

HEALTH INSURANCE REFORM COMPROMISE

Tentative Agreement

- A. An MSA experiment of a fixed duration, evaluated by an independent, nationally-recognized body, that requires an affirmative vote (under regular order procedures) to extend or expand the experiment.
- B. Populations eligible to participate in the experiment:
 - 1. The self-employed; and
 - 2. Businesses with 100 and less employees.
(Utilization of MSAs by businesses and the self-employed is limited to the number of users projected by the Treasury Department).
- C. Republican MSA tax policies and insurance provisions included in 6/10/96 offer, which assume that MSAs are an insured product that complies with state insurance laws and the insurance reform provisions in H.R.3103, (unless inconsistent with amendments outlined below).
- D. Catastrophic benefit package designed to be consistent with RAND study recommendations to avoid risk selection. Maximum deductibles (and total out-of-pocket costs) for individuals and families are set consistent with RAND recommendations (i.e., \$2,000/\$4,000) and the minimum deductible is set at one half the maximum deductible (i.e., \$1,000 for individuals and \$2,000 for families).
- E. Contributions to MSAs can be made only by employers and the amount of the contribution is limited to the lower of the plan's deductible OR the difference in the cost of the premium between the catastrophic benefit plan and the traditional plan. (Experts say that it is about one-half the set deductible.)
- * No requirement for a cap on build-up during the experiment; no requirement that insurers and plans must offer choice of traditional/MSA plans; no requirement that MSA account spending be solely limited to benefits covered by the catastrophic benefit plan; and no requirement that a risk adjustment mechanism must be in place to sell MSAs.

Issues To Be Resolved

- A. Mental health provision
- B. Definition of the self-employed and ways to address the potential problems associated with "favored tax status."
- C. Who evaluates and what is the design for the independent, nationally-recognized study?
- D. Other outstanding issues including, Medigap duplication issues, Medicare fraud and abuse, insurance reform provisions, and other issues that may arise after reviewing statutory language.

OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO: Jennings
Klein (Jennings)

- | | |
|-----------------------|-------------------------------------|
| Take necessary action | ☐ |
| Approval or signature | ☐ |
| Comment | ☐ |
| Prepare reply | ☐ |
| Discuss with me | ☐ |
| For your information | ☒ |
| See remarks below | ☐ |

FROM: Kountaues DATE: 4/15/96

REMARKS:

Repub ldrship Letter to
Focus on HR 3103 - MSA

6-2878

Congress of the United States
House of Representatives
Washington, D.C. 20515

April 10, 1996

President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

On Thursday, March 28, the U.S. House of Representatives, in a bipartisan vote, passed H.R. 3103, the Healthcare Availability and Affordability Act of 1996. This is a landmark piece of legislation. It represents the health reform Americans want.

The House has heard from people of all walks of life with specific and widespread concerns about health care availability and costs. Many families have breadwinners who are afraid to change jobs because they might lose critical insurance coverage for themselves or their dependents due to a pre-existing condition. Other families are burdened with thousands of dollars of expense every year to care for an elderly parent, a sick or disabled child, or a terminally ill family member, without government support.

Americans are rightfully indignant over costly experiences relating to fraudulent or abusive acts committed by a health care provider or insurer. All struggle with the administrative complexities and paperwork burdens of their health care records and the added costs to all our health care bills of unjustified lawsuits.

We have heeded the message on health care from the public, and the House has passed a measure that solves the many health care concerns Americans have identified. Our bill provides a real solution to the portability and job-lock concerns; allows fairer tax treatment for families with long-term care expenses; permits terminally ill individuals to cash-in life insurance benefits early to meet expenses; sets tougher penalties and gives needed funding to fight health care fraud and abuse; streamlines administrative transactions throughout the healthcare system; and makes critically important reforms to our medical liability system. We are confident you will want to join us in the health reform that Americans want, and we urge you to support our efforts to do so.

One of the key issues raised again and again by individuals and employers, especially the self-employed and smaller businesses, is the lack of affordable health insurance coverage.

They want health insurance coverage that:

- is more affordable than ever-more expensive, old fashion first dollar fee-for-service health plans,
- places individuals in charge of a greater portion of their health care spending, especially in light of the limitations managed care coverage may put on choice of doctors and hospitals,
- protects them against the high costs of an illness or accident, and
- receives fair federal tax treatment as compared with the tax-exclusion for employer-based health insurance benefits.

Our response in H.R. 3103 is to increase the deductibility of health insurance premiums for the self-employed from the current law 30% of premium expenses, to 50%. Second, we meet the needs of the self-employed and smaller businesses by enabling employer pooling, so small business can have the advantages in purchasing health coverage that big business has now.

Finally, we respond in our legislation by allowing individuals and businesses to pair together more affordable high-deductible health plans with medical savings accounts (MSAs), by providing tax treatment of the MSAs which is comparable to that afforded other types of group and individual health benefit plans.

Unfortunately, members of your administration and liberal Members of Congress have raised objections, frankly spurious, to the simple concept of encouraging Americans to pair high deductible health insurance coverage with MSAs. We are confident that upon closer examination you will agree that the MSA concept is sound, that it provides true portability, and that it will empower many Americans to obtain health coverage and make better health care choices. We sincerely hope you will reconsider the views of your administration on this issue.

First, it is important to review exactly what H.R. 3103 actually does. In order for MSAs to receive comparable tax treatment to employer-provided health benefit plans, H.R. 3103 would require a high-deductible plan to be paired with the MSA. It should be stressed that MSAs receive the same tax treatment all other forms of health

insurance receive *only* if they are paired with a qualifying high-deductible plan.

A high-deductible plan is a health insurance plan that has a deductible of at least \$1,500 in the case of single coverage and \$3,000 in the case of family coverage. H.R. 3103 would permit individuals (including self-employed) to make tax-deductible contributions (up to \$2,000 if single, \$4,000 if married) to an MSA if they are covered by such a high-deductible health plan. The earnings on amounts contributed to the MSA would be tax-free. The amounts could be withdrawn from the MSA tax-and penalty-free if used for medical purposes. Employer contributions to an MSA would not be taxable to the employee on whose behalf the contribution is being made.

We encourage your consideration of the distinct advantages of MSAs:

1) Comparable Tax Treatment: H.R. 3103 provides individuals, employers (including the self-employed) and employees more choices of health insurance coverage. It grants high-deductible health plans paired with an MSA comparable tax treatment to other forms of employment-based group health plans, and aids individuals who make their own contribution to the MSA portion, by granting them an "above-the-line" deduction. That is, people can claim the deduction even if they do not otherwise itemize their taxes. We have attached a chart which illustrates the tax treatment.

2) Better Incentives For Good Health Care Decisions: H.R. 3103 provides Americans the incentives to benefit from careful health care purchasing. The current unlimited exclusion for employer-based health care encourages excessive spending. In fact, under current law policies, individuals can be penalized for less spending, as in the "use it or lose it" feature of flexible spending accounts. The MSA design takes part of the money that would have gone to insurance companies as premiums and gives it instead to individuals to spend as they choose for medical expenses. MSAs permit people to personally manage, and even save, a portion of their health care funds. This fosters personal responsibility, cost-effective decisions regarding health care spending and freedom-of-choice of providers.

3) Major Medical Protection: H.R. 3103 ensures that when Americans with MSAs experience serious illness or a major accident necessary coverage will be there. With the requirement of higher deductible health plans, MSA beneficiaries will have comprehensive medical coverage for the costs of a serious illness or injury, and can also rely on funds accumulated in their MSAs as part of their overall protection.

4) Portability of Medical Savings: H.R. 3103 provides for real portability of health care dollars. Unlike other forms of employment-based health plans, medical savings in the MSA can be taken from job to job, easing worker mobility in the job

market. And, since more than 70 percent of all uninsured Americans during the course of a year go without insurance for just four months or less, MSAs could potentially reduce the number of Americans without resources for medical bills or coverage, perhaps significantly, as workers use their MSAs to pay for necessary health care or to purchase COBRA continuation coverage during these brief spells of unemployment.

5) More Choice and Flexibility for Consumers: H.R. 3103 enables people to make decisions about their providers rather than depending on their health plan to dictate which doctors and hospitals they will use. The MSAs also empower people to make other health care decisions. Funds in the MSA may be spent to fit each person's needs, for instance on qualified medical expenses that may not be covered under the high-deductible plan (prescription drugs, durable medical equipment, etc.).

6) Helps Meet Long-Term Care Needs: H.R. 3103 will help people who want to protect themselves against future long-term care needs or have long-term care needs not covered by other insurance. MSA funds can be used to purchase long-term care insurance or services.

7) States are Moving on MSAs: The MSAs in H.R. 3103 are not a new policy - many states have already acted to encourage MSA use. Fifteen states have already passed laws granting favorable tax treatment to MSAs. The failure to establish federal tax rules regarding MSAs will inhibit innovations that many states have decided is good health policy.

8) **Lower Administrative Costs:** H.R. 3103 will actually lower the administrative costs of insurance for many Americans. Insurance company administrative costs should be lower under MSAs than under other plan types because expenses below the deductible will be made by the MSA's owner out of the MSA instead of being filed as an insurance claim. Nine out of ten individual insured Americans spend less than \$2,000 a year on health care. For this and other reasons, the American Academy of Actuaries estimates that the administrative cost of MSAs would be just 2 percent.

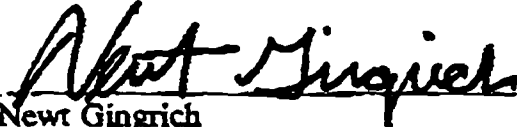
9) **Helps Middle-Income Americans:** H.R. 3103's MSAs will be for all Americans. Contrary to assertions that MSAs will attract only the 'wealthy,' MSAs may be used by Americans at different income levels because MSAs encourage people to take advantage of thrifty high-deductible policies, and because they provide a new opportunity to save. As a matter of fact, middle income Americans will be the big winners when it comes to MSAs. According to the non-partisan Joint Committee on Taxation, of the one million people who are expected to sign up for MSAs initially, 65 percent of them and their families will earn between \$40,000 and \$75,000 a year.

10) **Attractive to Both Healthy and Sicker Employees:** H.R. 3103 allows MSAs to be useful to the well and sick alike. The claim often repeated by liberals that MSAs will attract only the 'healthy' and thus upset the insurance market is a theory without a single bit of corroborating real-world proof. Sicker employees or families will find in MSAs two attractive features: greater personal choice and control, and a cap on out-of-pocket expenses. And, even if there were cases where MSAs did wind up attracting healthier employees in disproportionate numbers in a specific group, employers could simply counteract the problem by making sensible plan-design changes or by dropping the MSA option altogether. Obviously, for those smaller employers who provide only an MSA option, no 'adverse selection' problem is possible. The 'adverse selection' argument is an obvious red herring employed by liberals who want to see a good bipartisan idea quashed.

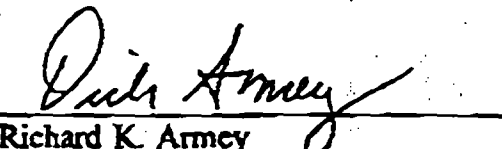
We hope you will consider these points carefully as you re-examine the initial position taken by some members of the Administration on the MSA issue, particularly in light of the fact that MSAs have both been endorsed and actually included in bills cosponsored by such leading Democrats as Representative Gephardt and Senator Daschle in recent years.

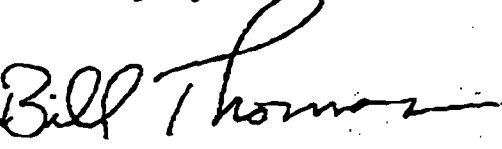
We feel strongly that you should join us in giving Americans this important tool to enable them to increase consumer choice, to gain or keep health care coverage, while reducing the costs of health care.

Sincerely,


Newt Gingrich
Speaker of the House


Bill Archer
Chairman
Committee on Ways and Means


Richard K. Armey
House Majority Leader


Bill Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means

Medical Savings Accounts (MSAs)

- **Adverse selection.** By providing a tax incentive for the purchase of catastrophic insurance, as opposed to comprehensive coverage, MSAs would further encourage healthy individuals to leave the insurance risk pool. The remaining participants in the pool would be sicker than average, and the costs for those employees would escalate. This segregation of winners from losers -- and providing a tax break for the winners - - embodies a "survival of the fittest" approach that is antithetical to sound health policy.
- **MSAs may turn out to be merely another tax shelter for the healthy.** MSAs would permit individuals with low medical expenses to save \$2,000 on a tax-free basis. Individuals could choose to pay their medical expenses out of other funds, and essentially let the MSA serve as an additional IRA. And to make matters worse, the MSA balance would not be included in the taxable estate.
- **Undermine targeted health spending.** Under the proposal, individuals would be free to use MSA funds on less critical health care items not covered by their current insurance and thereby deplete the funds set aside on their behalf for health care expenses. If they experience more serious health care problems, they would lack funds to finance more critical care.
- **Ineffective on cost containment.** Proponents of MSAs have overstated the amount employers could contribute to employees' MSAs without increasing employer cost. The reduction in premiums when employees switch from comprehensive to catastrophic coverage (the source of employer contributions to MSAs) will typically be less than the increase in the deductible. Therefore, employees with MSAs would be at risk for larger amounts than under current plans, because employers are likely to contribute less than the increase in the deductible. (In an impartial analysis by the American Academy of Actuaries, the mid-range estimate of these reductions in premiums was \$1,562 per family for an employer that switched from a plan with a \$200 deductible to a plan with a \$3,000 deductible for all its employees.) And because of adverse selection, if employers offered employees a choice between the plans, employers could not hold their costs constant without reducing their MSA contributions to a level which may be well below the \$1,562 amount described above.
- **Inconsistent with tax simplification and difficult to administer.** MSAs would constitute a major step away from tax simplification. The addition of a new arrangement under the tax Code, would add complexity for taxpayers and the IRS, create administrative problems for the tax system and could lead to a real risk of significant noncompliance. For example, at the end of the tax year, individuals would report how much they spent on medical costs. Individuals will have to keep their own records and determine what Section 213 expenses were not reimbursed by insurance to determine whether they constitute qualified medical expenses that could be paid with MSA withdrawals.

- **Needs further study.** It is important to make sure that we understand fully the consequences of this proposal for the tax system and health care. To that end, it should be analyzed in the context of the overall health care plan of which it is a part. In this case, it seems inconsistent with the basic thrust of the larger bill, which is directed toward broadening the risk pool.
- **Revenue loss.** The MSA proposal would result in a loss in revenue.

