was that this would be harmful to the employees until it was shown him how his family would benefit. He had two children, and he used to have $3,500 maximum out-of-pocket exposure, and now he has $900, so he was wiling to vote for it.

The third member of the Commission realized it was going to pass 2 to 1, or he could make it 3 to nothing, so it was 3 to nothing. But then, the majority of my Commission, actually, Mr. Chairman, threatened to fire the director of our personnel department if he in any way attempted to promote this plan to our employees.

Thereby, there are hundreds of our employees who don't even know in detail that we offer it. Basically, whatever communication was done to our employees, our 900 employees, I did, without sec-

retarial assistance, and I didn't get to all of them. But now I've got 170 people that are going to have cash in their pocket.

This thing has been roundly supported. It has been endorsed by our AFL–CIO affiliate union; it was endorsed in three separate editorials by the Idaho Statesman newspaper, which is not exactly a mouthpiece for a free market or a conservative philosophy, and it has been well received by the taxpayers who are able to understand the math, that they're going to save money when employees enroll in the plan.

Mr. MICA. Now, one of the parade of potential horribles is that, again, this cherry picking is going to result in increased premiums for someone else who remains. Now, you have other options, obviously, because you only have 170 covered by this. Is there any evidence, since starting this or offering this, that there has been any increase in premiums or costs or loss of benefits or services, some imbalance created by offering the MSA?

Mr. GLENN. Mr. Chairman, the answer to your question is no, but to be fair, it's too early in the process to tell you. We have totally put Blue Shield on notice, because Blue Shield handles both our medical savings account and our standard indemnity plan. Blue Cross has an HMO option for our employees. We've put Blue Shield on notice that, if they come in next year and try to raise premiums on the people who did not enroll in the MSA, that they're going to have to be able to prove it.

We anticipate that there will be fewer claims filed by those who enroll in the MSA, and that can be for one of two reasons. Either the people who enrolled in the MSA had a predisposition, a pre-existing record of being those less likely to file claims, or they filed fewer claims because, suddenly, it was their own dollars they were spending.

So if they come in to us and try—we intend to be pushing for a rate decrease, a premium decrease on our MSA enrollees. And, of course, we've always got the option of going back out for bid at any point.

We had Golden Rule Insurance of Indianapolis, Blue Shield of Idaho, and Blue Cross of Idaho bid on the MSA, and it's always our option to go out for bid on all of our insurance packages and force them right back into the marketplace. So we don't anticipate that kind of problem.

Again, the young and healthy, the single employees of Ada County, have the cash incentive. It is the larger families, those who by definition, you would think, demographically would prove out to be the older and more likely to be sicker. Because I've got six different members in my family, the chances of there being a sickness that has to be covered by my insurance is six times over.

Those people have two reasons, two incentives to switch—the cash and the reduction in maximum out-of-pocket risk. So I think the way we have designed our plan is we've given the "older, sicker" an additional incentive to enroll on top of the one that the young and healthy—those that are single—have to enroll.

Mr. MICA. Thank you. Mr. Hendee, do you see any reason for HMO's or fee-for-service or other medical option plans or approaches—is there any reason that they should fear, or can you see any endangerment to their activity, viability, ability to provide

services, by your review of this proposal? I guess there are 3,000 private plans, I heard someone say, so I guess there is some track record, maybe not in the public sector, but in the private sector.

Mr. HENDEE. I don't foresee that HMO's or traditional indemnity plans will for some reason not be able to continue to carry out their function. I do see that this will be an additional competitor on a market and, just like in any situation where you have an additional competitor, it will make you run harder.

Mr. MICA. Are you familiar with the private plans that have been instituted and offered? Is there any evidence of costs being driven up by instituting this for HMO participants or, for any other type of activity, or anyone being excluded as a result of this option being offered?

Mr. HENDEE. There is not much information available in the public domain on the private plans that have these programs, and, for the most part, those programs are not very old.

Mr. MICA. So there's not much information first, and there's not a long track record. So that's the biggest problem you're dealing with. But you're not aware of, say, an example of one MSA that has been instituted, Mr. Matthews or any of the panelists, where there has been a bad experience and where HMO's or doctors or other health providers have been hurt by institution of this approach?

Mr. HENDEE. I am not aware of any instance where the other—where there has been a choice provided and the other plans ended up with higher-cost individuals and a cost spiral resulted. I am not aware of any situation of that type.

Mr. MICA. Mr. Matthews, have you anything to add?

Mr. MATTHEWS. No, sir. Let me do address one issue, though. In a press conference about a month ago, a member of the press addressed to one of the NCPA people that he had heard that DuPont Corp. had implemented MSA's and that they had had only 2 percent of their people take it, as I got the message, and that they had had problems with adverse selection.

So I talked to people at DuPont. In fact, I talked to them just a couple of days ago, one of their chief administrators, and he said—to find out if that was, in fact, the case. I was having trouble imagining that was the case, because I talked to DuPont human resource people back in the summer, and they had not considered implementing MSA's at that time, and they were considering something like that.

In fact, they do not have anything like an MSA. They do have what they call a plan C option, which offers people the ability to take a $1,000 deductible policy. As I recall, I think he said they would give them a couple of hundred dollars in income, not an MSA, and that they had had about 4 percent of their employee work force take that.

So it had not been very popular, but there was no adverse selection element that they could recognize. But he did not characterize this as really an MSA plan. I think that's probably right. It's not a high enough deductible, and there's not enough premium savings in the plan that that would go to, to really warrant many people moving to it.

But apparently there are people who are saying that DuPont has implemented an MSA plan and that they are having problems. That is not the case, according to DuPont.

Mr. MICA. Now, I notice your organization offers it for your employees.

Mr. MATTHEWS. That's correct.

Mr. MICA. How long has that been in place?

Mr. MATTHEWS. We started that in January, and we did it as a result of wanting to—if we're going out and advocating this, as we had for so many years, we felt like we needed to practice what we preached, so we did this.

This was a lateral move for us at the NCPA. That is, the employer stated to the insurer, "We do not want to pay any more or less out of the company's pocket to get this plan." So it has worked out to be fairly beneficial. I might add that the NCPA's policy is to pay the entire premium for the employee. If you have a family plan, you have to pay that out-of-pocket.

I have a family plan, and I was paying about $330 a month under our old policy. Under our new policy, my premiums dropped by $150 a month. So, as a result, I have both a $1,500 contribution to my MSA at the beginning of the year and the potential to get back about $1,800 in savings that I was paying last year. So, together, that's a potential savings of about $3,300 to the person with a family plan at the NCPA.

Mr. MICA. Well, I thank the panelists, and I want to defer now to our ranking member. As you can tell, this has been one of the busier mornings on Capitol Hill. Don't come around when we're about to vote on Bosnia or balance the national budget or deal with the deficit. If we don't have those three minor things to deal with, we can pay even more attention to something that has a great potential, hopefully, for saving money and offering some choices.

With those remarks, I want to welcome our ranking member, Mr. Moran, and if he has any opening statement and, of course, any questions, they're welcome.

Mr. MORAN. Well, thank you very much, Mr. Chairman. I won't go into an introductory statement out of deference to the witnesses. I do apologize for being late. You've cited the reasons. We've got the Debt Ceiling bill and Bosnia and several other things that I was involved in, and they've proved to be inextricable commitments.

This issue of whether we ought to make medical savings accounts an option for the Federal Employees Health Benefits Plan is, at the very least, an intriguing idea, but I have a lot of reservations about it. The principal reservation is the Congressional Budget Office's scoring of this option, which is $1.3 billion. Under our pay-go plans, we would have to come up with $1.3 billion in reductions and benefits, presumably, someplace else within the account that it would come out of. So I think that's the biggest hurdle.

But there are also some very serious concerns as to the ramifications. One of the problems, for example, is the segmentation of the insurance market that this would invariably create for those folks who are less healthy, who are older, who are in a higher risk pool, what would happen is that their insurance premiums would inevitably go up as those folks who are the youngest and the healthiest within that pool might choose medical savings accounts. Everybody

makes their own risk/reward calculation, and if you're young and relatively healthy, you're probably going to take a chance at MSA's, at least until you get into your 40's. But those people who are in their 40's and who are retired or who have some medical history of illness, even within their family, are more likely not to take the risk, and their options, though, are very much affected by those who choose to take the risk, because their insurance premiums are going to go up. The pool of people who are going to be choosing the more expensive fee-for-service premiums is going to be smaller and, in fact, is going to be much less heterogeneous, much less diverse, and that has got to be a serious consideration when we entertain this idea of making MSA's an option.

One of my problems with the testimony that we have is that it is not, to my mind, sufficiently representative of an organization as large and diverse as the Federal Government. We are talking about 2 million active employees and, I guess, another—what?—3 million? So we're talking about a total of 9 million in a pool. That's quite a different pool than the insurance pools that are being represented in the testimony.

In terms of the private sector, I think that we have a similar concern in terms of the size of those corporations that have chosen MSA's, and I would like to look at some of the demographic characteristics to see what kind of behavioral patterns occur when people are faced with these options on not just the micro scale, the anecdotal scale, but the macro scale of the large organization.

So those are some of my concerns. I noticed, Mr. Glenn, your experience, which, while it is interesting, is not necessarily comparable to the scale of millions of public employees that we're talking about with FEHBP. But you had a vote on your County Commission, did you?

Mr. GLENN. Yes, sir, Mr. Moran.

Mr. MORAN. And what was the vote?

Mr. GLENN. Mr. Chairman, Mr. Moran, the vote was unanimous in favor of offering this as an option.

Mr. MORAN. And was it considered to make it the only option?

Mr. GLENN. Mr. Chairman, Mr. Moran, that was never considered because I'm surprised that it got passed as an option. There was no question that there was no support for making it the only option.

Mr. MORAN. And what percentage do you now have that are in MSA's?

Mr. GLENN. Mr. Chairman, Mr. Moran, we have about 20 percent of our work force voluntarily enrolled, which I believe is a very much held-down figure, in the sense that, certainly, not 100 percent of our employees were even aware, in a meaningful manner, of the option they had before them.

Mr. MORAN. OK. Thank you, Mr. Glenn. I would like to ask Dr. Johnson, some of the discussion that has gone on within the AMA—obviously, the AMA's view on this is going to be persuasive in terms of national legislation. Has there been consideration of the impact we would have on the status of our national health if there is a clear incentive to avoid the kinds of optional care that are generally more preventive in nature?

In other words, if people are paying for medical care, for visits, out of their own pocket, they're less likely to avail themselves of checkups and the kind of preventive maintenance care, if you will, than if it is covered, particularly those insurance plans, like many managed care plans, that encourage you to make those preventive maintenance visits and, in fact, offer them for free so that you will—just like a machine, the bodies of machines—so that you'll maintain yourself and avoid acute problems that oftentimes arise because there has been inadequate preventive care.

Can you address that, some of the dialog that has gone on within the AMA on this?

Dr. JOHNSON. Yes, thank you, Mr. Congressman. This is a very important issue. I did touch briefly on it before, but perhaps I can present it in a different way. Most of us own automobiles, and most of us realize that we should change the oil in the automobile at a fairly frequent 3,000 to 5,000 miles in order to maintain the integrity of the engine and have it function over a long period of time.

Few of us, however, purchase insurance to cover the cost of oil changes. Why not? Because the cost of the insurance adds an administrative layer so the oil change becomes more expensive. Now, what we have, then, are two kinds of mechanisms that you've discussed for financing those oil changes, in terms of preventive services within health insurance.

One is that we can build in the cost of that into the plan and encourage people to have it because it's free to them. They can have it, as you mentioned. The other is, we can allow the individuals to purchase those services at a lower cost to them by doing it on their own initiative.

Now, before you came in, I specifically raised this point in my testimony and urged that we believe that individuals, when they stand to benefit from cost-effective use of the system over a long run, will avail themselves of the appropriate preventive techniques, such as prostate screening for men, mammograms for women, the immunizations for children, and so forth and so on.

They will avail themselves of those things in order to not only live longer, healthier, and happier lives, but to save money over the long run. However, we recognize the possibility that we could be wrong in that, that that may not, in fact, occur, and the solution to that is very simple within the MSA framework.

It's to do the same thing that the HMO does, to pay for this service up front, to not have it included in what's covered under the deductible, but to actually pay for the service as a part of the insurance. So if we're wrong about what we think would happen in the MSA option for those people who choose the option, it's very simple to correct for that.

We don't think we're wrong, obviously. We've proposed dealing with the oil changes such as you and I do, as opposed to buying insurance for the oil changes, in the MSA option. But understanding that we might be wrong, we don't think the fix is very difficult for that.

Mr. MORAN. That's interesting. So you could, after a couple of years' experience, you would modify the plan and build in preventive measures?

Dr. JOHNSON. If circumstances indicate it, yes.

Mr. MORAN. You know, Mr. Chairman, another concern—I'll be very candid about this—that I've had with the MSA's is the principal firm that is identified with medical savings accounts. I've read a few articles in the Wall Street Journal, actually, and the fact they're heavy contributors to GOPAC or the Speaker, whatever, that's their business. I don't see that as a particularly damning indictment.

[The articles referred to follow:]

PETER FERRARA

Will Medicare refor

In the Senate last Friday night, Sen. John Chafee, Rhode Island Republican, joined the Democrats in a procedural move that, among other things, removed the Medical Savings Accounts (MSAs) from the Senate Medicare reform bill. Unfortunately, what is left in the Medicare reform plan cannot be supported by anyone who opposed the Clinton health plan last year.

Without the MSAs, where market incentives and competition would control costs consistent with patient preferences, the Medicare reform would only meet the budget targets through the same heavy-handed rationing mechanisms included in the Clinton plan last year.

For those who stay in Medicare, reimbursements to doctors and hospitals would be cut so much that many would refuse to treat Medicare patients. In particular, the elderly would no longer have access to the latest, most advanced, most sophisticated care. They would suffer with essentially the same low quality care as imposed on Medicaid patients today.

Yet, their alternative would primarily be only Health Maintenance Organizations (HMOs), or other forms of managed care, where they would have to give up control over their health care, to a third party bureaucracy. That bureaucracy would have no choice but to ration their health care to fit the limited budget targets.

The affluent elderly may still be able to opt for private fee-for-service plans that will enable them to obtain the health care they want. But without the incentives of MSAs to keep the costs of such plans under control, these retirees would have to dig deep into their own pockets to supplement what Medicare will pay for these plans. These extra costs would exclude most of the elderly, forcing them into HMOs or the budget-rationed public system. And even those who persist in fee-for-service plans will resent the burdensome extra costs, generating total dissatisfaction with the Republican reforms.

For these reasons, this week organizations across the entire conservative spectrum, from libertarians to the Christian right, will announce their opposition to the Medicare reform plan, unless MSAs are included. And they will oppose that reform with ultimately the same fury that they opposed the Clinton health plan, as they must if they are to remain faithful to their principles. The key dividing issue, in health policy is who will have control over health care, each individual patient, or the government and its designated rationing bodies. MSAs give power to the people. Without MSAs, the Medicare reform plan would only take control over their own health care away from retirees. Consequently, Republicans are suddenly on the verge of snatching defeat from the jaws of victory on Medicare.

The Republicans fell into this swamp because they allowed the Congressional Budget Office to blackjack MSAs with an intellectually indefensible budget estimate stipulating that MSAs would increase rather than reduce Medicare spending. While that estimated cost was a tiny $3 billion over seven years, it allowed Democrats to ask compellingly how the Republicans could include an ideologically favored component that would actually increase costs while they were otherwise slashing back on budget growth for everyone else. That argument was too much for weak-kneed liberal Republicans who don't understand the issues at stake.

The CBO estimates are demonstrably, grievously wrong. CBO assumed that MSAs would increase the possible out-of-pocket costs that the sick elderly would have to pay. As a result, they concluded that only healthy retirees who cost Medicare little today would opt for the MSA, leaving the sick who cost Medicare far more in the program. After Medicare got done paying for the MSAs for the healthy who left, Medicare would end up spending more overall.

But MSAs do not increase out-of-pocket costs for the sick. They reduce them, and provide other advantages for the sick over Medicare, as follows:

- The MSAs provide complete catastrophic coverage for all expenses over the deductible in the plan. Medicare does not provide such coverage.
- The MSAs cap possible out-of-pocket expenses for the elderly at the difference between the deductible in the plan and the amount put in the MSA each year to pay for expenses below the deductible. For example, if the MSA catastrophic insurance covered all expenses over $3,000 per year with $1,500 in the MSA to pay for expenses below $3,000, the most the retiree would have to pay in a year out-of-pocket would be $1,500. This is sharply less exposure than the retiree faces under Medicare, which has no cap on out-of-pocket expenses. Retirees can be liable for tens of thousands in expenses each year under the program. That is why 70 percent of the elderly buy private supplemental insurance to cover those gaps, which will cost almost $1,200 per person next year. With an MSA, the retire can skip such insurance and keep the money.
- Retirees can use the MSA funds to pay for health expenses not covered by Medicare, such as prescription drugs.
- MSAs allow broader freedom of choice of doctors and services than Medicare. Because Medicare already underpays health providers so substantially, many refuse to treat Medicare patients. As indicated above, that problem will only get worse in the future. But MSAs pay full market prices for health care. So retirees with MSAs will be able to choose from any doctor and service in the marketplace.

In contrast to these enormous benefits, Medicare offers no advantages to the sick over MSAs. So the sick as well as the healthy are likely to choose MSAs over Medicare. But with both higher and lower cost patients choosing MSAs, there will be no adverse selection problem raising overall costs to Medicare. Instead, more and more retirees will be drawn into this highly appealing private option for which Medicare would pay only the budget limited amounts, saving enormous amounts of Medicare spending while actually providing better benefits for the elderly. NCPA, the nation's leading MSA experts, estimates that over 40 percent of the elderly would choose MSAs after seven years, saving the program over $100 billion between now and then.

CBO has offered no reasoned response to this demonstration of their overwhelming estimating error. As a result, they have incompetently undermined, and quite possibly destroyed, the entire Medicare reform effort.

The House and Senate leadership needs to get CBO on the line and give them this directive — either provide a rational response to this analysis, or provide a new MSA estimate in accordance with it. Otherwise, the Medicare reform, and with it the entire year budget, is about to collapse.

Peter J. Ferrara is general counsel and chief economist for Americans for Tax Reform.

THE WALL STREET JOURNAL.

★ ★ EASTERN EDITION MONDAY, AUGUST 1, 1994 PRINCETON, NEW JERSEY

Let's Talk Health Reform, Mr. President

By BRET SCHUNDLER

JERSEY CITY, N.J.—President Clinton is scheduled to be in Jersey City today to meet his health care bus caravan and to campaign for government-directed health reform. As the city's mayor, I would like to invite him to talk with me about a different approach. We are about to provide our municipal employees with Medical Savings Accounts, which will ensure comprehensive coverage without tax increases and without the ultimate threat of rationing. If he likes what he sees here, Mr. Clinton could support the Medical Savings Account, or MSA, provisions that are in several bills on the national level.

In the past, like most municipalities in New Jersey, Jersey City has covered its employees through the State Health Benefits Plan. The state plan provides good coverage and allows employees to choose their own doctors, but it is enormously expensive and the premiums just keep rising. Family coverage costs $6,800 annually, despite a $200 front-end deductible and a 20% copayment requirement—which means an additional $400 in out-of-pocket expenses per family member. Making matters worse (and this could only happen in government), if two members of the same family work for the city, the city must pay full premiums for both.

We are now becoming one of the first cities in the country to move to an MSA plan. Under the policy we are negotiating with Golden Rule Insurance Company, family coverage for our 2,500 municipal employees will cost approximately $4,700 for a catastrophic insurance policy that covers 100% of costs above a $2,000 deductible. The city will then place an additional $2,000 into a Medical Savings Account in the employee's name.

The employee's first $2,000 of family medical expenses will be paid out of the MSA. Above $2,000 in medical expenses, the insurance policy will kick in and cover 100% of costs. Added together, this means that employees will no longer have any health care deductibles or out-of-pocket expenses for covered procedures. The most innovative aspect of the plan is that if the employee's total health care costs for a year fall below $2,000, and there is money left in the savings account, that money will be returned to the employee at year's end.

Because the money deposited in the MSA qualifies as taxable income, employees with low medical expenses in a given year will only net the after-tax amount. Even so, at no level of medical expenses will the employee ever be worse off under the MSA plan than under the current state plan, and in most cases the employee will do significantly better. The MSA policy will cover 100% of the same procedures as the state plan, and at the same level of coverage or better.

The city benefits, too. We get happier and healthier employees, some immediate cost savings and the prospect for significant premium reductions in the future.

The typical employee is happier because under most scenarios the employee not only eliminates out-of-pocket expenses, but even stands to gain a fairly sizable cash payout on Dec. 31.

The employee is healthier because a major disincentive to getting preventative care, such as check-ups, is removed. The state plan, like most standard health insurance products, does not cover check-ups; they have to be paid for out-of-pocket. In contrast, the funds deposited in the MSA can be used to pay for check-ups with no up-front cost, which removes the disincentive.