MEMORANDUM

June 10, 1996

TO: Laura Tyson and Carol Rasco
FR: Chris Jennings
RE: Republican MSA Proposal
cc: Elizabeth Drye and Jennifer Klein

Attached is the Republican MSA proposal which we received today as well as talking points based on our initial analysis. I have also enclosed a copy of the MSA proposal we offered last week.

The Republicans have reportedly dropped MEWAs and malpractice provisions. They have also dropped the Domenici-Wellstone mental health parity amendment as well as Domenici's compromise proposals.

I would like to talk to you about this new information tomorrow morning, if at all possible. Please feel free to give me a call at 6-5560 with any questions or concerns.

Initial Response to the Republican MSA Proposal

- We just received the Republican's latest MSA proposal and have just started the process of reviewing and evaluating it.
- This proposal represents an important step forward from the Republican's previous proposal for a full blown MSA. However, it appears that it does not adequately address the concerns we have previously raised.
- Specifically, the scope and design of the proposed MSA appears to be too broad. Moreover, the proposed procedure of automatically extending MSAs to the remainder of the marketplace without an affirmative vote by the Congress is of significant concern.
- We also want to make sure that the objectivity and legitimacy of any MSA evaluation cannot be called into question. We are concerned that the current outline of the study may fall short in that area.
- We look forward to working with Republicans and Democrats on an appropriate compromise that is acceptable to all parties.

6/10/96
6:30 pmJune 10, 1996
12:00 Noon

POSSIBLE MSA COMPROMISE

1. Orderly Phase-In of Medical Savings Accounts. Medical Savings Accounts (MSAs) would be available initially to employees in employer-sponsored high deductible plans if the employer has 50 employees or fewer, including the self-employed. MSAs would automatically be extended to employers with more than 50 employees ^{and individuals} on January 1, 2000, unless Congress acts to delay or repeal the expansion. Expedited procedures would apply to ensure that this measure to repeal or delay the expansion was considered and voted upon in the House and Senate. ~~MSAs would automatically be extended to individuals one year later, on January 1, 2001, unless Congress acts to delay or repeal the expansion. Again, expedited procedures would apply to ensure that this measure to repeal or delay expansion was considered by both the House and Senate.~~ (separate votes for large employers and individuals).

Rationale: This approach would target MSAs to that portion of the employer market where costs are highest and access is most difficult. Therefore, it would provide additional coverage options for small employers and allow for a more appropriate and fair evaluation of the potential advantages and disadvantages of MSAs before extending them to the majority of the market. Employees who work for small employers represent approximately 28 percent of those covered by employer-sponsored health plans.

2. Minimal Consumer Protections. MSAs offered in connection with employer-sponsored high deductible plans would comply with minimal consumer protection standards as a condition of deductibility-- similar to requirements contained in the bill for deductibility of long-term care insurance. First, MSA plans would be required to **disclose information about cost-sharing requirements, deductibles, and limitations on coverage, if any, under the plan.** This requirement is consistent with general disclosure requirements for small employers already in the bill's portability section and would provide small employers with basic information they need to decide whether to purchase an MSA for their employees. Second, MSA plans could have a maximum deductible of \$5,000 for individuals and \$7,500 for family coverage. ^{(The RAND study recently published in the Journal of the American Medical Association found that adverse selection problems are minimized significantly with lower deductible levels. Third, cost-sharing would be no more than 20 percent of the allowed amount for any given service under MSA plans. Because there are no cost-sharing limits under the House MSA proposal, individuals could face substantial payments for medical coverage under a tax-preferred MSA even after they meet or exceed the plan's deductible. Finally, States could impose requirements beyond these minimal standards, and the NAIC would be directed to develop model standards that the States could adopt voluntarily.}

(+\$5,000
and \$7,500
amounts
will be
indexed
for
inflation)

30%
unset
in 5
years)

- 2 -

3. Study On Adverse Selection by Independent Organization. In determining whether to make adjustments and expand the MSA program, Congress would be aided by a study regarding the effects of MSAs on adverse selection. The Chairman of the House Ways and Means Committee and the Senate Finance Committee would request ~~the American Academy of Actuaries, or other independent organization~~ to prepare a study regarding the effects of MSAs in the small group market on adverse selection, health costs, use of preventive care, and consumer choice. This study will be submitted to such Chairman by January 1, 1999.

4. Tax and Structure Changes. Structure and tax changes would be included, as agreed to by Chairmen of House Ways and Means and Senate Finance Committees. Under these proposals: (1) the exemption from the estate tax would be deleted; MSAs would be subject to estate tax under rules similar to individual retirement accounts (i.e., if the beneficiary is not the decedent's spouse, the MSA account balance would be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the MSA); (2) the additional tax on withdrawals for nonmedical purposes would be increased from 10 percent to 15 percent; (3) penalty-free withdrawals for nonmedical purposes could be made after age 65 (instead of after age 59 1/2); (4) in any year in which a contribution is made by an individual to a MSA, withdrawals from MSAs maintained by that individual would not be includible in income only if they are for medical expenses of the individual, and the individual's spouse and dependents, who are covered by a high deductible plan; and (5) the statements of managers would reflect Congressional intent that a high deductible policy is intended to provide meaningful health care coverage and the legislative language would specifically direct the Treasury Department to monitor the market for high deductible policies and report to the Congress if the need for additional anti-abuse rules develops (i.e., if individuals are obtaining high deductible policies that do not provide meaningful health care coverage).

Possible Medical Savings Account Compromise

Summary: Implement a staged, phase-in of Medical Savings Accounts (MSAs), which is preceded with a 3-year demonstration designed to study the potential benefits and problems with MSAs. This study would provide recommendations about the feasibility and advisability of expanding them nationwide. The results of the study, conducted by an independent recognized expert body would be provided to the Congress for its consideration. A fast-track procedure for affirmatively extending MSAs to large employers would require an up or down vote within 90 days of the receipt of the report. If the Congress passes this legislation, an automatic extension to small business occurs unless the Congress rejects it in a fast-track vote. In the third stage, an automatic extension to the individual market occurs unless the Congress rejects it on a similar fast-track vote. At each stage of Congressional consideration of further extension of MSAs, the nationally recognized authority would supplement their first report with recommendations related to the expansion to other markets.

Proposal

Demo: A 3-year demonstration project (similar to Empowerment Zones) would be conducted on the feasibility and advisability of implementing MSAs through the tax code. The tax provisions for the MSA demonstration project would be similar to those in the House-passed health insurance reform bill (except that the favorable tax treatment for MSAs would expire at the end of the study period and certain safeguards would be built into the design of the MSA to minimize adverse effects on health markets, the tax system, and to assure that the high deductible policy provides meaningful health coverage).

State and local governments would compete for 4 separate slots for the MSA demonstration project. At least one slot would be reserved for a rural area. Applications by two or more States would be permitted to create a regional demonstration project. Selections would be made by the Secretary of Health and Human Services, in consultation with the Secretary of Treasury, based on the overall strength of the application. Evaluation of submitted applications would be based on the strength of the experimental design and its ability to measure the effects of MSAs.

In the third year of the demonstration project, an evaluation would be completed by an independent, recognized expert body. The report of this evaluation would be forwarded to Congress with recommendations about the feasibility and advisability of extending MSAs nationwide.

Stage I: When the report is received marking the end of Stage I, a fast-track procedure would be started under which the Congress would have 90 days to consider whether to extend MSAs to large employers (at least 100 full-time employees) nationwide. Any Member could request floor action on the proposal to extend MSAs to all large employers (private businesses, non-profits, and governments). This extension could not take place without being enacted into law in the prescribed time period. In the second year after this extension takes place (if it occurs), a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to smaller employers.

Stage II: When the second report is received (two years after the implementation of the large business MSA), another fast-track procedure would be initiated under which the Congress would consider the extension of MSAs to small employers (under 100 employees). Under this procedure, the extension would take place automatically 90 days after receipt of the Stage II report, unless both Houses of Congress voted to prohibit it. (Any House or Senate Member could request this fast track vote). In the second year after this extension takes place (if it occurs) a follow-up study by the nationally recognized expert body would evaluate this extension and make recommendations about the feasibility and advisability of further extension of MSAs to the individual market.

Stage III: When the third report is received (two years after the implementation of the small business MSA), another fast-track procedure would be started under which the Congress would consider the extension of MSAs to the individual purchaser market. The extension would take place automatically 90 days after receipt of the report, unless both houses of Congress vote to prohibit it. -- (under the procedures outlined in Stage II).

National Center for Policy Analysis

BRIEF ANALYSIS

No. 203

For immediate release:

Monday, May 6, 1996

Misplaced Criticism of MSAs

Medical Savings Accounts (MSAs) have become the most controversial element of the health insurance reform proposal before Congress.

They should be the least controversial.

MSAs give people the opportunity to move from a traditional low-deductible health insurance plan to one with a high deductible (say \$2,000 to \$3,000) and to deposit the premium savings in a personal savings account. They use the account to pay for routine and preventive medical care, and the high-deductible policy pays for major expenses. If they have money left over in the MSA at the end of the year, they can withdraw it or roll it over to grow with interest.

Under a typical plan available now in the health insurance marketplace, a family with employer-provided health insurance can get a \$1,500 contribution to its MSA and a \$2,000 deductible policy. The employee pays for health care expenses with the \$1,500, easily enough to cover most families during a year. If the family exhausts the \$1,500, the employee pays the next \$500 out of pocket, and insurance pays everything over \$2,000.

Opponents of current MSA legislative proposals offer several criticisms of them. Yet anyone who understands the MSA and the private health insurance marketplace recognizes that the criticisms are unfounded.

Bogus Criticism No. 1: *MSAs would attract only healthy people, leaving the sick in a separate pool.* During the health care debate a few years ago, critics of the Clinton plan argued that his proposal would limit people's choices. President Clinton responded that

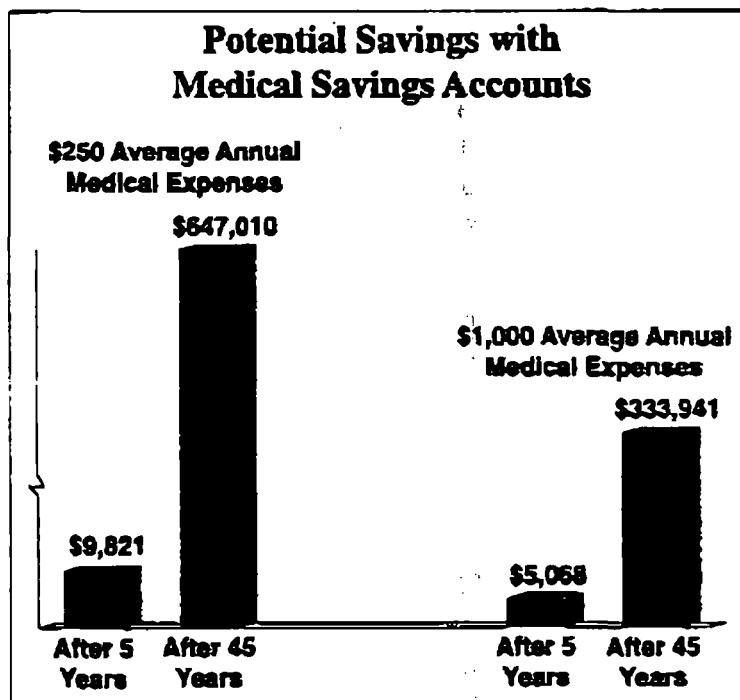
people's choices already were limited. Most people, he said, had only one employer health plan to choose from.

Precisely. Employers determine what type of health insurance their employees have. Most companies — 83 percent by one estimate — offer their employees only one policy. "Adverse selection" — in which the healthy move into one plan while the sick remain in another — is impossible because only one policy is available.

Many larger employers offer their employees a choice, usually between traditional health insurance and a health maintenance organization (HMO). However, they often

price the options to encourage employees to choose one health insurance plan over the other. For example, an employer may make participation in an HMO free, but require employees who want traditional health insurance to pay a contribution, deductible and/or copayment.

No employer is required to offer an MSA option. Those who do are free to structure and price their plan as they choose and to drop the plan if they find it unworkable.



Bogus Criticism No. 2: *MSAs would attract only wealthy people looking for a tax break.* The MSA legislation before Congress caps the annual tax-free deposit at \$2,000 for an individual and \$4,000 for a family. The MSA legislation also permits either the employer or the employee to make the deposit, but not both. Thus an individual with extra money cannot "top up" the account above the employer's contribution just to get some tax-free savings.

Furthermore, while the MSA legislation before Congress would permit people to make deposits with pretax dollars, hundreds of companies have already switched to

MSA plans in which the deposit is made with aftertax dollars. The MSA legislation would simply make those deposits tax free, giving individuals more money to cover routine care. This would primarily help lower-income workers, since high-income workers could more easily pay the \$500 out-of-pocket difference between the \$1,500 aftertax contribution and their \$2,000 health insurance deductible (as in the scenario above).

Bogus Criticism No. 3: *MSAs are being promoted by special interests.* MSAs let people keep some of the money they or their employer are currently giving to insurance or managed care companies. Not surprisingly, many managed care companies and insurers oppose MSAs. Yet MSA opponents are accusing supporters — who are working to let people keep more of their health care dollars, rather than giving them to insurers — of being controlled by special interests, while those who want insurers and managed care companies to keep all the money portray themselves as patients' advocates.

Bogus Criticism No. 4: *MSAs will never provide enough money for people to pay their health care bills.* The vast majority of people spend little money on medical expenses in any given year, so most would have a significant balance in their MSAs at year's end. Since the proposal before Congress imposes penalties for withdrawing those funds for nonhealth expenses, most people would roll over the balance. This makes MSAs a powerful mechanism for encouraging higher savings.

Consider the findings reported by health economists Gail A. Jensen and Robert J. Morlock in the *Journal of American Health Policy* (May-June 1994). Their 1989 survey of about one million individuals in large self-insured plans, many with generous benefits, found that:

- One-third filed no claims at all.
- 73 percent filed claims for less than \$500.
- 89 percent filed claims for less than \$2,000.

Thus, as in the example given above, about three-fourths of the employees would have between \$1,000 and \$1,500 available for savings at the end of the year.

Jensen and Morlock then calculated the growth of the MSAs under several scenarios to estimate the savings impact of MSA compounding.

Suppose a 20-year-old or his employer placed \$1,800 a year in an MSA. (That is the actual MSA deposit amount for employees of Jersey City, N.J.) Jensen and Morlock estimated the savings that would result if individuals spent, on average, \$250 and \$1,000 a year over their working lives and earned 8 percent interest on the remaining deposit. [See the figure.]

- The person whose expenses averaged \$250 a year would have \$9,821 after five years and \$647,010 at retirement, after 45 years of deposits.
- The person with an average of \$1,000 in medical expenses would have \$5,068 after five years and \$333,941 at retirement.