To top it all off, the city saves money both immediately and in the future. In the first year, we save through the elimination of the state plan's double billing for two-employee families. In the future, we will save on premiums for several reasons:

- Our workers will be healthier, thanks to preventative care.
- Administrative costs will be lower, since the insurance company does not really have to review medical bills very carefully until the total submitted in a single year exceeds the $2,000 deductible.
- There will be no incentives for fraud and cost-shifting. Employees don't make fraudulent claims when they know that MSA dollars not spent will be returned to them in cash, and doctors are less likely to shift costs onto patients when they know those patients will be personally affected by a padded bill.

How can Jersey City's experience be replicated nationwide? By replacing the current system of tax deductions for employer-provided health benefits with a system of refundable tax credits for individually purchased health insurance policies. This would allow every American, employed or not, to buy a basic health care policy at less cost than what we spend today.

With a federal MSA system, all Americans with an income would use their tax credits to buy health insurance from any group provider they choose—such as a church or bowling league, not just an employer. Those without sufficient income to fully benefit from the tax credits would receive a federally funded health insurance voucher to make up the difference.

This is a simple plan. It would get us as close to universal coverage for basic health care as anything the president is proposing. It would reduce the total cost of health care. And it would have several additional benefits: It would eliminate the "job-lock" of our current system, which sometimes forces employees to continue working at a company just to receive health benefits. It would remove the single greatest disincentive for people to get off welfare—the threat that a welfare recipient's Medicaid coverage will not be replaced by private insurance in a low-level job. And it would eliminate the risk of government rationing of health care.

The benefits of MSAs have been recognized on Capitol Hill. They are the centerpiece of the Dole health care bill. They are part of the House Ways and Means Committee bill. They are encouraged even in the bills shepherded by Sen. Edward Kennedy and Rep. Dick Gephardt. Alas, because this is a plan that keeps power in the hands of real people, instead of shifting power to government bureaucrats, the president will probably never go for it. But you never know. Amazing things have been known to happen in Jersey City.

Mr. Schundler is mayor of Jersey City.

Mr. MICA. I didn't know that, but thank you.

Mr. MORAN. But what I was particularly concerned about is, in the article, it cited the relationship, the proportion of revenue that went into medical care, and almost 40 percent of the revenue went into corporate profit, really, and only about 60 percent or, at best, $2 out of $3, in terms of insurance premiums, actually went to pay for medical care.

Now, some of that may get fixed as you expand the population, but the clear point that was being made was that this is one of the most successful ways of targeting, segmenting the market to the lowest risk portion of the population, and that's a concern when we're looking at a plan that has so many retirees in it and that we're trying to make not only efficient and affordable, but accessible to as many people as possible.

So I have a lot of reservations is the point, and I think it might be useful to put into the record a couple of the articles that have been in the Wall Street Journal on the medical savings accounts and how they work.

Would any member of the panel like to respond to some of those concerns?

Mr. MICA. Without objection, we'll make those articles a part of the record.

[The information referred to has been retained in the subcommittee's files.]

Mr. MORAN. Thank you, Mr. Chairman. Mr. Matthews.

Mr. MATTHEWS. I think I can, if I understand, Mr. Chairman and Mr. Moran, the concern that you have. When Golden Rule established a—Golden Rule is an insurer, as you know, and so they, in essence, when they provide a policy, they are just self-insured. They underwrite—I mean when somebody brings a claim, they're underwriting it themselves.

When they established the medical savings account, they expected savings in the lower dollar ranges, where people are operating on their own. What really surprised them was there was something like a 40 percent savings in the higher dollar ranges, where they really had not anticipated a great deal of savings. Their explanation for that was that perhaps the idea of being most cost-conscious actually impacts even in the higher dollar ranges, but that's just a speculation. the reason that goes into profits, though, for them is that by virtue of the fact that they did not spend that, they did not have the claims filed on medical care. That ends up not going out to paying in employee benefits; it therefore becomes employer profits, and so they had to pay higher taxes on that as a profit.

In other words, they could have—if I understand your concern, they could have conceivably channeled that money onto employees in other ways, and I think Mayor Schundler is saying that that's what they're trying to do. But by not spending the money on health care because they didn't have the claims, it ended up raising their profit ratio, so they have to pay more taxes.

Mr. MORAN. That does lend light onto it. I'm glad you put that explanation into the record. It seems to me, as I recall in the article, one of the criticisms also—or at least areas of controversy—was that not even all the employees of the Golden Rule Insurance Co.

itself were eligible to participate in MSA's, that some of them weren't healthy enough. Are you familiar with that at all?

Mr. MATTHEWS. I do not recall that at all. My understanding was that about 80 percent went in initially, and, after the first year, another 10 percent went over, and it is my understanding that they felt that the 10 percent or so who did not were probably getting health insurance through a spouse, that they wanted to stay in that plan, that they would rather stay in that plan. But about 90 percent ultimately went in there.

I can't imagine that Golden Rule or any insurer would exclude their own employees from that plan, though. So I would be surprised if that was the case.

Mr. MORAN. You're from the Center for National Policy Analysis?

Mr. MATTHEWS. National Center for Policy Analysis. I was just given a piece here, and I guess I have a few minutes. Thank you, Mr. Chairman. But I was just given an interesting paper here. Mr. Goodman is the president of the National Center for Policy Analysis.

Mr. MATTHEWS. That is correct.

Mr. MORAN. He says, "I think fee-for-service medicine probably won't survive, no matter what Congress can do. And, in the future, people will probably have to go into managed care, where someone else restricts your choice of doctor access, or if you want to make those choices for yourself, you're going to have to manage some of your own health care dollars through a medical savings account, and that's where the market's going to go."

And then he also said that, "According to Mr. Goodman, it was the MSA concept, not Golden Rule's Washington money, that sent medical savings accounts sailing through Congress this year."

I think that's important to point out, because it references what I recall reading in the Wall Street Journal, that Golden Rule gave Newt Gingrich's campaign committee $42,000, and Mr. Rooney, the president of Golden Rule, gave $117,000 to GOPAC, the political action committee connected by Mr. Gingrich, and between 1993 and 1994, Golden Rule gave the Republican Party almost $524,000.

Well, that obviously is the source of that controversy I was reading about in the Wall Street Journal. But, as it says here, he says that that's really not the reason that this is getting as much play as it is. It's because of the national trend toward more managed care and, in many areas, the kind of individual choice that medical savings accounts optimizes. This is a transcript from National Public Radio. Shall we put the context of this in the record?

Mr. MICA. I'm not sure, Mr. Ranking Member, about National Public Radio as a source, but, without objection, that will also be entered in the record. I want to be perfectly clear, and we'll put it in.

[The information referred to follows:]

National Public Radio®
635 Massachusetts Ave NW
Washington, DC 20001-3753
202.414.2000 Tel
202.414.3329 Fax

AIR DATE: Thursday, October 26, 1995

ORIGINATION: Washington, D.C.

EXECUTIVE PRODUCER: Ellen Weiss

CONDITION OF PRESS USE: Credit National Public Radio
All Things Considered

Segment # 11 : Congress Embraces 'Radical' Medical Savings Proposal

LINDA WERTHEIMER, Host: The medical savings account, a sort of IRA that could replace conventional health insurance for many people, may be an idea whose time has come. It's a pet cause of free market conservatives, and it's included in both the Senate and House budget reconciliation bills. But the medical savings account proposal has had more than just philosophy behind it, as NPR's Peter Overby reports.

PETER OVERBY, Reporter: When House Speaker Newt Gingrich was teaching his for-credit college course in February of 1994, he gave one of his highest accolades to an advocate of medical savings accounts.

Rep. NEWT GINGRICH (R-GA), House Speaker: Maybe the most radical view in how to take care of health in America today and take care of health care. What do you think?

PETER OVERBY: That radical thinker was Patrick Rooney [sp], president of an insurance company called Golden Rule, a company that's counting on medical savings accounts for its financial health. Gingrich played his students a videotape of Rooney explaining how savings accounts would work.

PATRICK ROONEY: [excerpt from videotape] Have you ever heard of a sale on mammograms? Well, I never have. But if people were spending their own money, pretty soon, there would be clinics offering sales on mammograms to get the business because now the consumers are spending their own money. There would be nothing so powerful to control the cost of medical care as having 200 million Americans that started asking the price ahead of time.

PETER OVERBY: And now, less than two years later, medical savings accounts, or MSAs, are in both the House and Senate reconciliation bills, to be available to anyone in Medicare or under age 65. An MSA would let you opt out of conventional health insurance and get cheaper insurance covering just catastrophic costs, with a yearly deductible of $3,000 to $10,000. Below that amount, you'd pay medical bills yourself out of a tax-free savings account funded by your employer or, more likely, you. The less you spent from that account, the more you'd get to keep. Critics say MSAs would encourage people to put off medical care. They also say MSAs undermine the concept of group insurance, letting companies like Golden Rule sell MSAs to healthy people and leave the less healthy ones to managed care plans. That would drive up costs for managed care, which is why the congressional budget office said last week that MSAs in Medicare would cost the government money.

So how did MSAs move from radical notion to national policy? In large part, it was because of Patrick Rooney and Golden Rule. Deborah Soleil [sp], an analyst with a Washington think-tank called the Alpha Center for Health Planning, says that's because Golden Rule did not follow bigger insurance companies in the switch to managed care.

DEBORAH SOLEIL, Alpha Center for Health Planning: And large insurance explicitly did this in the '70s and '80s. They went off and developed HMOs, they developed managed care networks, and put a lot of money into doing that. So we've developed a kind of dichotomy in the business, and Golden Rule really represents the end of the business that has tried to maintain a conventional financial insurance business, without investing in, essentially, holding sick patients and managing their care cost effectively.

PETER OVERBY: Instead, Golden Rule invested in Washington. For a relatively small company, its political spending has been sizable and well-placed. According to Common Cause, the government watchdog group, Golden Rule's executives, their families, and the corporate political action committee, gave Newt Gingrich's campaign committee $42,000 between 1989 and 1994. Golden Rule supports the Progress and Freedom Foundation, the think-tank that produced Gingrich's college course. Rooney has given $117,000 to GOPAC, the political action committee connected to Gingrich. And, between 1993 and 1994, Golden Rule gave the Republican Party almost $524,000. Rooney could not be reached for an interview. Golden Rule has also helped to finance the National Center for Policy Analysis, a free-market think-tank that has long advocated medical savings accounts. And, Rooney has been on the center's board.

John Goodman, the center's president, says he thought of MSAs before Rooney came along. He says Golden Rule is just defending its business.

JOHN GOODMAN, Pres., National Center for Policy Analysis: I think fee-for-service medicine probably won't survive, no matter what Congress can do. And, in the future, people will probably have to go into managed care, where someone else restricts your choice of doctor access, or if you want to make those choices for yourself, you're going to have to manage some of your own health care dollars through a medical savings account, and that's where the market's going to go.

PETER OVERBY: And, according to Goodman, it was the MSA concept, not Golden Rule's Washington money, that sent medical savings accounts sailing through Congress this year. I'm Peter Overby in Washington.

Mr. MORAN. There are a lot of quotes from Peter Overby and Patrick Rooney, who is the owner of Golden Rule, and John Goodman. Those seem to be credible sources.

Mr. MICA. I would unanimously seek approval for that and anything else that should be part of the record, and I always keep our subcommittee open to any line of questioning. Sometimes I even go beyond the bounds of being proper on the floor, but we won't get that far.

Mr. MORAN. No, we're not going to get into that.

Mr. MICA. We will allow this, without objection.

Mr. MORAN. Actually, I think it's a response to some of the criticisms that have been made.

Mr. MICA. The other thing, too, Mr. Moran, you haven't been here. I have some of the same questions, because I have the same concerns. I've heard the questions raised about cherry picking or adverse selection, however you term it, and what would the impact be.

I think it was mentioned by either previous panelists or this panel that, in fact, some people with prior existing conditions did choose to stay in. I don't know of anyone who has testified where this has been the only choice offered. In fact, I think anywhere this has been done, they did, in fact, offer this as a choice.

I kept asking if there was any indication of any increase in premium, lessening of benefits to all of the panelists, trying to find some example. Now, granted, too, Mr. Ranking Member, that there doesn't seem to be a long-term track record for this, so we don't know.

But I hope you get a copy of Dr. Johnson's testimony and questions. I'm sure you will have it. I asked the same questions, too, about isn't this going to stop preventive care? In fact, I said, shouldn't you go to the doctor regularly and seek preventive medical attention? So I share the same concerns and raised some of the questions.

It has been a very interesting panel. I think we'll have some additional questions. We may want the opportunity, too—there are some groups that aren't represented, that we didn't hear from today, that should be heard, and we should hear their objections or their input as we move forward. But we do have a vote. Did you have any other final questions?

Mr. MORAN. No, that's fine. I'm glad that you raised those issues, as well, and I appreciate it, Mr. Chairman. I appreciate the fact that we're having a hearing on this.

Mr. MICA. The other thing, too, I would like to leave the record open at least for 2 weeks and invite groups—there were some folks that were here; I saw the NARFE, the National Association of Retired Federal Employees—representatives were here earlier. I would like them to raise any questions and also submit them to the panel members or previous panel members, and anything else that may be necessary be part of the record, because we would like a fair, full, and open hearing on this and see if it does have potential for being beneficial to our Federal employee health benefit program.

With that, we've had the second bell on this vote. I would like to thank our panelists and those who participated for your testi-

mony and for coming here and sharing with us your experiences. We look forward to working with you, and if you have additional information, without objection, that will be made part of the record. So we thank you again for your testimony.

I also have a statement from Mr. Moran, the ranking member, that will be entered without objection as part of the record.

[The prepared statement of Hon. James P. Moran follows:]

COMMITTEE
ON
GOVERNMENT REFORM
AND OVERSIGHT

SUBCOMMITTEE ON CIVIL SERVICE
RANKING MINORITY MEMBER

COMMITTEE
ON
INTERNATIONAL RELATIONS

SUBCOMMITTEE ON
INTERNATIONAL OPERATIONS
AND HUMAN RIGHTS

Congress of the United States
House of Representatives
Washington, DC 20515–4608

JAMES P. MORAN
8TH DISTRICT OF VIRGINIA

WASHINGTON OFFICE
405 CANNON HOUSE
OFFICE BUILDING
WASHINGTON, DC 20515–4608
(202) 225-4376

Statement of Representative James P. Moran
On Medical Savings Accounts
Subcommittee on Civil Service
December 13, 1995

Mr. Chairman:

I am concerned about today's hearing and the focus of the Subcommittee's inquiry into medical savings accounts. This Subcommittee should be an oversight and policy committee that carefully evaluates all facets of a particular initiative and carefully analyses the impact it will have on the federal workforce before acting.

Initially, if I recall correctly, this hearing was scheduled to tell federal employees about what Congress had passed in the Budget Reconciliation Act. The original plan for this hearing was to explain Medical Savings Accounts after they had been enacted rather than to evaluate them before making any policy decisions. Fortunately, these plans were defeated.

Now, this hearing is designed as a "pep rally" for Medical Savings Accounts rather than a review of whether or not such an initiative is appropriate for the Federal Employees Health Benefits Program. I hope nobody hear confuses this hearing with a substantive review of the initiative. No objective parties have been invited to testify at this hearing and no opponents of the Medical Savings Accounts. In addition, no party with even a limited knowledge of the Federal Employee Health Benefits Program has been invited to testify. OPM is not here, nor is the General Accounting Office, or the Congressional Budget Office. The structure of this hearing is absurd.

Medical Savings Accounts are the in vogue issue for the Heritage Foundation and its subscribers. We do not, however, enact policy in this Congress based on what one think tank thinks. This is particularly true when the initiative being considered affects 2 million employees and changes the scope of a health benefits program that the Heritage Foundation said should be the model for health care reform. The FEHBP program was not created to allow Congress to experiment with different ideological initiatives on a captive population. It was created to ensure that federal employees have adequate access to health care and to ensure that the government is able to recruit and retain the best employees. The program works because it is very

cautiously managed and very deliberate. We should not abandon those successful principles to validate an ideology.

I am not convinced that Medical Savings Accounts will be a positive addition to the FEHBP. I do not think the biased approach to this hearing today will convince me of otherwise. Unless we objective and reliable parties testify as to the value of this initiative, I do not think this Committee should go forward with this initiative unless and until we have complete and accurate information of the impact our actions will have on the employees and on the plan as a whole. This is too important.

I look forward to the testimony of our witnesses.

Mr. MICA. There being no further business to come before the House Civil Service Subcommittee, this meeting is adjourned.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

CONGRESSWOMAN CONNIE MORELLA
GRO SUBCOMMITTEE ON CIVIL SERVICE
OPENING STATEMENT: HEARING ON MEDICAL SAVINGS ACCOUNTS

I would like to thank Subcommittee Chairman Mica for convening today's hearing. I welcome this opportunity to learn more about Medical Savings Accounts as we determine whether they could be successfully incorporated into the Federal Employees Health Benefits Program. While Medical Savings Accounts could expand federal employees' health care choices, I am concerned that they could potentially weaken FEHBP's existing health insurance options.

The Congress has already included Medical Savings Accounts in the budget reconciliation package, and they have the potential to improve our health care system. Medical Savings Accounts encourage health care consumers to be smart shoppers and spend health care dollars wisely. They provide a pool of money that can be spent on preventative care, and they provide dollars that can be saved for long-term care. But it is important to recognize that the Federal Employees' Health Benefits Program is unique. It has a large percentage of federal retirees, and it is underwritten by multiple insurers. It is important that we evaluate the impact that MSAs would have on our existing plans before adding them as an option to the FEHBP.

FEHBP is widely regarded as one of the best group health insurance plans in the country, and FEHBP sets the standard for what an employer-sponsored health insurance plan should be. OPM is able to negotiate favorable contracts with hundreds of health insurance plans to offer a wide range of choices to FEHBP's 9 million beneficiaries. While some federal employees may benefit from a Medical Savings Account, it is critical that we do not compromise the current program to add a new health insurance option.

I have concerns that the inclusion of MSAs in the FEHBP could lead to a two-tiered health care system in which very healthy recipients pay little for their care, and those who are less healthy are forced to pay higher premiums for expensive care. If the healthiest in the system opt for MSAs, the risk pool will shrink, and insurance carriers may raise their premiums or drop out of FEHBP. Adding MSAs will have a ripple effect on all of the other insurers, and I worry that many will drop FEHBP or raise their premiums.

I also have concerns about the catastrophic plans issued to those using MSAs. It is not clear what health expenses will go toward the deductible, what the catastrophic package would include, and what its co-payment would be. In the case of medical emergency, the catastrophic plan may not be such a good deal after all. I also worry that MSA enrollees will forgo preventative health care in order to save their money for other things, as those who have MSAs are

not required to spend the money on health care costs at the end of the year. Preliminary CBO estimates have indicated that the Medical Savings Account provisions would be costly, and I also ask that today's witnesses address the issue of cost.

Before adding Medical Savings Accounts as an option to FEHBP, it is critical that these concerns are addressed. I hope that today's witnesses will speak to the issues of adverse selection, the catastrophic plan, the cost of MSAs to the federal government, and the likelihood that recipients will forgo health care. I look forward to a continuing dialogue to examine the benefits and potential problems associated with the inclusion of MSAs in FEHBP.

JOHN N. STURDIVANT
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. Chairman and members of the Subcommittee: My name is John Sturdivant, and I am the National President of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 700,000 federal and District of Columbia employees our union represents, I thank you for the invitation to testify on the question of whether the Federal Employees Health Benefits Program (FEHBP) should include the option to set up a Medical Savings Account (MSA).

Medical Savings Accounts were first proposed as a solution to the problem of the uninsured during the ill-fated 1993 debates on national health care reform. The idea was to allow the uninsured to pay for health care costs out of tax-free money set aside in a special account designated solely for this purpose. In that context MSAs were merely a woefully inadequate response to the shameful fact that, according to the most recent Census Bureau figures, some 40 million Americans -- over 15 percent of the nation-- have no health insurance.

Today it seems that the momentum behind the campaign for the establishment of MSAs has more to do with the belief in simplistic free-market, individualized answers to every public policy question. The ideology is apparently so sacred that its adherents are willing to sacrifice efficiency and cost-containment, ideals they otherwise profess to value above all others. In the case of introducing MSAs into FEHBP, these ideals as well others would surely be compromised.

Medical Savings Accounts: An Invitation to Adverse Selection

The free market promotes efficiency and cost minimization in many instances, but in the case of health care, the free market is a notorious failure in many respects. Before the role of the federal government in purchasing and regulating health care markets degenerates into the issuing of vouchers, it is necessary to restore an understanding of the limitations of the market in efficient resource allocation.

The concept of group insurance has always been anathema to free-market adherents. At the very heart of the faith in the free market system is the belief that individualized consumption is the only type of consumption that maximizes one's well-being. Compulsory participation in a group endeavor like insurance is seen as oppressive, preventing the individual from pursuing his view of his own best interests. In this vein, those who believe that free market solutions are optimal oppose public schools, Social Security, publicly-funded mass transit, and many other publicly-funded goods and services.