Bogus Criticism No. 5: *Medical Savings Accounts will cost employers more money.* A new study shows that MSAs save employers about as much as managed care and could save them much more.

The study by Michael T. Bond, Brian P. Heshizer and Mary W. Hrivnak of Cleveland State University looked at 27 Ohio firms, all with fewer than 200 employees and each with an MSA plan. The professors compared the cost of the plans to the cost of traditional insurance.

On average, employees had lower out-of-pocket costs under an MSA plan than under a traditional health insurance plan — about \$317 less for individuals and \$1,355 less for families.

Employers saved, too. The MSA plan for individuals cost more than a traditional plan, but taking the individual and family MSA plans together, the employers saved about 12 percent per year.

Criticism of MSAs for the under-65 population represents a concerted effort to kill MSA legislation. But none of the criticisms are valid. Once people understand MSAs, they realize that tax-free Medical Savings Accounts would reduce health care costs and expand choices in the health care marketplace.

This Brief Analysis was prepared by NCPA Vice President of Domestic Policy Merrill Matthews Jr., Ph.D.

National Center for Policy Analysis

PRESS RELEASE
For Immediate Release
Wednesday, June 5, 1996

**NCPA's MATTHEWS SAYS
MSA CRITICISMS UNWARRANTED**

WASHINGTON, D.C. — Dr. Merrill Matthews, vice president - domestic policy of the National Center for Policy Analysis said today that most criticisms of Medical Savings Accounts (MSAs) are wrong. Matthews spoke at a Capitol Hill briefing jointly sponsored by the NCPA, the United Seniors Association, and the Business Coalition for Affordable Health Care.

MSAs give people the opportunity to move from a conventional policy to one with a high deductible and to accumulate premium savings in a personal savings account. These accounts, which are usually funded by the employer, can be used for routine and preventive medical care and the high-deductible policy pays for major expenses.

The briefing was held to explain MSAs and to address common criticisms, as conference action was about to begin on the recently passed health insurance reform legislation. MSAs have become the most controversial issue in the debate. Opponents say MSAs are desirable for the healthy but not for the sick, and provide a tax break for the wealthy.

"More than 2,000 employers are now offering MSAs and there is no evidence that they are only attracting healthy people," said Dr. Matthews. "In fact, the evidence is showing that employees have less out-of-pocket exposure and employers are saving money."

"Those arguing that MSAs are for the wealthy misunderstand how they work and who they benefit," Matthews said. "The country of Singapore adopted MSAs more than a decade ago in an effort to help low-income families afford health care, and now almost all Singaporeans have access to needed services. However, the country spends only 3.1 percent of GDP on healthcare, compared to 14 percent in the United States."

Two speakers at the briefing, Mr. Steve Forbes and Congressman Dick Chrysler, adopted MSAs for employees at their companies. Whereas MSA deposits in companies such as these are now taxed, the current bill would allow deposits with before-tax dollars, the same treatment given to health insurance premiums.

"I have seen MSAs work in the private sector at my own company," said Congressman Chrysler. "They are beneficial to the employee as well as to the employer."

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The National Center for Policy Analysis is a public policy research institute founded in 1983 and internationally known for its studies on public policy issues. The NCPA is headquartered in Dallas, Texas, with an office in Washington, D.C.

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RUBBER MANUFACTURERS ASSOCIATION

**Comments before the
Business Coalition on Affordable Health Care Press Conference
June 5, 1996**

**Gloria E.M. Bartholomew
Manager, Technical & Standards
Rubber Manufacturers Association
1400 K Street, N.W., Suite 900, Washington, D.C. 20005-2403**

Thank-you and good morning. It is literally a pleasure to be here and a pleasure to tell you about my experiences with the Rubber Manufacturers Association's medical savings plan or account.

When I joined the Association one of its major benefits was payment of medical insurance. Slowly over the years, this benefit eroded from full payment to each employee contributing an increasing share of rising insurance costs, along with fewer choices of insurance companies.

Then in late 1989, the Association converted over to a medical savings account called Plan 3. I was a skeptic, having come from more traditional insurance programs where you choose a plan, paid a deductible, and split the costs of every medical procedure. In Plan 3 each person chooses a deductible amount from zero to \$1,500. The Association sets aside an amount based on our chosen deductible amount, age bracket, and single versus family coverage. This amount is called a deferred deductible, which can be used to pay for prescriptions, glasses, and to reimburse us for expenses up to the deductible we originally chose. If we don't use the full amount of the deductible, it can be held and used for up to three years before it is paid back to us. Ever the skeptic, it seemed too good to be true, so I held onto my HMO coverage for a while.

I had just dropped my HMO coverage, when in February 1993, I was diagnosed with malignant, stage five breast cancer. In April, I underwent a mastectomy. In May, I began a series of four chemotherapy treatments. By July, I was being prepped for a bone marrow transplant. I entered Johns Hopkins Hospital in August and was released at the end of September, just before my 39th birthday. In November, I began six weeks of daily radiation treatments. I recovered and was able to return to work full-time in February 1994. I no longer glow in the dark and am now a three-year cancer survivor. And, it cost the Association's medical savings plan and insurance company, Guardian, about \$200,000.

I am here to tell you our plan worked for me. I realize not everyone is fortunate enough to work for a company or Association that pays insurance costs. But the options offered by good medical savings plans or accounts can be excellent ones. A good plan can keep costs level — Plan 3 has allowed the Association to use the same 1989/1990 budget in 1996. And, a good plan can help bring employees out of a medical crisis and back to work.

It was a pleasure to speak to you of my experiences. Thank you. Good health and good health insurance to you!

PROPOSED COMPROMISE

1) Senate-passed bill with a compromise on Mental Health parity provision.

2) MSA compromise - one of the following 2 options:

Option #1

--Demonstration with rigorous experimental design, data requirements, and sunset that will provide a fair test of MSAs

--Demonstration could include separate measurement of the program's impact on individual, small business, and large employer market

--Participation in the demonstration limited to the minimum number of people necessary to provide an adequate test of the MSA concept, including such issues as:

- o adverse selection
- o participation by income category
- o impact on cost of conventional policies
- o Impact on overall health care costs
- o impact on utilization of preventive services

--Companies authorized to sell MSA policies consistent with the experimental design, based on an RFP.

--Program could be administered by HHS or a private contractor in cooperation with Treasury.

Option #2

--Time-limited demonstration to sell MSA policies in a small number of

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states or geographic areas.

--Strong evaluation component to determine whether MSAs achieve their objectives or result in problems feared by the opponents.

HEALTH INSURANCE BILL - ADDITIONAL PROPOSAL

1) Senate-passed bill with a compromise on Mental Health parity provision.

2) New MSA compromise option

OPTION #3

--MSAs could be offered through health insurance purchasing cooperatives offered under the bill.

--Cooperatives offering MSAs would be required to:

- o Offer a choice of at least one standard insurance policy
- o Utilize a risk-adjustment mechanism between standard and MSA policies

--MSA policies offered would be required to limit allowable deductibles, eg., to \$1,500 per individual or \$3,000 to family and not could not require additional co-payments after deductible was reached

--Five year sunset with evaluation to be conducted by HHS or other appropriate body. Participating insurers and coops would be required to provide data needed for evaluation.

Richard Harwood

Getting It Right, Telling It Straight

Jack Fuller, at middle age, has passed through several incarnations: soldier, lawyer, novelist, government official, newspaper reporter and dispenser of opinion as an editorial writer. He now presides over the Chicago Tribune as its president and publisher. It is not illogical to suppose that he may one day inherit the management of the Tribune Co.'s empire of media enterprises and unrelated businesses including the Chicago Cubs. He is also on the way to becoming one of the most thoughtful and articulate thinkers the communications industry has produced since the prime of Walter Lippmann.

He addresses in his most recent book, "News Values," problems of journalism that are of deep concern to journalists and to the society that produces us and is affected by what we do and how we do it. What values do we honor or dishonor in our work? What is our conception of "truth" and how do we render it? We are expert and relentless in asserting our rights and privileges, some of them defined in the Constitution. Do we have "responsibilities" as well, a subject on which the Constitution is silent and on which there is no agreement among journalism's practitioners?

In dealing with "truth," he recalls Joseph Pulitzer's famous demand of the people who worked for him at the New York World in the late 19th century: "Accuracy! Accuracy! Accuracy!" He recognized that when we get even little things wrong, "readers will not trust you to get the big things right." This principle, Fuller notes, underlies the standards of manufacturers such as Motorola that demand "six-sigma" quality in their production processes, meaning three bad parts in a million.

Newspapers have no quantitative standards of this kind, and it is obvious to any careful reader that "six-sigma" quality is not a characteristic of American journalism. We correct a few errors when they are called to our attention, but most of them go unnoticed. The common view is that factual errors are an inconsequential inevitability of the production process; that is why there is no mechanism of quality control to count them and no recognized sanctions for those who commit them.

Yet our inaccuracies—the "falsehoods" we publish—are one source of the low levels of "credibility" newspapers enjoy; they can be seen by the audience not as a mere production line aberration but as incompetence and ignorance producing the opposite of

"truth." As Fuller says, "the reader of the news does not care [why errors are made] . . . any more than the driver of a new automobile cares why his door handle came loose."

That is the standard journalists apply to politicians; we are quite unforgiving. A few days ago a U.S. senator was ridiculed for confusing the Sunni and Shiite schools of Islam. This demonstrated, a Post columnist observed, that he may not be "ready for prime time." What conclusion should we draw when the columnist or reporter errs?

When newspapers were the prime source of information in our society we enjoyed a certain immunity from our failures. But no longer. "The rate of error," Fuller writes, "is a long-term problem of the first magnitude for news organizations." As more and more

"Objectivity": naive and disingenuous.

sources of information become available—through the Internet, for example—people "will not settle for shoddy goods."

Our competence or incompetence in getting things right—Omaha is not a West Coast seaport—is important in any discussion of "truth" and journalism. So are the concepts of "objectivity" and "bias." The idea of "objectivity" in journalism has been promoted for different reasons by different interests at different times in our history. It was promoted by journalists of many stripes when we were attempting early in this century to demonstrate that we could be "scientific" (and thus "professional") in what we do.

It was promoted in the 1930s and 1940s by publishers disturbed at the enthusiasm for the New Deal in their newsrooms and by reporters and editors who chafed at the news and editorial interference of publishers. It is promoted under the rubric of "professional autonomy" by journalists of the modern era who overwhelmingly prefer the Democratic Party, its candidates and programs.

But no matter the time or place, the whole idea of objectivity in journalism is naive and disingenuous. "No one," Fuller writes, "has ever achieved objective journalism, and no one ever could. The bias of the observer always enters the picture, if not coloring the details at

least guiding the choice of them. I don't use bias here as a term of opprobrium. One might have an optimistic bias or a bias toward virtue. It is the inevitable consequence of the combination of one's experience and inbred nature."

But it does not follow that there is no alternative to self-indulgent propagandizing. When American bombers attacked Libya a few years ago unintended targets were hit, including the French Embassy. The secretary of defense insisted this was "inconceivable" because precision-guided "smart bombs" were used. Critics of the raid, including many journalists, argued that the outcome proved the incompetence of the military and its weapons and invalidated the whole concept of the raid.

Fuller and members of the Tribune's editorial board got an alternative explanation from a veteran airman in the Pentagon: "Each aircraft carried two young men in their twenties who flew half a day in uncomfortable seats to reach the Libyan coast. At that point they ran into heavy flak. It flew up from all directions trying to kill them. They dropped down to low altitude and flew at a high rate of speed toward the target, then turned the plane upside down to make the final run. If they dropped a bomb one second early or late it would land miles off target. No, I did not think that missing was inconceivable."

It is essential, because of our biases, Fuller writes, that we apply to our work a Golden Rule of intellectual honesty which "links the truth discipline in journalism with the highest standards in scientific and academic debate. . . . In reporting a matter of legitimate debate (How big should the Pentagon budget be? Did Alderman X take a bribe?), the journalist will surely reach some conclusions. And with some constraints . . . he should feel free to share his conclusions with his readers. . . . [But] it is not too much to expect reporters . . . to play square with [opposing] arguments, stating them honestly and presenting the facts and logic supporting them."

We are not going to stop being Democrats or Republicans, liberals or conservatives or libertarians. Our reputations should not be judged by those things but, as Fuller concludes, by the "quality of [our judgments] in wisely sorting through . . . difficult issues so as to produce work of genuine intellectual integrity."

Joe White

Tax Breaks For Healthy People

James K. Glassman's endorsement of medical savings accounts (MSAs) unfortunately ignores a lot of the available evidence and fails to recognize glaring errors in the advocates' case ["\$2,000 Health Care Trick," op-ed, May 14].

His readers may mistake the implications of the Rand health insurance experiment in many ways, among them:

(1) Glassman argues that people who have to pay more of their own

Taking Exception

money for health care would "shop wisely" and be "price sensitive." In fact, none of the savings in the Rand experiment stemmed from shopping for better prices. All came simply from some people choosing not to go to the doctor in the first place. Once people consulted a physician, they spent just as much as anyone else.

(2) Glassman leaves the impression that the savings from MSAs would be comparable to those the Rand study showed from the difference between high-consumer payments and "free" care. In fact, cost-sharing in the average insurance plan is now so high that the Rand scholars themselves reported that more than half the savings from charging consumers are already part of the system.

(3) He assumes that people will be as unwilling to spend money in their MSAs as to spend other assets. But the MSA money could only be saved or spent on medical care—and is labeled as money for medical care. In the Rand experiment, people were choosing among spending for medical care or clothes or food or other goods. Most people are far more interested in consuming than in saving. So clearly the incentives not to spend on health care in the Rand experiment were much greater, and its estimates cannot be extended to situations where people have money in a medical savings account.

When he moves away from the Rand data, Glassman relies on the premiums reported by the Golden Rule Insurance Co. for its catastrophic insurance plans, and compares them to premiums for other, more comprehensive plans. He shows a \$2,700 difference. Glassman ignores the likelihood that these premiums are applied to different populations. Golden Rule is well known for "risk selection": selling only to healthier people, who therefore have lower costs. And the economic incentives also are for healthier people to choose MSAs. So just about every health policy analyst doubts those premiums would be true for the general population. We don't know for sure, because Golden Rule and other prototype MSAs refused to provide data about their risk profiles, or other relevant data, to the American Academy of Actuaries. But that itself should make fair-minded people wonder.

These are just some of the reasons why neutral analysts such as the Academy of Actuaries and the Congressional Budget Office do not believe the MSA advocates' savings estimates. So the tradeoff between the advantages and disadvantages of MSAs is likely to be much different from what Glassman suggests.

The basic disadvantage is that healthier people might choose MSAs, leaving sicker people in comprehensive insurance. The former get a tax break for being healthy: If their costs are less than the MSA contribution, the excess contribution is tax-free income.

But a diabetic, for example, will know that his or her costs would be so much higher than the MSA contribution that he or she would do better with the cost-sharing in traditional insurance. MSA advocates try to get around this by arguing that MSA benefits would actually be higher (compared, for instance, with policies that do not pay for pharmaceuticals). But if benefits are higher, then by the advocates' own logic there shouldn't be savings.

So sicker people should choose conventional insurance, and it should become much more expensive. Insurance for people who need it will be made less accessible, so as to give tax breaks for healthy people. That does not seem worth the small savings in total health care costs that responsible analysts would project from the catastrophic insurance/MSA combination.

MSAs are not an entirely bad idea. Under limited conditions, one could make them make sense. For example, MSAs with community-rated catastrophic insurance policies, sold at the same price to both sicker and healthier people, would be different from the version Golden Rule markets. The benefit to sicker people from community rating might be worth the reduction in total insurance coverage.

But the debate at least should begin from proper data about the possible savings. MSA advocates misuse the Rand data and refuse to submit their anecdotal evidence to neutral review. That's not a good basis for policymaking.

The writer is a senior fellow at the Brookings Institution.

For the Record

From remarks by Secretary of Veterans Affairs Jesse Brown at a White House press briefing on Agent Orange:

Q: Secretary Brown, forgive a sort of personal question, but do you recall being exposed to [Agent Orange] when you were over there?

A: No, I don't recall being exposed to it. All I saw while I was there was just the—I mean, it's kind of hard to understand just—if you look at all of the beautiful greenery, the vegetation that we have here, it's like, there one day and then you look back over that same area another day, and there's nothing. All you do is just see the trunks and limbs of trees.

So it's not something that you would feel or something that you can quantify by saying, yes, I was exposed to it. And that is one of the reasons why we just accepted the responsibility by saying that anyone who served in Vietnam was exposed, because when you put this stuff down, it blows, you know, with the winds. You can carry it from—it's contact transferable. You can transfer it from one person to another by their clothes, and so forth. So it's these kinds of risk hazards that our people were exposed to over there.

Q: What were troops told about it?

A: We didn't know anything about it. That was one of the things—none of this began to become clear to us until we returned many years thereafter.

You've got to remember that war was over in 1975, and I was there many years earlier than that. And all of a sudden the science is telling us about these cause-and-effect relationships.

You take, for instance . . . prisoners of war. We just now are beginning to understand that there is a relationship between being incarcerated and having . . . beriberi and ischemic heart disease. That is scientifically a proven situation.

THE WASHINGTON POST
WEDNESDAY, MAY 29, 1996



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

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February __, 1996
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Contact: HCFA Press
(202) 690-6145

MANAGED CARE IN MEDICARE AND MEDICAID

Overview: Since 1993, the number of Medicare and Medicaid beneficiaries enrolled in managed care plans has experienced unprecedented growth. As a result, the Health Care Financing Administration (HCFA), which administers these two programs, is the largest purchaser of managed care in the country, accounting for 15.5 million Americans. The Clinton Administration has worked in close partnership with the states to provide maximum flexibility through the waiver of Federal rules to expand the availability of managed care plans to Medicaid beneficiaries. The Administration has also worked to expand choices for Medicare beneficiaries and to ensure that all beneficiaries enrolled in managed care receive quality care.

Medicare

As of Feb. 1, 1996, almost 4 million Medicare beneficiaries were enrolled in managed care plans, accounting for more than 10 percent of the total Medicare enrollment population. That represents a 67 percent increase in managed care enrollment since 1993. In 1995, an average of 68,000 Medicare beneficiaries voluntarily enrolled in risk-bearing HMOs each month. Medicare beneficiaries can enroll or disenroll in a managed care plan at any time and for any reason with only 30 days notice.

Managed care plans can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs). All plans receive a monthly payment from the Medicare program.

- o Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses. With the exception of emergency and out-of-area urgent care,

members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan.

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Since Jan. 1, 1993, enrollment in risk plans has grown 105 percent. Currently, 81.6 percent of Medicare beneficiaries in managed care are in risk plans. As of Feb. 1, 1996, risk plans made up 194 of the 278 managed care plans participating in Medicare.

- o **Cost plans** are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer. Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.
- o **Health Care Prepayment Plans (HCPPs)** are paid in a similar manner as cost plans but only cover part of the Medicare benefit package. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care) but some do arrange for services and may file Part A claims for their members.

Nationally, 74 percent of beneficiaries have a choice of at least one managed care plan while 56 percent of beneficiaries have a choice of two or more plans. Medicare managed care enrollment varies greatly depending on geographic location. The majority of beneficiaries enrolled in such plans live in California, Florida, Oregon, New York, Arizona, and Hawaii. In some of those states, more beneficiaries are enrolled in managed care plans than in traditional fee-for-service.

HCFA recently launched "Medicare Choices," a demonstration project designed to allow beneficiaries to join a greater variety of managed care plans, including provider sponsored organizations (PSOs) and preferred provider organizations (PPOs). This project will also experiment with alternative payment methods such as partial capitation, risk adjustment, and competitive bidding. A major goal of this project is to increase access to Medicare managed care organizations in rural communities.

Medicaid

The growth in Medicaid managed care enrollment has been even greater than that experienced in Medicare. Since Jan. 1, 1993, enrollment in Medicaid managed care plans has increased 140 percent, including a 51 percent increase in 1995 alone. As of June 30, 1995, 11.6 million Medicaid beneficiaries were enrolled in managed care plans, representing 32 percent of total beneficiaries.

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Currently, 49 states offer some form of managed care. Since 1993, states have utilized federal Medicaid waivers to increase enrollment in managed care and to develop other innovative changes to their Medicaid programs. Several states have used the resulting savings from managed care enrollment to expand the number of individuals covered by Medicaid and/or the number of services covered under their programs.

The federal government grants two kinds of Medicaid waivers: Section 1915(b) "freedom of choice" waivers and Section 1115 demonstrations. Freedom of Choice waivers permit states to require beneficiaries to enroll in managed care plans. To receive such a waiver, states must prove that these plans have the capacity to serve Medicaid beneficiaries who will be enrolled in the plan. States often use Freedom of Choice waivers to establish primary care case management programs and other forms of managed care. In 1995 alone, HCFA approved 58 Freedom of Choice waivers.

Section 1115 demonstrations allow states to test new approaches to benefits, services, eligibility, program payments, and service delivery, often on a statewide basis. These approaches are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people. Since January 1, 1993, comprehensive health care reform demonstration waivers have been approved for 13 states and eight have already been implemented. When all 12 are implemented, 2.6 million previously uninsured individuals will receive health coverage.

Quality

As the number of beneficiaries enrolled in managed care plans has increased, the Clinton Administration has been working closely with states, insurers, health care professionals, and consumers to assure the quality of care provided in that setting. Several initiatives are already underway. For example:

HHS Interagency Managed Care Forum is chaired by HCFA Administrator Bruce C. Vladeck and Assistant Secretary for Health Philip R. Lee, M.D., and is made up of representatives from operating and staff divisions of the Department of Health and Human Service. The forum meets regularly to share information concerning ongoing managed care activities and to coordinate managed care policy on cross-cutting issues.

Medicaid Health Plan Employer Data Information Set (HEDIS) was developed in partnership with the National Center for Quality Assurance (NCQA) to provide states, managed care plans, health care professionals, and consumers with the information and tools they need to assure high quality in managed care plans serving Medicaid beneficiaries. Medicaid HEDIS is an adaptation of the commercial HMO sector's performance measurement system used by more than 300 private plans.

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Medicaid HEDIS will provide states with information on the performance of their Medicaid managed care contractors, assist managed care plans in quality improvement efforts, support efforts to inform Medicaid beneficiaries about managed care plan performance, and promote standardization of managed care plan reporting across the public and private sectors. Medicaid HEDIS was released to the states in February 1996.

Medicare HEDIS is a parallel effort in partnership with the Kaiser Family Foundation to establish a proven performance measurement system that will minimize reporting burdens on managed care plans serving Medicare beneficiaries. The new measures will help plans to improve the quality of their care and support efforts to improve the health status of beneficiaries. Medicare HEDIS is expected to be implemented in the beginning of 1997.

Foundation for Accountability (FACct) is a collaboration of private and public health care purchasers (including HCFA) and consumer groups working to develop outcomes measures that will allow comparison of the quality of care delivered in managed care settings to that provided in fee-for-service settings. Information is expected to be released in May.

Quality Assurance Reform Initiative (QARI) is a collaborative effort of HCFA, states, the managed care industry, consumer advocates and others to design practical and credible approaches to monitoring and improving the quality of Medicaid managed care services. In July 1993, QARI issued *A Health Care Quality Improvement System for Managed Care*, providing states with a broad range of Federally-recommended guidelines for building and operating quality assurance and improvement systems. These guidelines were tested in three states in 1993-95 by the Kaiser

Family Foundation and the results were issued in 1995 through the National Academy for State Health Policy's *Quality Improvement Primer for Medicaid Managed Care*. In 1995, QARI published *Health Care Quality Improvement Studies in Managed Care*, in partnership with the National Center for Quality Assurance (NCQA).

Medicare Managed Care Quality Improvement Project is being conducted in partnership with the Delmarva Foundation for Medical Care to develop performance measures as part of the strategy to overhaul external peer review of HMO contractors and promote quality improvement in Medicare managed care. Preliminary results are expected in Spring 1996.

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M E M O R A N D U M

April 18, 1996

TO: Carol Rasco, Laura Tyson, John Hilley, Nancy-Ann Min, Susan Brophy, Jennifer Klein

FR: Chris Jennings

RE: Statement on MSAs

Attached are the prepared remarks we used following the 52-47 defeat of medical savings accounts (MSAs). Thought you might like to have these on hand.

Today's vote against Medical Savings Accounts (MSAs) is a victory for the mainstream, a victory for bipartisanship, and -- most importantly -- a victory for the American public. It responds to the President's State of the Union call on the Congress to pass a long overdue package of much needed health insurance reforms. By defeating MSAs, the Senate took an important first step toward achieving this goal.

The Senate showed today that Democrats and Republicans can work together to pass health reform initiatives that reflect the priorities that the vast majority of Americans support. And that they can do so without insisting on controversial amendments that could hurt the health care delivery system and that have no broad-based support.

It is our hope that the upcoming conference will follow the Senate and report out a bill that can retain the bipartisan support that the Kassebaum-Kennedy bill currently has. We look forward to working with the conferees in the upcoming days and weeks to producing a bill that we all can proudly support.

Research Agenda Brief

cc: CHRIS

January 1996

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Medicare in a Consumer-Choice Environment: Competitor or Residual Program?

Prepared by

Lynn Etheredge
Consultant

Health Insurance Reform Project, George Washington University
Prepared with support from the Robert Wood Johnson Foundation

Summary: The Medicare provisions of the reconciliation bill and President Clinton's proposals would both allow many new health plans to compete for Medicare enrollees and structure a competitive, consumer-choice system. Medicare will enter this new environment with serious shortcomings. The logic of market competition will call for upgrading many aspects of Medicare if it is to be successful. Among Medicare's features that need to be reconsidered are benefits, consumer focus, premium financing, payment policies, provider arrangements, performance accountability, management systems, risk adjustment and market strategies, social mission responsibilities, and research and development.

The recent national political discussions about Medicare's future reflect an apparent consensus that the 37 million elderly and disabled persons eligible for Medicare should have expanded choice of enrollment in private health plans. The 1996 reconciliation bill (H.R. 2491) passed by both houses of Congress allows many new health plans to compete for Medicare enrollees and structures a competitive consumer-choice market for Medicare and these other plans. President Clinton's Medicare proposals, although differing in important respects, would also open the Medicare market to many new health plans and structure a competitive consumer-choice system. The apparent agreement on enhanced competition and consumer choice suggests a challenging future for the Medicare program, which remains a fee-for-service insurance program. For the under-65 population, competition by "managed care" health plans has rapidly displaced fee-for-service health insurance; managed care enrollments rose from 30% of workers in 1988 to 70% in 1995.

Medicare may not experience the same rapid demise as other fee-for-service plans. It is still the program of choice for 90% of the Medicare eligible population, and it has a strong "brand name," the wide provider choice of fee-for-service insurance as well as its lack of limits on service use, and the im-

portant capacity to use government-set payment rates to help control costs. But Medicare's past successes and popularity should not engender complacency about its potential future as a competitor with private health plans. Medicare decision makers and administrators have usually been able, over the past 30 years, to think and act as monopolists. That will no longer be the case. The future reality is that Medicare's policy will need increasingly to take into account the demands—and limitations—imposed by a competitive, individual-choice market.

How should the Medicare program be redesigned for this new, competitive environment? What program areas need to be addressed to shape up the Medicare program's shortcomings as a competitor in an individual consumer-choice market?

This paper aims to provide an overview of the Medicare program's new competitive environment and of the specific Medicare policies that political decision makers, administrators, and constituency groups will need to reconsider. It is divided into two major sections:

- A summary of the basic areas of agreement between the reconciliation bill and the president's proposals that would fundamentally change the competitive environment for the Medicare program. Even if Medicare reforms are not enacted this year, these areas of agreement provide a useful template for considering what statutory changes may be coming in future legislative sessions.
- A discussion of ten key aspects of the Medicare program that will need to be reconsidered as the Medicare market evolves and Medicare faces new challenges from competitive health plans.

MEDICARE IN A COMPETITIVE ENVIRONMENT

The reconciliation bill and Clinton's proposals would create a much tougher competitive environment for the Medicare program. They would

bring into the marketplace many new competing health plans, open up competition by health plans with better benefits than Medicare, allow more attractive design features than traditional HMOs, and structure an annual "open season" consumer-choice system in which beneficiaries would be able to make informed, side-by-side comparisons about remaining in the current Medicare system. Specific shared elements of the two plans include the following:

- *Attractive health plan features.* Both proposals would open the Medicare market to competition from HMO point-of-service (POS) plans and preferred provider organization (PPO) plans. These managed care designs, which offer greater freedom of choice of provider than traditional HMOs, have proved popular with the under-65 population. For an elderly population that is aware of its needs for medical care, such flexibility may prove particularly important.
- *Better benefit options.* Both proposals allow competing health plans to offer better financial protection than Medicare as well as enhanced supplemental benefits that are important to the elderly and disabled, such as prescription drug coverage.
- *More health plan sponsors.* Both proposals also allow provider-sponsored networks to offer plans to Medicare enrollees. Marketing by physicians and other health care providers to their patients may further encourage patients to join health plans, as well as bringing more plans to the market.
- *Improved quality assurance.* Both proposals require accreditation of health plans (as well as state licensure), both require health plans to have approved quality assurance programs, and both require reporting of selected quality and health outcomes data for "report cards" that will provide more information to help beneficiaries make their choices.
- *An organized "consumer choice" competitive system.* Both proposals also structure an annual "open season" in which Medicare eligibles

can choose to enroll (or disenroll) in Medicare and its competing health plans. To assist in these choices, Medicare enrollees will have comparative information on the benefits and premiums offered by each plan, as well as other information. To date, Medicare has made little effort either to alert Medicare enrollees to their options for electing competitor health plans or to provide side-by-side comparisons. A new government-sponsored choice system may go far toward informing Medicare enrollees about the better benefits available in private health plans and encouraging them to give serious consideration to selecting one of these plans.