To free-market purists, group health insurance is a particularly problematic example of coercive, collective consumption. While many individuals might voluntarily sign up for group health insurance, there are always some who would prefer to go it alone. But this is where the market fails. Once low-risk individuals are permitted to quit the group, the group's average risk rise. Premiums, which reflect average risk, rise as well. This is a type of market failure called "adverse

selection," which occurs "when those most likely to receive benefits from the insurance are the ones who are most likely to purchase it." (Harvey Rosen, Public Finance 3rd Edition, 1992, Richard D. Irwin: Homewood, Illinois, p.597).

Thus a vicious cycle is born. As adverse selection raises premiums, the cash inducement to quit the group (which is the difference between the catastrophic back-up premium and the maximum government contribution to regular insurance premiums) will rise, encouraging more individuals to quit. The stubborn remainders in the group insurance pool will be those with manifest high risk, and the premiums charged to them will reflect this.

The government's willingness to maintain its contribution levels to these premiums will likely wane and what will have been accomplished is the replacement of managed competition among group insurance plans with MSAs or vouchers. Federal workers will no longer have employer-sponsored group health insurance coverage. They will begin the year with a little extra cash, but according to the calculations of the Congressional Research Service, they will almost inevitably be financially worse off at the end of that year than if they had been in a traditional FEHBP plan financed at rates currently in effect.

FEHBP Costs will Rise as a Result of MSAs

Despite the fact that MSAs will leave almost all federal employees financially worse off, the costs to the government of

operating FEHBP will rise. Adverse selection costs money. Virtually all the negative effects of medical savings accounts can logically be traced to competitive health care markets' natural tendency toward adverse selection. It is worth enumerating these effects separately in order to understand just how insidious they are.

First and perhaps most ironic is that MSAs deprive the FEHBP of its ability to use its huge purchasing power to maximum advantage in negotiating with health plans. Although proponents of MSAs are often the same individuals who have quite recently extolled the virtues of managed care health insurance arrangements, the economic gains from managed care would be the first casualty of any proliferation of medical savings accounts.

All the gains from aggressive negotiating on price and coverage with managed care insurance carriers are lost to those with an MSA. Proponents envision individuals shopping around freely for the best deal they can get, comparing price and quality from a multiplicity of providers. But the reality is something quite different.

Indeed, the idea of Medical Savings Accounts is best understood as one more step in the continuing process of shifting costs and responsibilities for health care away from employers onto workers. As health care costs have risen at rates which far exceed the general rate of inflation, employers have responded by reducing the scope of employer-paid health insurance benefits. Thus over the past two decades, more and more workers have been

forced to shoulder a larger share of premiums, and higher deductibles and co-payments. At the same time, restrictions on utilization have been introduced under the broad heading of managed care: Under these terms, refusal to acquiesce to the rationing decisions of health care managers has meant paying for care independently, with no subsidy from the health plan or the employer.

Managed care can be and has been a success in cases where there is an explicit trade-off between restrictions on choices among providers and an expansion of benefits, lowering of co-payments, and a reduction in premiums. That people are willing to accept limitations on their choice of providers in exchange for more comprehensive benefits and lower out-of-pocket costs argues for expanding insurance coverage as a means of controlling aggregate health care spending. Medical savings accounts, however, move us in the exact opposite direction.

In addition to the lost opportunities for cost savings from rate negotiations with providers, medical savings accounts create incentives to forgo preventive care and delay treatment. Under MSAs, the behavioral incentives would be identical to those of the uninsured, only stronger because the money not spent on health care would be tax-free. Consumers would delay medical treatment until it was absolutely necessary, a practice which has been shown to be more costly in terms of dollars and health outcomes than regular preventive care and diagnosis and treatment in the early stages of disease.

Another likely outcome of the financial incentives created by MSAs would be to "game" the system. OPM has warned that continuing the annual open season in the context of an MSA option would invite enrollees to join a traditional plan any year when they would anticipate health care costs greater than or equal to the "high" deductible in under the MSA plan. This would only exacerbate adverse selection in FEHBP and compound the extra costs that the MSAs would impose on other enrollees in the system.

The cost impact of this gaming of the system is likely to be considerable. It is already possible to exploit the fact that FEHBP plans offer dissimilar benefits, encouraging workers to switch from plan to plan depending on the particular type of service they may need in a particular year. CRS found in 1989 that the lack of uniformity among FEHBP plans imposed costs on the system from this type of behavior, and they recommended standardization of benefits in order to forestall it. But MSAs would create an even greater incentive than now exists. It is not difficult to imagine someone waiting until after a new open season to schedule non-emergency surgery or even spacing out regular check-ups or treatments over a thirteen-month interval in order to preserve the cash in a medical savings account.

Not only would the introduction of MSAs worsen the rate of growth of costs of the FEHBP, it creates its own new costs. AFGE finds it odd that after a year of relentless assaults on the pay and benefits of federal employees and retirees in the name of

cost-cutting that Congress would want to create new compensation costs through the introduction of MSAs into the FEHBP. Under the current financing formula for FEHBP, CBO estimates that MSAs would cost FEHBP $1.5 billion over seven years. This is a conservative estimate which uses a set of very optimistic, perhaps unrealistic assumptions. In order to arrive at this low cost figure, CBO assumed that there would be no lag between claims or cost increases and premium increases.

But it would be a mistake to assume that individual insurance carriers can predict with accuracy how the exit of some fraction of their enrollees or their potential reentry in subsequent years might impact on insurance claims. Choice among dissimilar plans leads inevitably to adverse selection, and adverse selection inevitably imposes aggregate cost increases. CBO does not dispute this fact, but has not accounted for it in its $1.5 billion cost estimate.

The CBO estimate also ignores the possible revenue impact of the introduction of MSAs as well as the impact of Medicare cuts on the premiums in FEHBP. These latter costs are likely to increase the incentive for the healthiest, lowest-risk segments of the FEHBP population to choose MSAs. The proposed Medicare cuts will shifts greater responsibility for retiree health care costs onto the FEHBP, raising both total and average costs.

The Benefits of Medical Savings Accounts are Regressive

One of the features of MSAs which is meant to encourage their use is the right of an individual to keep and invest the tax-free money deposited on his behalf. While presumably the tax-free status of the funds in MSAs is meant to mirror the tax-free status of the compensation represented by employer-paid health insurance premiums, there is a difference. An annual health insurance premium is completely used up in any given year regardless of whether the individual uses that insurance policy to pay for health care costs. Its "value" to the individual is not known until the end of the year and depends as much on health status as on income. The cash deposited in an MSA, if unspent at the end of a year, becomes a tax-free lump sum owned by the individual for whom it was deposited. Its value is a function of the individual's income tax rate.

The value of an MSA to an individual federal employee who incurred no health care costs and was in a 28 percent income tax bracket and who itemizes his deductions is greater than it is for the federal employee, say a GS-5, who is in the lowest tax bracket and who does not itemize. The regressive nature of this differential is reason enough for AFGE to object to the introduction of MSAs into the FEHBP.

In the same way that the incentive and reward for choosing an MSA is greatest for those with the highest incomes, the cost to the government in terms of lost tax revenue is highest for this group as well. Currently the government's costs for its

contributions to FEHBP are unrelated to the worker's income: premium contributions are the same for GS-15s as they are for GS-2s. With MSAs, it is as though the government were giving the GS-15s a 15 percent higher health insurance benefit along with his income differential. AFGE opposes these regressive measures.

Because MSAs are only a prudent option for the highest income federal employees, AFGE also fears that their introduction will serve to reduce support for the FEHBP among the entire federal employee population. Currently all federal employees, from the rank and file General Schedule and Federal Wage System workers to high-level political appointees have a stake in the integrity of the FEHBP. MSAs will fracture support for the FEHBP along the lines of income, turning it into an increasingly expensive program serving a decreasing and lower income constituency. It will thus be ever-more vulnerable to further cuts in funding and oversight.

Unanswered Questions

The idea of introducing Medical Savings Accounts into the FEHBP raises several questions which need to be fully considered before their real impact can be foreseen. Some are basic: What benefits would be in a catastrophic plan? Would these benefits be subject to change or would they be a standard package? Would there be a choice among catastrophic plans? Would the catastrophic plan be entirely paid for by the government? Would

there be a cap on the dollar value of the government's catastrophic premium payment?

If costs rise in the traditional "low deductible" plans as a result of the introduction of MSAs as we have predicted, will the government's contribution to these traditional plans be augmented to compensate? If costs rise in the traditional "low deductible" plans as a result of the introduction of MSAs as we have predicted, is the government committed to maintaining its 100 percent catastrophic premium payment?

AFGE believes that MSAs are a potential administrative nightmare for the Office of Personnel Management. In effect, MSAs would function like thousands and thousands of individual self-insured plans that OPM would be required to administer and oversee. For example, would there be explicit restrictions on what constitutes a "qualified" disbursement from the MSA? Which types of health care expenditure would be "covered?" Would abortion services be allowable? Would it be constitutional to deny disbursements for abortion services or to refuse to count these expenditures toward the deductible? Is OPM equipped to make these decisions?

If part of the point of MSAs is to expand the freedom of federal employees to design their own unique insurance plan, on what basis could non-mainstream health care services be denied? Would experimental therapies count against the deductible? Would visits to a homeopathic practitioner count against the deductible? Is OPM equipped to make these decisions?

Centralizing, rationalizing and administering decisions like these constitutes a large part of what makes traditional group insurance more efficient and less costly than individualized arrangements. With every health care dollar being so precious, we cannot afford to waste money on dubious experiments like medical savings accounts.

Conclusion

AFGE opposes introducing medical savings accounts into the FEHBP. They will raise costs for the program, and the burden of these inflated costs will be borne by those least able to afford it: the elderly, the ill, young families, and low-income workers. Medical Savings Accounts are inefficient and costly, and should not be distributed as an extra bonus to those already blessed with good health and high income.

The FEHBP has been held up as a model employer-sponsored health insurance program on the basis of its success in using competition among similar plans to hold down costs in recent years. Introducing MSAs into FEHBP would rob the program of this strength and we urge you to abandon this proposal.

TESTIMONY OF
ROBERT M. TOBIAS
NATIONAL PRESIDENT

Mr. Chairman, Members of the Subcommittee,

I am Robert Tobias, National President of the National Treasury Employees Union (NTEU). Thank you for this opportunity to share the views of the more than 150,000 members of NTEU on the possibility of Medical Savings Account (MSA) options under the Federal Employees Health Benefits Program (FEHBP).

As you know, the FEHBP provides health insurance coverage to more than nine million federal employees, retirees, and their dependents. While the federal health program certainly has its flaws, since 1959 it has provided solid health coverage options to the federal community and has been held out by some in this body as an example, or model that a national health care plan might emulate.