This apparent legislative consensus would address many of the competitive disadvantages that have limited the growth of the Medicare competitive market. It is reasonable to think that if this legislation is enacted the Medicare program will face much stiffer competition and, for the foreseeable future, the current rate at which Medicare's competitor plans are increasing their Medicare enrollments—25% to 30% annually—will continue or possibly accelerate.

In addition to having common elements in their approach to structuring the future competitive environment, the two proposals differ somewhat in other respects. The reconciliation bill would offer high-deductible plans and medical savings accounts, allow associations and unions to sponsor plans, permit premium rebates, and allow door-to-door marketing. The Clinton plan would add medigap policies to the annual open season enrollment competition.

MARKET-ORIENTED THINKING ABOUT THE MEDICARE PROGRAM

With the enactment of a consumer-choice arrangement, determinants of Medicare's future will shift from what goes on inside the Beltway (the political marketplace) to what goes on in local health care markets, as competing health plans target some of Medicare's 37 million eligible individuals to convince

them to enroll. The logic of market competition will call for upgrading many aspects of Medicare if it is to be successful in this new environment.

For an overview of Medicare's competitive position vis-à-vis private health plans, let us consider a hypothetical situation in which there are just two competitors for a market of 37 million individuals. One competitor can offer only a single product (developed 30 years ago) that has less attractive benefits than are being purchased by 80% of its customers, and it cannot offer supplemental benefits. This competitor can set only a single national price for its product, can pay its suppliers only by a national computer-based price schedule, must accept virtually all suppliers, and, as primarily a bill-paying organization, has little influence on supplier performance. This competitor also is not allowed to market its products, and it has to depend on its major competitors to operate its program. Its personnel and operating policies, regulations, and policymaking are subject to political decision makers and government-wide policies. It must bear social costs not paid by its competitor.

The other competitor can offer the range of benefits and supplemental packages wanted by consumers, and it can adjust its premiums to reflect costs and market opportunities. It can select its suppliers for economy, quality, and service; can hold them accountable for performance; and has organized management systems. It can advertise and market its products. This competitor uses private-sector administrative practices and can offer comprehensive benefits for \$1,000 per person (\$2,000 per couple) less expense. As the market grows from 37 million to 70 million persons by the time the baby boom generation is fully retired, most of the new customers will already be signed up with the second competitor, and the first competitor will have to persuade them to leave. Which competitor will be in the better position?

As a new competitive market system is initiated, Medicare will be in a competitive

position similar to that of the first competitor. It will probably face a number of health plans that are similar to the second competitor in each major market area. Nearly all fundamental aspects of the Medicare program will need to be "reengineered" for it to be successful in this environment. Among the aspects of the Medicare program that will need to be reconsidered for their competitive fitness are the following:

- benefits,
- consumer focus,
- premium financing,
- payment policies,
- provider arrangements,
- performance accountability,
- management systems,
- risk adjustments and market strategies,
- social mission responsibilities, and
- research and development.

This agenda involves consideration of potentially far-reaching, even revolutionary, changes in the Medicare program. Given the apparent agreement that Medicare-eligible persons should have the benefits of better private health plan options and competition, its implications for Medicare's future now need consideration. What kind of Medicare program do we want in the future? Shouldn't we want the Medicare program to be a first-rate competitor with private health plans, one that is allowed to provide its enrollees with the benefits they want, and to adopt the best practices from private-sector health plans? Should public policy try to foster competition between a public Medicare program and competing health plans, with the view of trying to get the best of what the public and private sectors can offer? Or should public policy—explicitly or by default—leave Medicare basically unchanged and likely to become a residual program?

The following sections propose some starting points for new thinking about the Medicare program in each of the ten areas mentioned above and sketch some of the potential implications for Medicare's future.

Benefits

Medicare's benefits will need to be seen as a product—or a product line—that is in competition with other offerings in the marketplace.

The Medicare program now offers a single product designed to match the prevailing insurance plans of 30 years ago. It offers basic hospital coverage (90 days per benefit period, 60-day lifetime reserve, no coverage thereafter), steep hospital benefit cost-sharing (\$736 deductible per benefit period, \$184 per day for days 61 through 90, \$368 per day for the 60 lifetime reserve days), and includes no limit on out-of-pocket expenses for physician service benefits (for which there is a \$100 annual deductible and 20% copayment). Medicare does not cover outpatient prescription drugs. To fill in these amounts, 78% of Medicare enrollees obtain medigap or other supplemental coverage. Medicare's competitors, in addition to offering comprehensive coverage, can also tailor benefit packages to Medicare markets and subpopulations with a variety of benefits and cost-sharing options.

For the future, the Medicare program will need to consider both improving its basic benefits and expanding its "product line" of supplemental benefits to enhance its competitive position. Such options could include:

- *Improved basic benefits*, offered either across-the-board or through high-option plans. The standard option could consist of the current Medicare benefits, and the high-option plan could include the comprehensive hospital benefits and annual out-of-pocket spending limit that are popular features of private medigap plans.
- *Supplemental benefit options* that have proved broadly attractive for Medicare's competitor plans, for example, prescription drugs, eye exams and eyeglasses, and hearing aids. The medigap market now includes ten government-determined plan designs; potentially all ten could be offered by the Medicare program itself.¹

- *A high-deductible and medical savings account option*, if that is allowed for private-sector competitors. Medicare may have some competitive advantages in the administrative costs of setting up and operating such arrangements.

A decision to offer improved basic or supplemental benefits will draw the Medicare program into competition with the Medicare supplementary coverage market. In 1992, this market covered about 27 million Medicare enrollees, with premiums of \$27 billion; about half of the policies were employer-sponsored benefits and half were medigap policies. The arguments for a competitive Medicare program offering such benefits, at least vis-à-vis medigap policies, are as follows: (a) Medicare can offer such benefits at significantly lower costs, for example, less than a 3% administrative expense versus an average premium retention of 15% for group medigap policies and 25% for individual medigap policies in 1993,² and (b) the high costs of private medigap premiums (about \$1,000 annually) mean that a Medicare enrollee must pay about \$1,000 (\$2,000 per couple) more for comprehensive Medicare-plus-medigap coverage than for comparable comprehensive benefits from HMOs that enroll Medicare beneficiaries.³ This is a significant market disadvantage for the Medicare program.

Consumer Focus

Medicare's eligible populations will need to be seen as 37 million individual customers with differing needs and desires who can choose among competitor products.

Medicare has been described as an "IBM mainframe" program in what will be a "PC"

¹Medicare's economies come from lower marketing expenses (signup at the same time as SMI benefits); lower premium collection costs (automatic electronic deduction from social security checks, like the SMI premium); and reduced claims processing costs (automatic electronic adjudication along with basic benefits.)

future. Its design philosophy as a single national program with a monopolistic viewpoint will be increasingly challenged as its customers have a variety of choices from health plans that are actively marketing to them, designing products to meet their needs and desires, pricing them competitively, and seeking to satisfy customers. There is considerable diversity among Medicare's enrollees. In a consumer-choice environment, each of these individuals will be able to choose annually to stay with one health plan or switch to another one. Increasingly, newly eligible persons will already be enrolled prior to age 65 with a competing employer-based health plan that is working hard to retain their enrollment. Medicare will need market research about consumer preferences with respect to Medicare and its competing plans, such as is carried out by private insurers. This research will need to include:

- *Analyses of "joiners" and "leavers"* to determine their characteristics and the comparisons between Medicare and its competitors that entered into their decision.
- *Analyses of "stayers"* to determine what factors account for "brand loyalty" to the Medicare program and to its competitors.
- *Focus groups and opinion research polls* to better understand what changes Medicare's customers would like to see in the program.

Premium Financing

Medicare's financing from beneficiary premiums will need to be assessed in terms of the value provided compared to marketplace premiums for its competitor plans.

Medicare now charges a uniform national premium (the SMI premium) of \$42.50 per month for its single national policy. Since the Medicare spending for the SMI program varies by more than 2 to 1 among states, the federal premium subsidy amount varies. With no flexibility for pricing its product to reflect actual costs, Medicare may be at a competitive disadvantage in some areas. In contrast, competing private health plans can adjust their enrollee

premiums, as well as benefits and copayments, to match actual costs and market conditions. Over time, Medicare may need to consider allowing the beneficiary premiums to vary with the costs of insurance coverage, in order to bring Medicare's premium closer to a competitive market amount.

Payment Policies

Medicare's fee-for-service payment policies will need to be assessed to identify where national payment formulas result in over- and under- payment of market rates and how such payments affect the program's competitive position with beneficiaries and providers.

As a near-monopoly bill-payer for 37 million individuals, the Medicare program has been able to use its financial leverage to set hospital (DRG) and physician (RBRVS) rates, unilaterally, at amounts needed to meet budget projections. Medicare's major budget-control strategy, for more than a decade, has been to tighten its payment rates to below average market prices and to restrain annual rate updates. This strategy is continued in both the reconciliation bill and the Clinton proposals; specifically, budget control for the Medicare fee-for-service system would be exercised by reducing Medicare payment rates, on a sector-by-sector basis, if spending exceeded legislatively set targets. Using national payment rates—and nationally uniform adjustments in these fee schedules—is the only major competitive strategy allowed to the Medicare program in the current reconciliation legislation.

The competitive world of the future will introduce two new constraints on the usefulness of this strategy. If Medicare's payment rates drop below what hospitals and physicians can receive from private health plans that compete with Medicare (for example, provider-sponsored networks), providers will have financial incentives to join (or start) such plans and encourage their Medicare patients to enroll in them. If Medicare's payment rates drop far enough below market rates to impinge on access to services, consumers interested in leaving

Medicare will also have many more health plan options to choose from.

The Medicare program will thus need to be alert to the potential failures of its principal competitive strategy. Among the options that may need to be considered are for Medicare to move away from national computer-formula price schedules and nationally uniform adjustments and begin to set its prices on a market-by-market and a service-by-service basis. In some areas, Medicare may be able to achieve greater economies than now provided by the DRG and RBRVS systems; in other cases, it may need to pay more so that it does not induce providers and patients to switch to competitor plans.

Provider Arrangements

Medicare's provider arrangements will need to evolve so that Medicare can become an effective purchaser of health care services and adopt the best practices of private health plans to manage costs, quality, and service.

Medicare is now among the last of the "any willing provider," fee-for-service insurance plans; the resulting inability to manage quality and volume of services is its major competitive disadvantage vis-à-vis private health plans. The Medicare program runs the risks of being the "mother lode" for all of those hospitals and physicians that, because of their unacceptable costs, quality or service, are not included in private-sector managed care plans. Medicare currently holds out to such providers the lure of a population with large medical needs and a program with little control on quantity of services.

The Medicare program will need to consider developing various forms of preferred provider networks, so that it can build its future around those providers offering the best quality, costs and service but still allow individuals to use out-of-network providers of their choice (for higher copayment or premium amounts). This would help to preserve the basic Medicare program by protecting it from

being driven out of the competitive market by a concentration of uncompetitive providers. Many other specific changes would also help to further Medicare's evolution from a bill-paying insurer to an effective purchaser of health care that can use the best practices of private health plans; these are discussed in an earlier Health Insurance Reform Project paper (*Reengineering Medicare: From Bill-Paying Insurer to Competitive Purchaser*). As discussed in that paper, such changes should be selective and targeted at specific program management problems.

Performance Accountability

Medicare's performance accountability will need to reflect the same "report card" data and accreditation standards as applied to its competitor plans.

The Medicare program needs to recognize that it will be in competition based not just on benefit packages and costs but also on quality of care and effectiveness in improving health of its enrolled populations. There is ample evidence of quality problems in the Medicare program to warrant more effective quality-oriented efforts, particularly to deal with chronic and preventive care concerns. To identify—and deal with—its own competitive weaknesses vis-à-vis private health plans, Medicare needs to (a) adopt a new mission philosophy of accountability for health of its enrolled population and (b) assess its performance—nationally and by market area—through "report card" information that the reconciliation bill and Clinton plan propose be required from Medicare's competing health plans. Using the same logic, Medicare should also apply the accreditation standards required for its competitor health plan to its own contractors (intermediaries, carriers, and peer review organizations [PROs]) to assure that they have the quality, internal processes, and effectiveness in improving health status needed in the new health care market.

Management Systems

Medicare's management systems will need to evolve to deliver a range of products, to many different customers, at cost, quality and service performance that meets or exceeds competitive standards.

Medicare's management system has the potential strengths of a unique public-private partnership. Nearly all of Medicare's day-to-day operations are carried out by private-sector contractors, primarily health insurance companies and the PROs. The ability to seek out new management partners gives Medicare a potential for partnering with state-of-the-art performers in the private sector as well as potential flexibility and innovation capability that would be far more difficult in a government-run program. Medicare will increasingly need to consider establishing relationships with new sets of contractors and using private-sector contractors to accomplish its new tasks.

The Medicare program will also need to consider issues that will arise because its most important contractors—particularly, Blue Cross and Blue Shield plans and other insurance companies—have growing conflicts of interest with the Medicare program. These insurers will own and operate some of the Medicare program's major competing health plans; the Blues and Prudential, as well, are the leading writers of medigap benefits, which Medicare may want to incorporate into its own product line in competition with medigap policies. These contractors may have considerable difficulty in resolving these difficulties in ways that best serve the Medicare program's needs: Will they put their best resources and efforts into the success of their own ventures or into that of a major competitor, the Medicare program? The medical society-sponsored PROs may also have conflicts of interests if medical societies form provider-sponsored networks to compete with the Medicare program. Possibly, there may be ways to build "fire walls" and other means by which these companies can be effective Medicare partners

while their private operations seek to prosper by attracting Medicare enrollees. Medicare's resolution of these issues is complicated by the statutory franchises guaranteed to its contractors. These franchises include the "provider nomination" clause that allows hospitals to choose the Medicare contractors that will audit their bills and cost reports, the reservation of Part B contracts to insurance companies, and the preference for medical society-sponsored groups as PRO agents. Medicare should have new administrative flexibilities to use whatever private-sector organizations will best serve the public in the future.

The Medicare program is also at a disadvantage with private business operations since its authorities for hiring, promotion, and compensation are set by civil service regulations; its major policy changes need to be approved by both houses of Congress and the president; and its administrative practices, governed by the Administrative Procedures Act, involve a three-year-long process for establishing new operating policies. All of these characteristics will also need to be reconsidered.

Risk Adjustments and Market Strategies

Risk adjustments between Medicare and its competing health plans are essential to providing a market in which competition is based on cost, quality, and service rather than on risk selection. Medicare will also need to develop differentiated market strategies for a variety of competitive environments.

The shortcomings of the current risk-adjustment (AAPCC) methodology for paying Medicare's competing health plans puts Medicare at a competitive disadvantage. It encourages its competitor health plans to engage in risk-skimming and means that such practices will drive up Medicare's average per enrollee costs. As many fee-for-service insurance plans have discovered over the past decade, such (uncorrected) competitive practices are quite dangerous and can quickly make fee-for-service insurers irreversibly and fatally noncompetitive. Without better risk-adjustment approaches, the

Medicare program is in considerable peril of becoming a residual program with a concentration of the highest-expense populations that private health plans do not wish to enroll. Moreover, as discussed above, Medicare's ability to continue to compensate for this shortcoming through reducing provider payments will be constrained. The serious problems facing Medicare in this regard, and the possibilities of better options, are discussed in a recent Health Insurance Reform Project paper by Stanley Jones (*Why Not the Best for the Chronically Ill?*).

Medicare will also need to develop market strategies that recognize the differences among competitive market areas. Medicare was designed with a great deal of uniformity in enrollment, benefits, financing, provider payment policies, regulations, and administrative structure. But, at the health market level, it is far from a uniform or steadily changing program. There is great diversity in nearly every dimension of service use, rates of increase, and expenditures. Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2 to 1—from 1,735 days per 1,000 enrollees in the western states to 3,455 days per 1,000 enrollees in the northeastern states in 1992. From 1986 to 1992, Medicare Part B expenditure growth varied by more than 3 to 1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina. Medicare needs strategic planning that recognizes the great diversity of the problems it faces and the need for differentiated management strategies tailored to its problems in individual markets.

The competition for the Medicare program from competing health plans also varies widely among areas and results partially from the AAPCC payment methods. As of January 1995, 2 states alone—California and Florida—accounted for nearly 60% of Medicare HMO enrollment, while 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations enrolled in HMOs. In some areas (for example, Los

Angeles), 50% of Medicare enrollees have already opted for private health plans. Medicare needs strategic planning that recognizes the diversity of the competition that it faces and the need for market-focused analyses, including how different premium risk adjusters can affect competitor behavior. Such capabilities will be particularly important in adjusting to the rapid changes that would follow enactment of Medicare reform legislation.

Social Mission

Medicare's social mission responsibilities—such as funding for graduate medical education and disproportionate share hospitals—will need to be reconsidered for financing that will not result in Medicare's being at a competitive disadvantage.

The Congress has given Medicare a number of social missions—and financing responsibilities—that are not required of its competitor health plans. These include financing for graduate medical education and hospitals with disproportionate shares of charity populations. In 1993, these expenses were \$5.4 billion for graduate medical education and indirect medical education and \$3 billion for disproportionate share hospital payments. As Medicare must increasingly compete with private health plans, political decision makers will need to consider various alternative financing for such burdens, including removal of these expenses from Medicare, with new financing provided from general revenues or other government sources, and/or requirements that Medicare's competitor plans provide equivalent payments.

Research and Demonstrations

Medicare's research and demonstrations need to provide the basis for an integrated strategy for shaping Medicare's future in a competitive, consumer-choice market.

The Medicare research and demonstration authorities have often had a focus oriented to the Washington political process. Increasingly, Medicare will need to be market-oriented and

studies will need to provide the information, insights, and prototypes it will need to excel in a competitive environment. Among the types of useful studies would be the following:

- Consumer market research on Medicare vis-à-vis its competitors.
- New approaches for risk-adjustment and service contracting.
- Studies of Medicare's most successful competitors, to determine how their offerings are superior to Medicare's.
- Improved clinical effectiveness and outcomes studies to provide an adequate scientific basis for dealing with the very large regional variations in Medicare service volume among areas and in rates of service use increase.
- Studies of Medicare's high-use populations, who are likely to be "demarketed" by Medicare's competitors and remain in the Medicare program.
- Studies of disease management and prevention initiatives. Members of Medicare's elderly population, many with chronic conditions, are with the Medicare program for an average of more than a decade and up to 40 years or more; individuals in the Medicare disabled populations may be enrolled even longer.

MEDICARE'S FUTURE

In a comprehensive analysis, the Medicare program's future could look brighter than discussed above, particularly if some of its most important competitive shortcomings are resolved. Similarly, Medicare's potential competitors have a number of problems of their own to address. But complacency about Medicare's future would be imprudent (at least).

The Medicare program has been a great social policy success for its first 30 years. But many of its major elements will require rethinking for this new competitive, consumer-choice environment. At first, Medicare may

start out in a disastrously noncompetitive position. How well Congress, HCFA, and constituency groups understand and respond to the needs for some of the changes described above will help to determine whether Medicare will be an effective competitor or a residual program in the future.

The author thanks Stanley Jones and a number of other health insurance experts for discussions about Medicare and its competing health plans.

ENDNOTES

1. Medicare drug coverage is discussed in *Pharmacy Benefit Management: The Right Rx?* Health Insurance Reform Project, April 1995.
2. In 1993, 38% of medigap policies failed to meet federal minimum standards for benefit payout rates of at least 65% for individual policies and 75% for group policies. General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988-93* (GAO/HEHS-95-151), August 1995.
3. George Chulis et al., "MCBS Highlights: Ownership and Average Premiums for Medicare Supplementary Insurance Policies," *Health Care Financing Review*, Fall 1995, pp. 255-275.

Medical Savings Accounts as Proposed in HR 3065

HR 3065, the "Medical Cost Containment Act of 1993", was introduced by Congressmen Jacobs, Archer, Inhofe, Torricelli, Lipinski and Poshard in 1993. Employers could establish a mechanism that would create tax preferred medical savings accounts (MSAs).

- HR 3065 is one of many early MSA proposals. Since 1993, several proposals have been modified to better target MSAs. Congressman Jacobs also introduced several other MSA bills (HR 2220 in 1995, HR 4410 in 1994 and HR 3413 in 1993). HR 2220 is similar to HR 3065.
- There are several features in HR 3065 which may be desirable to incorporate into more recent proposals.
- Under HR 3065, MSAs are limited to employer-provided health insurance plans. There is great uncertainty over the impact of MSAs on the health insurance market, especially on premiums for families with lower incomes and poorer health status. Because of this uncertainty, if it is considered desirable to allow MSAs at all, it would be best to introduce MSAs on a targeted experimental basis. The employer-provided health insurance market may be the natural place to begin.
- To ensure that high-deductible plans provide real insurance, HR 3065 does not allow the deductible for a health insurance plan to exceed \$5,000. Otherwise MSAs may create a new incentive for the insurance market to develop extremely high deductible plans, for example with a \$50,000 deductible. Employers that do not currently provide insurance could buy this very cheap plan and establish MSAs for their employees. Essentially employees would gain a tax-preference for out-of-pocket expenses without having real insurance protection. The \$5,000 limit in HR 3065 could be improved by establishing separate limits for single and family plans to ensure that real insurance is provided for each family type. For example, a lower limit for single plans would be appropriate if the family limit were \$5,000.
- HR 3065 contains the following features that are not desirable. The vetoed budget reconciliation bill made improvements in some of these areas.
 - There would be no required minimum deductible amount under HR 3065. By requiring a minimum deductible amount of \$1,500 singles (\$3,000 families), the budget reconciliation bill provides much greater incentive for people to be cost conscious. Low-deductible health insurance plans should not qualify for MSAs.

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January 19, 1996

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DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

January 23, 1996

MEMORANDUM FOR CHRIS JENNINGS
NATIONAL ECONOMIC COUNCIL

FROM: ERIC TODER
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: Talking Points for Congressman Jacobs' Proposal
For Medical Savings Accounts (HR 3065)

Attached are talking points for Congressman Jacobs' Medical Savings Account (MSA) proposal. The proposal is similar to his more recent proposal (HR 2220), which was introduced in 1995. The attached comments apply to HR 2220 as well.

The talking points make some comparisons with the vetoed budget reconciliation bill. In particular, some of the improvements made by the budget reconciliation bill are noted. We still, however, have concerns with the budget reconciliation bill. Because we were requested to provide talking points on the Jacobs proposal, we have not noted our remaining concerns with the budget reconciliation bill in these talking points. We could provide you with additional material on the budget reconciliation bill.

Attachment

cc: Jennifer Klein
Glen Rosselli
Gillian Hunter



**DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
1500 PENNSYLVANIA AVENUE, NW
WASHINGTON, DC 20220**

Number of pages to follow: 3

Date: January 23, 1996

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Addressee's Confirmation Number: 456-2599

From: Eric J. Toder
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

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January 19, 1996



GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

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11

COMMENTS:

RISK SELECTION ISSUES UNDER MEDICARE REFORM PROPOSALS

**Prepared by Gary Claxton and Larry Levitt
Lewin-VHI, Inc.**

Executive Summary

Reform proposals that encourage beneficiaries to enroll in private health plans for the delivery of Medicare and related services raise issues of risk selection for the Medicare program. Risk selection is the segregation of people by health status across different health plan options. Risk selection can occur when people are given a choice among multiple, different health insurance options. While the proposals include some elements to guard against risk selection, a number of provisions have the potential to segregate sicker beneficiaries into more costly or less generous health plans.

Background: Insurance is intended to pool risk across a large number of people. While the annual health care costs of any one individual are generally very difficult to predict, the average costs across a large pool of people can be quite stable. Therefore, when people are distributed roughly randomly across insurers with large numbers of enrollees, each insurer's exposure to high cost cases will likely be similar to every other insurer's exposure. Risk selection — also referred to as biased selection or risk fragmentation — occurs when the distribution of people across plans is not random, but rather is systematically skewed (e.g., where one plan has a substantially larger proportion of high cost cases than other plans). This phenomenon can distort competition among the plans and create inequities for enrollees of the different plans.

Under the current Medicare program, most beneficiaries (about 90%) obtain coverage on a fee-for-service basis, though beneficiaries also have opportunities to choose private health plans for their Medicare coverage. The most prevalent private plan option is the so-called "risk contracting" program, which offers the opportunity for beneficiaries to enroll in health plans operating like Health Maintenance Organizations (HMOs).

The current Medicare program has largely been structured around a single risk pool, meaning that the vast majority of beneficiaries receive the same coverage at the same price. However, the options for enrolling in managed care plans (e.g., through the risk contracting program) present opportunities for risk selection to occur. The results of risk selection under the current Medicare program are that the federal government faces lower than expected savings (or even higher costs) as a result of managed care enrollment and that beneficiaries enrolling in managed care plans receive additional benefits (in effect subsidized by the federal government). Studies indicate the presence of risk selection, but the results have been disputed by the HMO industry and others.

Medicare Reform Proposals: Both the Seven Year Balanced Budget Act of 1995 (H.R. 2491) as passed by the Congress in November 1995, and the Clinton Administration budget proposal of December 1995, would make a number of changes to the current Medicare program that are intended to encourage beneficiaries to enroll in private health plans contracting with Medicare. The Congressional proposal would expand the types of private health plans that can contract with Medicare — including plans with high deductibles offered in conjunction with medical

savings accounts (MSAs), health plans sponsored by trade or professional associations, health plans sponsored directly by providers, and private fee-for-service plans. The proposals also would provide for a structure to inform beneficiaries about the choice of plans available to them.

The Clinton Administration has proposed a more limited expansion of the range of plans available to beneficiaries. Provider-sponsored and preferred provider organization (PPO) plans would be newly eligible to participate in Medicare, but the Administration proposal does not include MSAs, plans sponsored by trade or professional associations, or private fee-for-service plans.

Both proposals contain provisions to guard against risk selection that could occur as a result of the expansion of private plan options. These provisions include:

- Rules for health plans prohibiting discrimination based on health status.
- A structured open enrollment process, which would help to prevent health plans from materially affecting their enrollment mix through decisions about how to market, where to market, and what to say in their marketing materials.
- The Congressional proposal includes an annual (rather than monthly) disenrollment option, which would help to prevent beneficiaries from switching plans immediately after the onset of a serious illness (e.g., to a plan with more benefits or more choice of providers).
- Limits on benefit variation, which would help to limit opportunities for health plans to attract a healthier mix of beneficiaries by offering a more limited set of benefits.
- Suggestions for the development of more accurate risk adjustment systems, which can adjust for the effects of risk selection.

Despite the provisions in the proposals intended to reduce problems with risk selection, there are several provisions in the proposals that could lead to significant fragmentation of risk in the Medicare program.

- The inclusion of an MSA plan option into Medicare under the Congressional proposal is likely to increase risk selection in the program because it is structured in a way to be attractive to relatively healthy people and unattractive to those in poorer health.
- The provisions in the Congressional Medicare proposal that allow limited enrollment health plans — such as association-sponsored health plans — also are likely to increase risk selection in the Medicare. Many associations are organized around the trade or occupation of their members, and in the non-Medicare market there is a correlation between occupation and the need for health care. Participation in certain trades or occupations may be stratified by income or other factors that are related to health status — including income and place of residence. Health plans formed by professional associations — such as national or state bar associations — may attract healthier than average mixes of enrollees because they are drawing from pools of members with higher than average incomes.

- The Congressional Medicare proposal also includes caps on Medicare spending over time, which could affect the nature of risk selection in the program, as well as its implications. If risk selection of significant magnitude were to occur, the cap on spending under Medicare's traditional fee-for-service program could lead to large curtailments in provider fees and reduced access to services.
- Both the Congressional and the Clinton Administration's Medicare proposals pose the potential for risk selection along geographic lines. Of particular concern is the new opportunity both proposals create for the development of provider-sponsored organizations with geographically-distinct service areas that may not include an average mix of enrollees. A provider-sponsored organization developed by a group of suburban hospitals, for example, will not be designed to serve beneficiaries living in the inner city. If such plans proliferate and are permitted to serve small service areas, risk selection based on geography may increase.
- The Clinton Administration's proposal retains current law that permits Medicare beneficiaries to disenroll from private plans on a monthly basis. Retaining this provision, rather than limiting disenrollment to the annual open enrollment period, perpetuates the risk selection that is likely to come from allowing people to change plans when they get sick.