The respected 1989 Congressional Research Service study of the FEHBP continues to offer the most complete analysis of the federal health plan. (The Federal Employees Health Benefits Program, Congressional Research Service, May 24, 1989) The CRS study concluded that perhaps the biggest problem with the FEHBP is one of risk segmentation. Risk segmentation occurs when plans compete for enrollees, not through efficiency and reduced costs, but by attempts to repel those potential enrollees who might require expensive health care. The study goes on to say that premiums for

plans in the FEHBP continue to be little reflection of the value of benefits offered by a particular plan, but rather are a reflection of the enrollees of that plan. In the opinion of this Union, efforts to alter the FEHBP, such as through the addition of an MSA option, could have the unintended effect of exacerbating existing risk segmentation problems within the program.

The premise behind MSA's is that they allow consumers to choose a health care option with a high deductible that provides coverage for catastrophic medical expenses only above a certain level. The consumer would also receive a pool of money to be used for medical expenses of his or her choosing. Medical expenses incurred over and above this pool of money, but below the level at which the catastrophic coverage becomes available would be the responsibility of the medical consumer. If the pool of money is not spent, it can usually be rolled over and used the following year, or even revert to the consumer for personal use . While this might provide some medical consumers with a greater financial stake in purchasing their health care, in the FEHBP it is likely to expose health care consumers to greater health care costs in the future.

If an MSA option were made available under the current FEHBP, the healthiest individuals would be most likely to choose this approach. Those health care consumers choosing to remain in traditional health care plans with lower deductibles would logically be the less healthy and elderly FEHBP participants. In a relatively short period of time, the per person premiums for the

low-deductible, traditional FEHBP plans would necessarily increase, and eventually could be expected to soar out of reach for most federal employees and retirees.

An October, 1995 study by the American Academy of Actuaries probably summarizes our concerns best. The Actuaries' report concluded that if medical savings accounts were adopted for all Americans, the sick and the elderly would be hurt. Conversely, the young and the healthy would be better off. Since 1959, the FEHBP program has attempted to provide health coverage at reasonable rates for the entire federal community -- young families, the elderly, the healthy and the frail. Any effort to alter this basic premise will not have the support of this Union. Yet, absent other dramatic changes in the basic operation of the FEHBP, it is difficult to imagine how the addition of MSAs could avoid this very same effect envisioned by the American Academy of Actuaries.

Conventional health plans participating in the FEHBP would find themselves caring for the old and the ill. Young and healthy individual federal employees and their families would be attracted to the possibility of the extra cash that MSA's would offer. This would allow insurance carriers to practice the very worst kind of health care practice -- often referred to as cherry picking -- seeking only those risks that are considered to be the best risks. There is little question that this would upset the delicate balance inherent in the FEHBP and perhaps lead to the demise of the FEHBP as it currently exists.

The combination of MSA's and the annual FEHBP open season could place a strain on the program of unimaginable proportions. Enrollees would be tempted to join a traditional health care plan in years in which they anticipated high health care needs. Once the needed health care procedures were completed, these same individuals would have an incentive to join the MSA option the following open season. This practice cannot help but wreak havoc with the FEHBP. Some observers have suggested that these problems can be combated by imposing waiting periods or pre-existing condition requirements on the FEHBP. However, the addition of restrictions such as these would destroy yet another strength of the FEHBP and would certainly not have the support of this Union.

Furthermore, it is not inconceivable that federal workers or retirees currently enrolled in MSAs, upon discovering that they require a particular medical service might wait for the next open season to switch to a traditional medical plan and thus avoid using their own "banked health fund" for the procedure. The issue of consumers delaying health care treatment until absolutely necessary, (or in this case until the next open season) has been shown time and again to add untold costs both in terms of dollars and health outcomes to medical spending in this country. I seriously question whether this is the direction in which we want to take the FEHBP.

Yet another aspect of MSAs which must be considered is the

possibility that they may deprive the FEHBP of its ability to use its purchasing power to maximum advantage both in negotiating with health plans and in taking advantage of the large managed care component currently operating in the FEHBP. HMO and PPO networks currently provide major cost savings in the FEHBP. According to the Office of Personnel Management, PPO networks in the FEHB in the 1994 contract year alone reduced medical expenses in the program by $1.3 billion. These savings were realized in large part because of the access provided these medical providers by the large employee and retiree group assembled under the FEHBP. It is difficult to imagine that these discounts would not erode as some FEHBP enrolles choose MSA coverage and the size of the group is reduced. This would be particularly true if enrollees remaining in the traditional FEHBP plans were less healthy than those removed from the group, as would likely be the case with MSA participants.

In conclusion, although we have not been asked to comment on a specific legislative proposal, it is doubtful that the National Treasury Employees Union could support the addition of Medical Savings Accounts to the current FEHBP. It is difficult to see the addition of MSAs as an advantage to the current program and, at a minimum, much remains to be learned concerning the potential impact MSAs would have on current FEHBP participants -- the healthy as well as those less fortunate. Much remains to be learned before such a move can be considered.

Thank you again for this opportunity to share our views.

NTEU
The National Treasury Employees Union

NEWS

FOR IMMEDIATE RELEASE
December 13, 1995

CONTACT: (202) 783-4444
Jim Watkins, Ext. 2604
Kathy Walsh, Ext. 3747

MEDICAL SAVINGS ACCOUNTS COULD 'WREAK HAVOC' ON FEHBP
NTEU SUPPORTS SOLID HEALTH COVERAGE FOR FEDERAL COMMUNITY

Washington, D.C. -- National Treasury Employees Union (NTEU) President Robert M. Tobias said adding Medical Saving Accounts (MSA) to the Federal Employees Health Benefits Program (FEHBP) could "wreak havoc" on the highly successful program.

In testimony submitted today to the House Subcommittee on Civil Service, Tobias said the combination of MSA's and the yearly FEHBP "open season" could place a strain on the program of unimaginable proportions.

"Enrollees would be tempted to join a traditional health care plan in years in which they anticipated high health care needs. Once the needed health care procedures were completed, these same individuals would have an incentive to join the MSA option the following open season. This practice cannot help but wreak havoc with the FEHBP," said Tobias.

While there are those who suggest that these problems can be combated by imposing waiting periods or pre-existing condition requirements on FEHBP, Tobias said the addition of these type of restrictions would "destroy yet another strength of the FEHBP and would certainly not have the support of this Union."

(OVER)

The premise behind MSA's, noted Tobias, is that they allow consumers to choose a health care option with a high deductible that provides coverage for catastrophic medical expenses only above a certain level. He said the consumer would also receive a pool of money to be used for medical expenses of his or her choosing. If the pool of money is not spent, it can usually be rolled over and used the following year, or even revert to the consumer for personal use.

An October 1995 study by the American Academy of Actuaries, said Tobias, concluded that if MSA's were adopted for all Americans, the sick and elderly would be hurt, while the young and healthy would be better off.

"Young and healthy individual federal employees and their families would be attracted to the possibility of the extra cash that MSA's would offer. This would allow insurance carriers to practice the very worst kind of health care practice -- often referred to as cherry picking -- seeking only those risks that are considered to be the best risks. There is little question that this would upset the delicate balance inherent in the FEHBP and perhaps lead to the demise of the FEHBP as it currently exists," said Tobias.

"Since 1959, FEHBP has attempted to provide health coverage at reasonable rates for the entire federal community -- young families, the elderly, the healthy and the frail. Any effort to alter this basic premise will not have the support of this Union," said Tobias.

-30-

The American Psychiatric Association

The American Psychiatric Association (APA), a medical specialty society representing more than 40,000 psychiatric physicians nationwide, is pleased to present this statement for the "Medical Savings Accounts in the Federal Employee Health Benefits Program" hearing.

I. APA's Position on Health Insurance Reform Legislation

The APA's efforts with respect to health care legislation are guided by 12 principles approved by the APA Assembly of District Branches and the Board of Trustees (See Attachment A). For purposes of today's testimony, three of those principles form the core of our views at today's hearing:

1) Non-Discriminatory Coverage of Treatment for Mental Illness

APA's overarching objective is to seek the elimination of any and all arbitrary limits on scope, coverage, duration, or patient cost-sharing of treatment for mental illness, including substance abuse. We believe there is no rationale or justification for imposing any such limits based on the patient's diagnosis. Psychiatric patients -- like all other patients requiring medical treatment -- should have access to the full array of services available for their treatment throughout the full continuum of care, including inpatient, outpatient, partial hospitalization, and home and community-based services, as the patient's medical and clinical needs require. These services should be included as a uniform health benefit in <u>any</u> health care reform proposal, subject only to the same scope and duration, cost containment, and reviews/protocols as are applied to non-psychiatric medical illness.

2) The Right to Seek Treatment from the Physician of Choice

Under <u>any</u> health care plan, patients should be guaranteed the right to seek treatment from their physician (or other health provider) of choice. There are numerous reasons patients need the ability to see a provider outside of their regular insurance plan. For psychiatric patients, for example, confidentiality is often a leading reason prompting patients to seek treatment outside any approved network of providers, since they wish to ensure that no record -- including no claims form -- is registered when treatment is initiated.

APA believes that there are two simple and effective means available to the Congress to ensure that patient freedom of choice is protected. First, patients should be given at least the option of electing a point-of-service feature at time of enrollment in their health plan. A reasonably designed point-of-service feature -- without deliberately penurious cost sharing by the health plan -- would allow health plans to encourage their enrollees to stay within the designated provider network, but give patients the freedom to seek care when needed or desired outside the network. Second, "private contracting" for medical services would allow patients the freedom

to seek treatment with any provider -- at no cost to the health plan -- while maintaining absolute confidentiality of medical history and patient data.

3) Protection Against Abusive Managed Care Tactics

The patients of psychiatrists, perhaps more than any other medical patients, are subjected to unwarranted and unreasonable managed care practices designed simply to frustrate -- through inappropriate intrusions, requirements and administrative burdens -- the efforts of these patients to seek and receive medically necessary care. Health insurance reform legislation should include a variety of patient and provider protections against egregious and abusive utilization review and patient care management tactics used by some managed care companies.

Some of the most abusive managed care tactics psychiatrists have confronted include: gate keeping and financial incentives used to clamp down on access, claims denials with no appeal, failure to make utilization review criteria and treatment protocols/ screens publicly available, inappropriate specialists/patient ratios, utilizing "economic credentialling" -- lowest utilization and lowest use of high tech or costly procedures -- as a criteria for provider participation in networks, "gag rules" which prohibit advising patients of any limitations on providing treatment, and arbitrarily decertifying providers from networks when those providers advocate for additional coverage authorization for their patients. In order to guard against these practices, APA recommends that any health insurance reform legislation include meaningful patient and provider protection standards such as those articulated in our attached model managed care and utilization review legislation (Attachment B).