In sum, The Clinton Administration's Medicare reform proposal would pose less significant issues related to risk selection than HR 2491 because it expands the type of plans available to beneficiaries in a more limited way and does not include a cap on spending over time. However, the Administration proposal also raises risk selection concerns. Whatever legislative action is taken, care is needed to avoid the inequities in care and financial burdens that would result if Medicare's single risk pool were fragmented into multiple pools that segregate beneficiaries based on their health status.

RISK SELECTION ISSUES UNDER MEDICARE REFORM PROPOSALS

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Background and Introduction

Risk selection, sometimes called biased selection or risk fragmentation, is the tendency for people in systems with multiple competing health plans to be segregated by health status across different plans. Risk selection skews competition by distorting the prices of competing health plans and increasing costs for people enrolled in plans with a disproportionate share of higher risk enrollees. Congressional proposals to make greater use of the private insurance market to deliver services under the Medicare program intensify issues related to risk selection in the program.

To date, the Medicare program has escaped these problems because it has largely been operated through a single risk pool, meaning that the vast majority of beneficiaries receive the same coverage at the same price. Although Medicare beneficiaries currently can select among private health plan options in the Medicare risk contract program, enrollment in these plans is too small (about 8 % of beneficiaries) to have a significant impact on the program as a whole. However, as efforts are made to expand enrollment of Medicare beneficiaries in private health plans, attention to the potential problems posed by risk selection is necessary in order to ensure that competition among health plans is on a fair basis that produces efficient results.

This paper discusses risk selection issues as they relate to Medicare reform proposals, and is organized as follows:

- A general description of risk selection and fragmentation issues under insurance-based health systems.
- A discussion of how choice of managed care plans currently operates under Medicare, including an analysis of risk selection issues under the current Medicare program.
- A discussion of the Medicare changes being proposed by the Congress and the Clinton Administration to encourage expansion of private health plans options. This discussion will include analyses of how the Medicare proposals help guard against risk selection and areas where risk selection could pose problems under the reform.
- A discussion of how a cap on Medicare spending over time (that is, a failsafe mechanism) could exacerbate problems of risk selection raised by the Congressional proposal.

Risk Selection in Health Insurance

Insurance offers coverage of an uncertain event for a fixed premium payment. By its nature, insurance is designed to pool risk across a large number of people. While the annual health care costs of any one individual are generally very difficult to predict, the average costs across a large pool of people can be quite stable. Therefore, when people are distributed roughly randomly across insurers with large numbers of enrollees, each insurer's exposure to high cost cases will likely be similar to every other insurer's exposure.

Risk selection occurs when the distribution of people across plans is not random, but rather is systematically skewed (e.g., where one plan has a substantially larger proportion of high cost cases than other plans).

Risk selection can cause a number of problems in a health care system, including:

- **Distortion of competition.** Ideally, health plans compete based on their ability to provide quality services in the most efficient manner. If risk selection exists, however, it is difficult to determine whether one plan is more effective in managing costs than another, or simply has a healthier mix of enrollees.
- **Inequities.** Under a system characterized by risk selection, sicker people will be segregated from healthier people. As a result, the sicker people will tend to pay higher premiums or receive fewer benefits, which many would view as inequitable.

Biased selection can occur as a result of choices made by individuals or as a result of health plan behavior.

- **Individual choices.** Given the choice, individuals will tend to choose an insurance option that provides the greatest benefit to them. For example, someone who is sick will tend to choose a plan that offers more benefits at lower cost sharing than someone who is healthy. Where there are a variety of choices available, this phenomenon will tend to segregate people according to health status.

Risk selection may also occur where there is a choice between a plan that offers a largely unrestricted choice of providers (e.g., a fee-for-service plan) and a plan that has a limited network of providers (e.g., an HMO). Sicker people may tend to choose a plan with fewer restrictions because they are more concerned about being able to have access to particular types of providers or a certain type or level of care.

- **Health plan behavior.** In any given population, health care expenses tend to be highly skewed, with a small number of people using a large percentage of the services. In Medicare, for example, 10% of beneficiaries use about 70% of the services. Health plans, therefore, can often compete (i.e., lower their costs) more easily by attracting healthier beneficiaries and avoiding sicker beneficiaries than by delivering services more efficiently. The more plans are able to market selectively, the better is their potential to attract healthier and lower cost beneficiaries.

There are a number of steps that can be taken to mitigate risk selection. Rules governing plan behavior can help to eliminate the most egregious risk selecting activities by plans. For example, all plans can be required to accept any applicant regardless of health status.

However, subtler forms of risk selection by plans can be more difficult to eliminate through rules. For example, plans can create biased selection by marketing more aggressively to people likely to be healthier than average. This selective marketing can be accomplished particularly effectively through direct marketing activities (e.g., with agents and brokers visiting prospective enrollees in person). One defense against this form of risk selection is to structure the market so that plans have few opportunities to market directly to individuals (e.g., through an annual open enrollment process with standardized information and no or limited direct marketing).

Risk selection resulting from individual behavior will inevitably occur to the extent that benefits and delivery approaches vary from plan to plan. It can be mitigated by standardizing elements across plans, including: covered services, cost sharing, and uniform contracting with designated "centers of excellence."

Ultimately, a perfect risk adjustment system — which effectively involves transferring funds from plans with healthier than average enrollees to plans with sicker than average enrollees — could adjust for the effects of risk selection, regardless of how it occurs. In adjusting for biased selection, a perfect risk adjustment system also eliminates the incentive for health plans to engage in risk selecting activities. However, current risk adjustment techniques are not sufficiently sophisticated to compensate fully for risk selection or to separate completely the effects of risk selection from differences in efficiency across plans.

The Current Medicare Program

Under the current Medicare program, most beneficiaries (90%) obtain coverage on a fee-for-service basis, with the remainder obtaining coverage through managed care plans.

In Medicare's fee-for-service system, beneficiaries can obtain services from any provider accepting Medicare payments (which the vast majority do). In most cases, payments to providers are made according to pre-determined fee schedules (e.g., using the DRG system for hospitals and the RBRVS system for physicians). Federal laws and regulations specify the parameters of the Medicare fee-for-service system, including the out-of-pocket costs required of beneficiaries and the types of services covered.

Beneficiaries also have opportunities to choose private health plans for their Medicare coverage. The most prevalent private plan option is the so-called "risk contracting" program, in which approximately 8% of beneficiaries are enrolled.

Under the risk contracting program, health plans operate like Health Maintenance Organizations (HMOs). For each enrollee, a plan is paid an amount based on the average Medicare fee-for-service costs in an area (adjusted for the demographic characteristics of the enrollee). If the plan expects to be able to deliver Medicare benefits and cost sharing for less than

this payment, it can add benefits or lower required cost sharing.¹ Plans may charge an additional premium for supplemental benefits, but may not offer cash rebates. In effect, plans compete by offering supplemental benefits (i.e., the most efficient plans can offer supplemental benefits with the greatest value). In some areas with a large percentage of the population enrolled in HMOs, it is common for Medicare risk plans to charge only nominal cost sharing and to offer additional benefits (commonly preventive services and prescription drug coverage) at no additional premium.

About 57% of beneficiaries live in a county where one or more Medicare HMOs with risk contracts operate,² but only about 8% of beneficiaries are enrolled in such plans. Enrollment in risk plans varies substantially across geographic areas. For example, nearly one-third of Medicare beneficiaries in Arizona and California are enrolled in risk plans. But, in the majority of states, fewer than 1% of Medicare beneficiaries are enrolled in such plans.

Risk Selection In the Current Medicare Program

While the current Medicare program has largely been structured around a single risk pool — meaning that the vast majority of beneficiaries receive the same coverage at the same price — options for enrolling in managed care plans (e.g., through the risk contracting program) present opportunities for risk selection to occur.

Conceptually, risk selection could occur in the Medicare program if beneficiaries choosing to enroll in managed care plans are healthier than beneficiaries who choose to remain in traditional fee-for-service coverage. The effects of this risk selection would be as follows:

- **The federal government could face lower than expected savings (or even higher costs) as a result of managed care enrollment.** The Medicare program pays managed plans based on 95% of the estimated average cost of fee-for-service coverage in an area (theoretically generating 5% savings for the federal government). However, if managed care enrollees are healthier than average, then the federal government's payment to health plans could be higher than what these enrollees would have cost if they had remained in the fee-for-service program.
- **Beneficiaries enrolling in managed care plans would receive additional benefits (in effect subsidized by the federal government).** Theoretically, managed care plans contracting with Medicare offer additional benefits to beneficiaries if they can achieve savings relative to fee-for-service costs of greater than 5%. However, if managed care enrollees are healthier than average and the federal government's payments do not

¹Plans also can return the excess payment amount to Medicare or make contributions to a "stabilization fund," but these options are less attractive to plans than providing additional benefits to their enrollees.

²Estimate from Health Care Financing Administration, based on May, 1995 plan participation.

reflect this fact, then health plans would be able to offer additional benefits at no cost to beneficiaries simply due to risk selection and not necessarily due to savings resulting from managed care.

A study found evidence of risk selection in the Medicare risk contracting program, concluding that Medicare pays plans 5.7% more than the federal government would have spent on the same beneficiaries under the fee-for-service program (rather than 5% less, as envisioned under the program).³ The results of this study have been disputed recently by the HMO industry and others.⁴ A recent analysis by staff at the Physician Payment Review Commission also suggests favorable selection into Medicare HMOs. The analysis looked at the Medicare expenditures for beneficiaries that enrolled in HMOs during the three months prior to their enrollment. On average, the expenses of HMO enrollees in the three months prior to their enrollment were only 58% of average Medicare fee-for-service expenses in their areas.⁵

Medicare Reform Proposals

The Congressional Medicare proposals would make a number of changes to the current Medicare HMO risk contracting program that are intended to encourage beneficiaries to enroll in private health plans contracting with Medicare (called "MedicarePlus" plans under the Congressional proposal). The proposals would expand the types of private health plans that can contract with Medicare and provide for a structure to inform beneficiaries about the choice of plans available to them. The proposals also contain a number of provisions to address potential risk selection problems. These provisions are described and discussed below.

³Brown, Randall, Jeanette W. Bergeron, Delores Gurnick Clement, et al., *The Medicare Risk Program for HMOs — Final Summary Report on Findings from the Evaluation* (Princeton, NJ: Mathematica Policy Research, February 18, 1993), at 56.

⁴An unpublished paper by Thomas McCurdy of Stanford University offers several criticisms of the methodology used in the Mathematica study, particularly that the study did not take into account the spillover effects on fee-for-service Medicare costs from increases in Medicare HMO market penetration; that the sample for the study excluded beneficiaries that had died during the sample year (1988); and that the model used to predict beneficiary costs used different variables for beneficiaries in fee-for-service Medicare and beneficiaries in Medicare HMOs.

Randall Brown, one of the authors of the Mathematica study, has responded to the critique, defending the methodology and basic conclusions of the Mathematica study, although he acknowledges that the 5.7% estimate may be somewhat too high. See Brown, Randall, *Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Contract Program for HMOs, Response to Comments*, prepared for American Enterprise Institute Conference, Medicare Reform — What Can the Private Sector Teach Us? (Princeton, NJ: Mathematica Policy Research, July 24, 1995).

⁵Staff presentation to the Physician Payment Review Commission, October 26, 1995.

Provisions to Expand Health Plan Choice

Participation in the current Medicare risk contracting program is essentially limited to federally qualified or state-licensed HMOs.⁶ The Congressional and Administration Medicare proposals would expand the types of private health plans available to beneficiaries.

Under the Congressional proposal, the following types of health plans would be able to offer Medicare Plus plans to beneficiaries:

- Private fee-for-service health plans.
- Managed care plans, including HMOs, preferred provider organizations ("PPOs"), or point of service ("POS") plans.
- Health plans with high deductibles (e.g., \$5,000) offered in conjunction with a medical savings account ("MSA plans"). The Medicare contribution for beneficiaries choosing this option would be divided between the premium for the high deductible plan and a contribution to the beneficiary's MSA.
- Health plans sponsored by Taft-Hartley or association sponsors. This could include plans offered by trade or professional associations (e.g., national or state bar associations). These plans would be permitted to restrict enrollment to beneficiaries that are members of the sponsoring organizations.⁷
- Health plans sponsored by a health care providers — referred to as provider-sponsored organizations ("PSOs"). Organizations meeting federal or state standards could contract directly with Medicare, bypassing traditional insurance arrangements.

Health plans contracting with Medicare would be required to meet minimum standards in a number of areas, including solvency, quality assurance, service capacity and consumer protection. In most cases, plans would need to be licensed to bear insurance risk under state laws, although there are exceptions for Taft-Hartley plans and association sponsors, and provider-sponsored organizations could seek a federal waiver from this requirement in certain instances.

MedicarePlus plans would provide benefits to beneficiaries in about the same manner as Medicare HMOs do today. The plans would receive a capitated payment from Medicare for each beneficiary they enroll. The current payment formula for reimbursing health plans contracting with Medicare would be modified to reduce the geographic variation in payment levels and remove the

⁶Although the program is technically open to other types of health plans, regulations relating to assumption of risk tend to limit the ability of non-HMO plans to participate. New guidelines are under consideration that would broaden the types of plans that could participate under the program.

⁷These sponsors could offer managed care plans, fee-for-service plans or potentially MSA arrangements.

connection between the growth in payments to health plans and the growth in the traditional Medicare fee-for-service program. Plans would be responsible for providing at least the level of benefits Medicare provides, plus any additional benefits that the plan offers. Plans could modify the manner of cost-sharing, as long as the total cost-sharing does not exceed the total under the Medicare fee-for-service program.⁸ Beneficiaries enrolling in plans would pay the difference (if any) between the Medicare payment to the plan and the plan premium.⁹ If a plan is able to deliver coverage for less than the payment received from the federal government, 75% of the savings can be rebated to beneficiaries (with the remaining 25% going to the federal government).

Under the Administration's proposal, health plan choices would be expanded in a more limited way to include PPO and provider-sponsored plans. The Administration would not permit MSAs, Taft-Hartley plans, or association-sponsored plans. The current payment structure of the Medicare risk contracting program would remain largely intact under the Administration's proposal.

Enrollment Process

The Medicare proposals passed by the Congress and put forward by the Clinton Administration seek to encourage more beneficiaries to consider enrolling in private health plan alternatives by structuring the enrollment process and providing beneficiaries with more information about private health plan options.

A coordinated annual enrollment period would occur each year, during which beneficiaries would be able to change plans if they wished. To assist beneficiaries in making this choice, the Congressional proposal would require that the Secretary of Health and Human Services ("HHS") assure that beneficiaries receive information about coverage choices, including:

- Premium information, including premiums for supplemental services;
- Covered services, including benefits offered in addition to Medicare covered services;
- Cost-sharing;
- Plan restrictions, appeal rights, and coverage for out-of-area coverage and emergencies;
- Renewal provisions; and
- Quality information, including the percentage of beneficiaries that voluntarily disenroll and information about enrollee satisfaction.

⁸There is an exception for high deductible plans, which are permitted to have higher cost-sharing levels.

⁹Under the proposal, plans could not charge additional premium for Medicare benefits themselves. They could charge more for reducing cost-sharing or for providing benefits in addition to the Medicare benefits.

Under the Congressional proposal, the enrollment process would be coordinated by HHS. Beneficiaries would be permitted to enroll through HHS or directly with a health plan.

The Administration proposal also requires the Secretary of HHS to provide standardized, comparative information about health plans. All enrollment would be carried out through the HHS.

Provisions in Medicare Proposals that Guard Against Risk Selection

Both the Congressional and the Administration Medicare proposals have a number of provisions to discourage fragmentation of the Medicare risk pool due to risk selection. Both proposals include measures to prohibit intentional risk selection behavior by health plans or individuals. An example is the prohibition against health plan discrimination on the basis of health status. Both proposals also take additional steps, such as the provision for the Secretary to develop a more accurate risk adjustment system, to attempt to correct for the market distortions that result from selection bias.

The key provisions that guard against risk selection are discussed briefly below.

- **Antidiscrimination provisions.** The most efficient way for health plans to influence their enrollment is through explicit policy — by refusing to cover people that are in poor health or by excluding certain preexisting conditions from the coverage offered. These techniques are widely used in the individual insurance market as a way for health plans to protect themselves from adverse selection by less healthy people.

Both Congressional and Administration Medicare proposals prohibit health plans from discriminating against beneficiaries in enrollment or premiums based on their health status or need for health care services. These provisions are similar to provisions adopted by states in the area of small group health insurance reform, which by and large have been effective in preventing explicit discrimination based on health status.

- **Structured open enrollment process.** A primary place where selection bias can occur is in the enrollment process. Health plans can materially affect their enrollment mix through decisions about how to market, where to market, and what to say in their marketing materials.

The Congressional Medicare proposal attempts to deal with this problem through a coordinated open enrollment process and through a broad distribution of standardized information about health plans. These provisions should be fairly effective in preventing health plans from limiting their enrollment to a target set of beneficiaries. However, provisions that permit health plans to directly solicit and enroll beneficiaries leave some opportunity for selective marketing by health plans, particularly plans with limited enrollment capacity. If those plans can concentrate their marketing and enrollment on potential enrollees from less costly areas, they may be able to fill-up their available enrollment capacity with a relatively healthy mix of enrollees.

The Administration proposal provides greater protection against selection bias by specifying that enrollment would be carried out through HHS and by giving the Secretary of HHS authority

to review and disapprove health plan marketing materials that are materially inaccurate or misleading.

- **Annual disenrollment option.** The decision by beneficiaries about when to leave health plans also can lead to biased selection. There is a concern that beneficiaries are more likely to switch plans after the onset of a serious illness, either for a plan with more benefits or more choice of providers. This option could particularly be a concern for beneficiaries in high deductible plans, who may want more comprehensive coverage after the onset of a chronic illness with high annual expenses.

The Congressional Medicare proposals address this problem by generally limiting the opportunity for beneficiaries to switch plans to the annual open enrollment period.¹⁰ The Administration proposal does not include a similar provision. It retains current law which allows beneficiaries to disenroll from a plan during any month. The monthly disenrollment option allows people to leave plans when they get sick, thereby posing selection problems.

- **Limits on benefit variation.** Variation in benefits across health plans will tend to lead to risk fragmentation, with less healthy beneficiaries preferring plans with richer benefits and fewer out-of-pocket expenses (e.g., cost-sharing). Health plans can attempt to influence their enrollment mix by the way they structure their benefits. For example, plans can attempt to attract healthier enrollees through higher cost-sharing, structuring additional benefits to wellness, or placing low annual limits on certain benefits, such as prescription drug coverage.

Both the Congressional and Administration Medicare proposals attempt to address the potential risk selection problems associated with benefit variation in several ways. First, they require all health plans to cover at least the Medicare benefit package. This requirement provides for a common core set of benefits across all plans. Second, they limit the level of cost sharing in health plans (other than high deductible plans) to the aggregate level of cost-sharing in the Medicare fee-for-service program. These provisions help to mitigate the potential risk selection associated with benefit variation, with one major exception: the selection problems associated with high deductible plans and MSAs, which are discussed below.

Third, both proposals recognize that variation of benefits beyond the common core can be used to attract or discourage enrollees. To address this problem the Congressional proposal requires the Secretary of HHS to approve additional benefits. The Administration proposal goes a step further requiring the Secretary of HHS (in consultation with the National Association of Insurance Commissioners and other groups) to develop a standard package of benefits that may be offered by plans.

¹⁰There are some exceptions. Beneficiaries have an option to disenroll within 90 days of their initial enrollment in a private health plan. Beneficiaries also will be able to disenroll for qualifying events (e.g., change of residence) or cause.

- **Risk adjustment.** Risk adjustment systems are processes that attempt to correct for the potential effects of biased selection by transferring premium revenues from health plans that achieve favorable selection to health plans that experience adverse selection. To do this effectively, the system must be able to identify the extent to which the health risk of the enrollees of each health plan vary from the "average" distribution of risk in the community.

The Congressional and Administration Medicare proposals authorize the Secretary of HHS to make appropriate adjustments to the payments to health plans to assure actuarial equivalence. This authorization would permit the Secretary to adjust payments to health plans to account for differences in health status. Several systems are currently in the development stage, and demonstrations are possible within the next year. Full implementation of such systems would appear to be several years away. In the interim, it may be appropriate for Medicare to incorporate more limited risk adjustment approaches that have been implemented at the state level. Mandatory reinsurance programs (such as the programs in operation in New York and under consideration in California) are one option.

Potential Risk Selection Problems Under Medicare Proposals

Despite the provisions in the proposals intended to reduce problems with biased selection, there are several provisions in the Congressional and Administration proposals that could lead to significant fragmentation of risk in the Medicare program. These are the provisions permitting beneficiaries to enroll in MSA plans and plans formed by associations, and provisions that permit plans to define limited service areas.

- **MSA plans.** The inclusion of an MSA plan option into Medicare is likely to increase biased selection in the program because it is structured in such a way as to be attractive to relatively healthy people and unattractive to those in poorer health.

Under the Congressional proposal, beneficiaries joining MSA plans would be covered under a catastrophic health insurance plan covering all expenses over a high deductible amount (e.g., \$5,000). Any difference between the amount contributed by Medicare for private health plans and the cost of the catastrophic plan would be deposited into an MSA. Beneficiaries could use the funds in their MSA to pay for medical expenses up to the catastrophic plan deductible amount or to pay for health services that are not otherwise covered under Medicare (i.e., prescription drugs, etc.). Beneficiaries would be able to withdraw a portion of the funds in their MSAs for other purposes after they had accumulated a balance equal to 60% of the deductible amount in their catastrophic policy.

Beneficiaries that join MSA plans will be personally at risk for the difference between the catastrophic deductible and the amount in their MSA. For many

beneficiaries, this could be a substantial amount.¹¹ As a result, MSAs would tend to attract a healthier than average enrollment mix simply because healthier people are more likely to accept the risk of higher out-of-pocket costs under these plans. The Congressional Budget Office has estimated that incorporating MSA plans into Medicare encourages biased selection and actually increases Medicare costs.¹²

As discussed above, the potential selection effects of MSA plans can be mitigated to some extent by limiting the opportunities for beneficiaries to enroll and disenroll in MSA plans. Beneficiaries may be discouraged from enrolling in these arrangements if they know they cannot easily switch to a richer health plan when they develop a serious or chronic illness. The effects of biased selection also could be mitigated if better risk adjustment methods could be developed. However, neither of these methods is likely to eliminate the effects of biased selection.

- **Limited service areas.** The mix of enrollees served by a health plan can be influenced by how the plan defines the areas that it will serve and by where it locates facilities within the service area. Health plans with service areas that avoid higher-cost portions of counties may attract a healthier than average enrollment mix. Neither the Congressional nor the Administration proposal specifically address the service area issue.

This issue could be exacerbated by provisions in the Congressional and Administration proposals that permit provider-sponsored organizations to form and contract directly with Medicare to provide benefits to beneficiaries on a capitated basis. Because these plans would be new and based around particular health care providers, they may tend to have smaller, more geographically-distinct service areas that may not include an average mix of enrollees. For example, a provider-sponsored organization formed by a group of suburban hospitals may not be designed to serve beneficiaries living in the inner city. If these plans proliferate and are permitted to serve small service areas, fragmentation along geographic lines may increase. Provider-sponsored organizations raise the additional concern that the providers who form them will have

¹¹The amount could be significant even if beneficiaries were willing to contribute the amount that they would have used to purchase Medigap insurance. For example, Lewin-VHI estimates that over one-half of beneficiaries would receive an MSA contribution of less than \$500, assuming a \$3,000 deductible plan with a catastrophic premium based on average an average mix of enrollees.

¹²The CBO preliminary staff estimate for the original House proposal estimated that 2% of beneficiaries would join MSA plans by 2002 and that Medicare spending would be increased by more than \$4 billion between 1996 and 2002. Lewin-VHI has estimated that 1.1 million beneficiaries would join MSAs and that Medicare costs would increase by \$15.6 billion between 1996 and 2002.

detailed knowledge of their patients, as well as the incentive, to select or avoid enrollees.¹³

- **Association plans.** The provisions in the Congressional proposal that allow limited enrollment health plans — such as association-sponsored health plans — also is likely to increase biased selection in the Medicare. Under the proposal, trade and other associations can form health plans and limit enrollment in them to association members. Associations would be required to meet standards to assure that they were bona fide membership associations and were not formed merely to offer health insurance to their members.

These arrangements have the potential to increase selection for several reasons. The first is that many associations are organized around the trade or occupation of their members. In the non-Medicare market, the industry and occupation of a group is a significant factor in determining premiums because insurers believe that there is a correlation between occupation and the need for health care. If this correlation carries over into retirement, then associations with healthier-profiles would be in a position to benefit from offering health plans to their members.

Participation in certain trades or occupations may be stratified by other factors that are related to health status, such as income. In general, people with lower incomes tend to have poorer health status. Health plans formed by professional associations — such as national or state bar associations — may attract healthier than average mixes of enrollees because they are drawing from pools of members with higher than average incomes.

Association plans may also facilitate fragmentation by geographic location. Many trade or other associations are defined by location. If an association's membership is concentrated in lower cost or higher cost areas, this factor will contribute to selection bias.

- **Monthly Disenrollment.** The Administration's proposal retains current law that permits Medicare beneficiaries to disenroll from private plans on a monthly basis. This provision was intended to protect beneficiaries against poor quality of care by enabling dissatisfied beneficiaries to leave plans at will. However, this provision also raises risk selection issues. There is a concern that beneficiaries are more likely to switch plans after the onset of a serious illness, either for a plan with more benefits or more choice of providers (e.g., the traditional fee-for-service Medicare program).

Interaction Between Risk Selection and Caps on Spending

The Congressional proposal includes caps on Medicare spending over time, which could also affect the nature of risk selection in the program, as well as its implications.

¹³Medicare Work Group (Roland E. King, Chairperson) American Academy of Actuaries, Comments and Recommendations on Medicare Reform, December 21, 1995.

Under HR 2491, payments to plans would be capped over time at growth rates substantially below the spending increases projected by the Congressional Budget Office (CBO) for Medicare or private sector spending. Plan payments would grow at different rates across geographic areas. Spending under Medicare's fee-for-service program would also be capped, independent of growth in health care costs. Establishing a fixed cap is a departure from previous efforts to control program costs that have relied on specific changes in policies toward provider payment. Under the Congressional proposal, if spending in a given year is expected to exceed the pre-determined growth targets set in the statute, provider fees are reduced by the Secretary of HHS to bring spending in line with the targets.

The structure of the caps or fail-safe limits puts the providers that serve the traditional fee-for-service program "at risk" if private health plans get a healthier than average mix of enrollees.¹⁴ Biased selection that favors private health plans would leave the traditional fee-for-service program with less healthy enrollees, which would both increase the program's costs and the likelihood that the fail-safe limits would be exceeded, thus triggering reductions in the payments to fee-for-service providers. Unless some adequate method of adjusting for biased selection (e.g., a risk adjustment system or higher fail-safe limits) is developed, fee-for-service providers could be financially penalized for cost increases that are outside of their control. This process could eventually affect the willingness of providers to serve beneficiaries in the fee-for-service program, reducing access for those beneficiaries that prefer to remain in fee-for-service Medicare.

Conclusion

Risk selection can cause serious problems in a health care system, distorting the prices charged by competing health plans and potentially segregating sicker individuals in more costly or less generous health plans. As Medicare incorporates more aspects of private health insurance, the need to address the potential problems posed by risk selection will increase.

Specific provisions have been included in both the Congressional and Administration Medicare reform proposals that are designed to guard against risk selection, including: antidiscrimination rules, a structured enrollment process, and some limits on benefit variation.

However, there are several provisions in the proposals that could lead to significant fragmentation of risk in the Medicare program, particularly those permitting beneficiaries to enroll in MSA plans and plans formed by associations. Provisions that authorize MSA and association plans, that permit plans to limit their service areas within counties, or that continue to permit beneficiaries to disenroll on a monthly basis could each contribute to greater fragmentation of the Medicare risk pool in the future.

The Congressional Medicare proposal also includes caps on Medicare spending over time, which could affect the nature of risk selection in the program, as well as its implications. If risk selection of significant magnitude were to occur, the cap on spending under Medicare's traditional

¹⁴In the same way, fee-for-service providers would benefit if there were adverse selection against private health plans.

fee-for-service program could lead to large curtailments in provider fees and reduced access to services.

The Clinton Administration's Medicare reform proposal would pose less significant issues related to risk selection because it expands the type of plans available to beneficiaries in a more limited way and does not include a cap on spending over time.

Whatever legislative action is ultimately taken, attention to preventing risk selection is essential. Medicare's single risk pool currently ensures that the vast majority of program beneficiaries receive the same coverage at the same price, regardless of their health status. Risk selection that would segregate sicker beneficiaries into more costly or less generous health plans would undermine this critical and valued element of the Medicare program.