II. Medical Savings Accounts Legislation

While Medical Savings Accounts (MSA)s are not in and of themselves an answer to all of the problems confronting health care planners and policy makers, we believe that they are an important health care option which -- if properly designed -- will provide consumers with greater choice, quality, flexibility and affordability in health care. Incorporating MSAs into the Federal Employee Health Benefits Program (FEHBP) would allow Federal employees and their dependents to manage their health care in a cost-effective manner and would relieve them from paying administrative and profit charges to a third party.

For example, MSAs would bring market forces to bear by encouraging patients to "shop" carefully for the health care plan which best meets their anticipated health needs. Patients would now be financially responsible for managing their own health care dollars, not simply passing health costs on to a third party payor.

We believe that this would result in a reduction in unnecessary care and potentially significant cost savings as Federal employees spend their own discretionary -- not third party -- health care dollars.

MSAs offer great potential in addressing each of APA's stated objectives in health insurance market reforms.

First, to the extent that an individual health plan inappropriately imposes -- because of stigma rooted in fear and ignorance -- arbitrary limits on the scope, duration and coverage of treatment for mental illness, or on the cost sharing required of a patient, MSAs will allow individuals to offset such discriminatory coverage out of tax-preferenced savings. While we reiterate that we believe there is no justification for such limits, MSAs would at least provide a bridge between current coverage limits and the eventual achievement of non-discriminatory coverage of treatment for mental illness. "Prudent purchasers" of health insurance could also be assured of a lifeline against unexpected costs in the event of a sudden onset of severely disabling psychiatric illness.

Second, MSAs dovetail effectively with APA's recommendation of support for point-of-service and "private contracting" for health care services. Both options emphasize consumer freedom-of-choice and individual consumer responsibility. Use of a MSA to cover the additional out-of-pocket costs to consumers maximizes market freedom without financially punishing patients for exercising their rights to select their health provider of choice.

Third, MSAs would provide a critical safety valve to offset the excesses of abusive utilization review and subsequent patient care denials by behavioral health care companies or other managed care operations which are too-often interested in cutting outlays at the expense of medically necessary patient care. Patients would have a lifeline to needed care with their preferred provider, even if they are denied treatment by their managed care companies. MSAs would also allow patients to receive treatment pending resolution of appeals of claims denials without having to choose in the interim between their physician and their next meal, for example.

III. General Design of MSAs

APA believes that an FEHBP MSA plan should be required to meet several key Federal standards. These include:

1) Definition

For purposes of tax deductibility, MSAs should conform with the current Internal Revenue Code definition of "medical expense", a clear-cut definition of "medical care". As we understand Internal Revenue Code, it defines medical care as

those amounts paid for, among other key factors, the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, as well as prescription drugs and biologicals. We urge that this broad definition be retained with respect to MSAs.

2) Reimbursement Standards

MSA plans should be required to reimburse providers at a standard rate. We suggest a payment floor set at the average local FEHBP provider usual, customary and reasonable payment rate as a viable standard. If the FEHBP MSA includes no payment standard, there is a serious risk that the catastrophic coverage component will set rates arbitrarily and deliberately low, through some self serving inappropriate fallacious standard, thus effectively denying patients access to quality medical care. We note that a reasonable reimbursement requirement is in conformity with current Majority thinking as evidenced by a similar requirement in the conference agreement on Medicare reconciliation.

3) Tax Treatment of MSA Contributions

FEHBP beneficiaries selecting the MSA option should be entitled to make contributions to the MSA using pre-tax dollars. This is simply in conformity with current tax treatment of "employee health spending accounts" in the private sector. Federal employees and their qualified dependents should be accorded the same right to make their contributions with pre-tax dollars. Further, we urge the Congress to specify that Federal employees may contribute pre-tax dollars to the MSA up to the current Internal Revenue Code limit on "employee health spending/savings accounts", not just to the level of the average employee share of the typical FEHB plan. This provides a meaningful incentive to Federal employees at all income levels to select the MSA option.

4) Allowable Expenses

As noted, we believe that the definition of "medical care" for purposes of MSA distributions be conformed to current applicable Internal Revenue Code definitions. Further, all out-of-pocket expenses incurred prior to the triggering of the catastrophic plan should be reimbursable from the MSA, including medical expenses beyond whatever the specified coverage limits are in the average or typical FEHB plan. For example, if the typical FEHB plan limits coverage of outpatient psychiatric services to 20 visits, the limit should not apply to reimbursable expenses from the MSA. If this provision is not included, individuals selecting the MSA option precisely to ensure that they will have specific out-of-pocket expenses covered may suddenly find that they have the limit they sought to escape reimposed through the back door.

5) Risk Pooling & Reinsurance Requirements

APA believes that there may be some initial risk of adverse selection if Federal employees perceive MSAs as a means of guaranteeing coverage of health care services that are, in the traditional FEHB program, subject to limits on scope and duration, or differential patient cost sharing. To guard against threats to solvency, APA believes that the Congress should impose reasonable reinsurance requirements on MSAs, and should also facilitate risk pooling between various MSA plans in order to minimize the risk of insolvency.

6) Coverage Requirements for Catastrophic Plans

APA recommends that Congress require MSA catastrophic plans to cover all medical conditions. Absent a meaningful coverage requirement, APA is concerned that MSA/catastrophic plans may "cherry pick" by deliberately excluding specific illnesses or conditions.

IV. Conclusion

There are a wide range of options for coverage of treatment of mental illness in the current FEHBP system and APA believes that MSAs properly designed, subject to the recommendations we have made in this testimony, offer an important adjunct benefit. While MSAs would not in and of themselves end discrimination by diagnosis in coverage of psychiatric patients within the FEHB program, they would help reduce the financial burden our patients must routinely address.

While APA continues to urge the Congress to end all health insurance discrimination against our patients, APA believes in the near-term, MSAs could be a significant step in the right direction.

Attachment A

THE AMERICAN PSYCHIATRIC ASSOCIATION

RECOMMENDS THE PURSUIT OF THE FOLLOWING PRINCIPLES AS PART OF NATIONAL HEALTH CARE REFORM

The American Psychiatric Association views national reform of the health care system as an opportunity to correct historic inequities in access to health care, particularly for the mentally ill. Transition to the new system must accommodate the needs of identified vulnerable populations, especially the third of the 37 million uninsured under the age of 18, the working poor, the mentally ill homeless, and minorities. The reform must provide quality of care, medically necessary, appropriate, and cost-effective treatment of mental disorders, and prevent harm to patients.

The following principles shall apply to national health care reform:

1) We shall first advocate for nondiscriminatory coverage of all medical disorders including mental illness (which includes substance abuse) for any medically necessary treatment under health care reform legislation. Uniform benefits in all fifty states for the treatment of mental illness should assure universal coverage and should be equal to other medical illnesses with respect to dollar limits (annual and lifetime), deductibles, coinsurance, and stop-loss provisions. Rather than arbitrary limits on hospital days or outpatient visits, professional standards should govern the intensity and duration of treatment.

2) We recommend *consideration* of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.

3) We shall relentlessly pursue, at state or federal levels, non-discriminatory catastrophic coverage for patients with severe mental illnesses, irrespective of the basic defined benefit.

4) As the professional organization responsible for the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, we urge adoption of a definition of severity that is based not only on diagnosis, but also on other criteria, including duration, danger to life (self or others), *pain*, interference with functioning, and interference with emotional and mental development in children and adolescents. The definition should be applicable, on a case by case basis, to severe cases of both Axis I (including substance abuse) and Axis II mental disorders in children, adolescents, and adults, including the elderly.

5) Utilization management should be no more stringent for mental illness than for other medical illnesses and should incorporate safeguards against clinically unrealistic, inefficient, abusive or unethical review practices. A mechanism for impartial appeal of decisions is essential. Utilization management procedures must protect the physician-patient relationship to avoid harm to the patient. The quality of care should be carefully monitored in all payment systems, in a timely fashion.

6) Provision must be made for cost-effective preventive services.

APA Principles of Health Care Reform - page 2

7) Provision must be made for appropriate continuing care for severe mental illness.

8) We advocate access to individualized treatment in the most clinically appropriate and cost-effective environment. Funding, therefore, should be available for treatment in the full continuum of scientifically-based psychiatric treatment modalities.

9) The APA is able to support budget targets which include fair and equitable reimbursement for the diagnosis and treatment of mental illness. We oppose the incorporation of undefined "global budget targets" as part of health care reform.

10) Insurance coverage must be uninterrupted. Pre-existing illness must not be a barrier to enrollment in health insurance coverage. Premiums shall be community-rated without reference to previous history of illness.

11) We affirm the historic principles underlying patient care: The preservation of confidentiality, the privacy and security of sensitive personal information and the freedom of patients to select their own physicians in organized systems of care.

12) Patients shall be allowed to contract for care at their own expense outside the system.

9/12/93

Attachment B

American Psychiatric Association

1400 K Street, N.W., Washington, D.C. 20005 • Telephone: (202) 682-6000

DISCUSSION DRAFT
"THE PATIENT PROTECTION IN UTILIZATION REVIEW AND MANAGED CARE ACT"

APA STATEMENT: The attached proposed bill, "The Patient Protection in Utilization Review and Managed Care Act," is a staff-developed discussion draft. In response to the growing concern among patients and health care providers about the problems associated with what is typically unregulated utilization review and managed care, this draft bill was developed in an effort to initiate physician member participation in the legislative process and respond to these problems. This draft bill does not represent policy or proposed policy of this organization. As an amalgam of ideas for addressing deficiencies in the utilization review process, it is a draft document for discussion and debate.

SUMMARY: All non-hospital affiliated entities performing utilization review or managed care are to be regulated through a certification/registration process under the state Secretary of Health and the Commissioner of Insurance.

KEY PROVISIONS

- Requirement that private review agents provide patients and providers with its utilization review or managed care plan, including review criteria, standards and procedures.
- No determination adverse to patient or provider vis-a-vis necessity or justification for any hospital, medical or other health care service may be made without prior evaluation and concurrence by a physician.
- Any determination resulting in denial of reimbursement or pre-certification must include evaluation, findings and concurrence of physician trained in the relevant specialty.
- Prohibition of incentive or contingent fee arrangement based on the reduction of health services.
- Requirement of nondiscriminatory utilization review of treatment of medical/physical and mental illnesses.
- Private review entities must have policies and procedures to ensure compliance with state and federal confidentiality laws, protecting medical records.
- Aggrieved patient or provider given the right to file a complaint alleging a reviewer's failure to comply with requirements of law and/or regulations. Judicial appeal available.

American Psychiatric Association
1400 K Street, N.W., Washington, D.C. 20005 • Telephone: (202) 682-6000

DISCUSSION DRAFT

STATE OF _____

LEGISLATIVE ASSEMBLY

BILL NO. _____

AN ACT TO PROVIDE FOR THE PROTECTION OF PATIENTS' HEALTH CARE MADE AVAILABLE THROUGH PRIVATE UTILIZATION REVIEW AGENTS AND MANAGED CARE SYSTEMS BY A CERTIFICATION PROCESS AND PUBLIC DISCLOSURE OF CERTAIN INFORMATION ABOUT THEIR ACTIVITIES.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF _____ :

Section 1. Short title.

This Act may be cited as "The Patient Protection in Utilization Review and Managed Care Act," hereinafter "the Act."

Section 2. Purposes.

The Legislative Assembly hereby finds and declares that the purposes of this Act are to:

(A) Promote the delivery of quality health care in a cost effective manner;

(B) Foster greater coordination between health care providers, third-party payors and others who conduct utilization review and managed care activities;

(C) Protect patients, employers and health care providers by ensuring that private review agents are qualified to perform utilization review and managed care activities and to make informed decisions on the appropriateness of medical care.

(D) Protect patients' health care interests through public access to the criteria and standards used in utilization review and managed care activities;

(E) Ensure the confidentiality of patients' medical records in the utilization review and managed care activities in accordance with applicable state and local laws; and

(F) Provide for nondiscriminatory utilization review of treatments for all illnesses, without regard to whether an illness is classified as medical/physical or mental.

Section 3. Definitions.

For purposes of this Act:

(A) "Certificate" means a certificate of registration granted by the Secretary to a private review agent.

(B) "Commissioner" means the Commissioner of Insurance.

(C) "Health care provider" means any person, corporation, facility or institution licensed by this state to provide health care services, including but not limited to a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist or psychologist, and officer, employee or agent of such provider acting in the course and scope of employment or agency related to health care services;

(D) "Health care services" means acts of diagnosis, treatment, medical evaluation or advice or such other acts as may be permissible under the health care licensing statutes of this state;

(E) "Physician" means a person licensed to practice medicine in all of its branches;

(F) "Private Review Agent" means a nonhospital-affiliated person or entity performing utilization review or managed care that is either affiliated with, under contract with, or acting on behalf of:

(1) A business entity in this state; or

(2) A third party that provides or administers hospital, medical or other health care benefits to citizens of this state, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization authorized to offer health insurance policies or contracts in this state;

(G) "Secretary" means the Secretary of Health.

(H) "Utilization review" or "managed care" means a system for reviewing the appropriate and efficient allocation of hospital, medical or other health care services given or proposed to be given to a patient or group of patients for the purpose of recommending or determining whether such services should be reimbursed, covered or provided by an insurer, plan or other entity or person;

(I) "Utilization Review Plan" means a description of the criteria, standards and procedures governing utilization review or managed care activities performed by a private review agent.

Section 4. Certification of Private Review Agents.

(A) A private review agent who approves or denies payment, or who recommends approval or denial of payment for hospital or medical services, or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review or managed care in this state unless the Secretary has granted the private review agent a certificate;

(B) The Secretary shall issue a certificate to an applicant who has met all the requirements of this Act and all applicable regulations of the Secretary;

(C) The Secretary may delegate the authority to issue a certificate to the Commissioner for any health insurer, nonprofit health service plan or health maintenance organization or other third party regulated by the insurance laws of this state that meets the requirements of this Act and all applicable regulations of the Secretary;

(D) A certificate issued under this Act is not transferable;

(E) The Secretary shall adopt regulations to implement the provisions of this Act. No later than one year after the effective date of this Act the Secretary shall adopt regulations establishing:

(1) The requirement that the private review agent provide patients and providers with its utilization review or managed care plan including the specific review criteria and standards, procedures and methods to be used in evaluating proposed or delivered hospital, medical or other health care services;

(2) The requirement that no determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician;

(3) The requirement that any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of pre-certification for that service shall include the evaluation,

findings, and concurrence of a physician trained and experienced in the relevant specialty or subspecialty to make a final determination that care rendered or to be rendered was, is, or may be medically inappropriate;

(4) The circumstances, if any, under which utilization review may be delegated to a hospital utilization review program;

(5) The provisions by which patients, physicians or hospitals may seek prompt reconsideration by or appeal to an independent panel of physicians of adverse decisions by the private review agent;

(6) The type, qualifications and number of personnel required to perform utilization review or managed care;

(7) The requirement that no determination that care rendered or to be rendered is medically inappropriate shall be made until an appropriately qualified review or managed care physician has spoken to the patient's attending physician concerning such medical care;

(8) The requirement that any determination that care rendered or to be rendered is medically inappropriate shall include the written evaluation and findings of the reviewing or managed care physician;

(9) The requirement that a representative of the private review agent is reasonably accessible to patients, patient's family, and providers at least five days a week during normal business hours and that payment may not be denied for treatment rendered during a period when the review agent is not available;

(10) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(11) The requirement that no private review agent be permitted to enter a hospital to interview a patient unless approved in advance by the patient's attending physician and that the attending physician or a designee be entitled to attend the interview; and

(12) The prohibition of a contract provision between the private review agent and a business entity or third-party payor in which payment to the private review agent includes an incentive or contingent fee arrangement based on the reduction of health care services, reduction of length of stay, reduction of treatment, or treatment setting selected.

(13) The requirement that there be nondiscriminatory utilization review of treatment for all illnesses, without regard to whether an illness is classified as medical/physical or mental.

Section 5. Application for Certification.

(A) An applicant for a certificate shall:

(1) Submit an application to the Secretary; and

(2) Pay to the Secretary the application fee established by the Secretary through regulation.

(B) The application shall:

(1) Be on a form and accompanied by any supporting documentation that the Secretary requires; and

(2) Be signed and verified by the applicant.

(C) The application fees required under subsection (A)(2) of this section or section 6 of this Act shall be sufficient to pay for the administrative costs of the certificate program and any other costs associated with carrying our the provisions of this Act.

(D) As part of the application, the private review agent shall submit information required by the Secretary, including but not limited to:

(1) A utilization review or managed care plan that includes specific review or managed care standards, criteria and procedures to be used in evaluating delivered or proposed hospital, medical or other health care services, and the citations to the scientific literature relied upon in establishing such standards, criteria and procedures.

(2) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(3) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review or managed care plan; and

(4) A list of the third-party payors and business entities for which the private review agent is performing utilization review or managed care in this state and a brief description of the services it is providing for each client, and a statement regarding whether the payment system for such services contains an incentive or contingent fee arrangement.

Section 6. Renewal of Certification.

(A) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this section.

(B) Before the certification expires, a certification may be renewed for an additional two-year term if the applicant;

(1) Otherwise is entitled to the certificate;

(2) Pays to the Secretary the renewal fee set by the secretary through regulation; and

(3) Submits to the Secretary:

a. A renewal application on the form that the Secretary requires, including a list of all complaints made to the private review agency by patients or providers and a description of how such complaints were resolved; and

b. Satisfactory evidence of compliance with any requirements under this Act for certificate renewal.

(C) If the requirements of this section are met, the Secretary shall renew a certificate.

(D) The Secretary may delegate to the Commissioner the authority to renew a certificate to any health insurer, nonprofit health service plan, health maintenance organization or other third party regulated under the insurance laws of this state that meets the requirements of the Act and all applicable regulations of the Secretary.

Section 7. Denial/Revocation Of Certification.

(A) The Secretary shall deny a certificate to any private review agent whose application fails to:

(1) Provide information required by the Act and regulations adopted pursuant to the Act;

(2) Provide satisfactory assurance of the ability to comply with the Act and regulations adopted pursuant to the Act; or

(3) Demonstrate the availability of a sufficient number of qualified health professionals supported and supervised by appropriate physicians tc carry out the utilization review activities.

(B) The Secretary may revoke a certificate if the holder does not comply with performance assurances under this section, violates any provision of this Act, or violates any regulation adopted pursuant to the Act.

(C) The following procedural requirements shall govern the denial or revocation of a certificate:

(1) Before denying or revoking a certificate under this section, the Secretary shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of this Act and the opportunity to request a hearing.

(2) If an applicant or certificate holder requests a hearing, the Secretary shall send a hearing notice by certified mail, return receipt requested, at least 30 days before the hearing.

(3) The Secretary shall hold the hearing in accordance with the procedures set forth under [relevant state law].

(D) Any aggrieved patient or provider may file a complaint with the Secretary alleging that a private review agent is not in compliance with this Act or the regulations issued thereunder and requesting that the Secretary revoke the certificate of such private review agent or require that such agent comply with the Act and/or regulations. The Secretary's decision with respect to such complaint shall be subject to judicial review upon appeal by the patient, provider or

private review agent. If the Secretary fails to render a decision upon a complaint brought by a patient or provider within ninety (90) days, the patient or provider shall have the right to bring a judicial action to compel the Secretary to revoke the certificate of the private review agent or to require the private review agent to comply with the Act and/or regulations.

(E) Nothing in this section shall be deemed to deprive a patient or provider of any other cause of action available under state law.

Section 8. Waiver of Certification.

The Secretary may waive the requirements of this Act for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act, Title XIX of the Social Security Act and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Section 9. Reporting Requirements.

The Secretary shall establish reporting requirements to:

(A) Evaluate the effectiveness of private review agents; and

(B) Determine if the utilization review or managed care programs are in compliance with the provisions of this Act and applicable regulations.

Section 10. Confidentiality.

A private review agent may not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review or managed care activities.

Section 11. Penalty for Violation.

A person who violates any provision of this Act or any regulation adopted under this Act or who submits any false information in an application required by this Act is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding $5,000 [or penalty under relevant state law for submission of false information]. Each day a violation is continued after the first conviction is a separate offense.

Section 12. Appeal by Aggrieved Party.

(A) Any person aggrieved by a final decision of the Secretary in a contested case under this Act may take a direct judicial appeal.

(B) The appeal shall be made as provided for the judicial review of final decisions under [relevant state law].

Section 13. Annual Report.

The Secretary shall issue an annual report to the Governor and the legislature concerning the conduct of utilization review and managed care in the state. Such report shall include: a description of utilization and managed care programs and the services they provide; the type of criteria and standards used to perform utilization and managed care review; the feasibility of adopting uniform criteria and standards for one or more aspects of utilization and managed care review; an analysis of complaints filed against private review agents by patients or providers; and, an evaluation of the impact of utilization review and managed care programs on patient access to care.

Section 14. Effective Date.

This Act shall take effect January 1, 19___.

○