

NAVAL POSTGRADUATE SCHOOL
Monterey, California



THESIS

**IMPLICATIONS OF THE MEDICAL SAVINGS
ACCOUNT PROVISION OF THE
BALANCED BUDGET ACT OF 1997**

by

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December 1998

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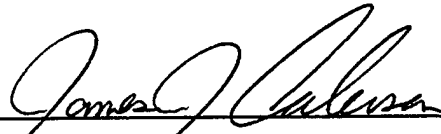
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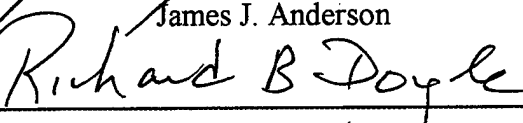
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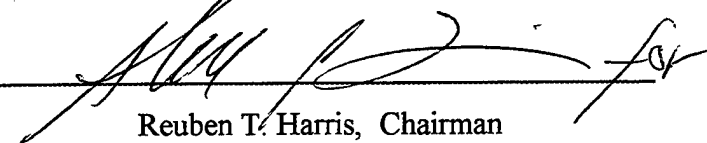
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ABSTRACT

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I. INTRODUCTION

From 1980 to 1996 Medicare spending has increased from 34 billion dollars to over 203 billion dollars (HCFA, January 1998, p. 1). That rate of increase is nearly 11.8 percent each year, outpacing average annual economic growth by 450 percent (Bureau of Economic Analysis, August 1997, pp. 8-10) and is projected to result in Medicare spending in excess of 305 billion dollars by 2003 and over 448 billion dollars by 2008 when the baby boomers start to retire (CBO, January 1998, p. 5). In order to try to manage the rising cost of the Medicare program, Congress enacted Medicare+Choice (Part C) which provides Medicare participants a wide range of options to manage their own medical expenses. One of the most important and controversial of those options is Medical Savings Accounts, which emerged from the Balanced Budget Act of 1997 as a test program for Medicare.

A. INTRODUCTION OF MEDICARE+CHOICE

Until recently, Medicare, managed by the Health Care Financing Administration (HCFA), covered all Americans and permanent residents 65 years of age or older, persons with end-stage renal disease (ESRD), and those receiving Social Security Disability Insurance (DI) benefits for at least two years. It was divided into two components: Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B).

Part A helps pay the cost of hospital inpatient and skilled nursing care, and is considered an earned benefit for most people, requiring no premium upon eligibility. It is funded by current employees and their employers, each paying 1.45 percent of the workers salary (self employed workers pay 2.90 percent) to the Hospital Insurance Trust Fund. Part A benefits are considered to be earned, much as those from a conventional

insurance policy, by the payroll tax deductions beneficiaries and their employers contributed to these programs.

Part B is voluntary insurance for physician services financed through monthly premiums (\$43.80 in 1998). The premiums cover about 25 percent of costs; federal tax revenues cover the remaining 75 percent. Part B generally pays 80 percent of the physician and outpatient services after the annual \$100 deductible. Unlike most private insurance, Medicare does not cap beneficiaries' out-of-pocket expenses. (Gieri, 1997, p. 3)

In 1997, Public Law 105-33, The Balanced Budget Act of 1997 established Medicare+Choice (Part C), a new authority permitting contracts between HCFA and a variety of different managed care and fee-for-service entities and Medical Savings Accounts (MSA's). (HCFA, 1997, p. 1)

MSA's allow participants to select, from an approved list, their own catastrophic medical policy that (1) fits their requirements and (2) meets Medicare's minimum coverage qualifications. Funding for the policy comes from Medicare, but Medicare does not tell the beneficiary where they can or cannot obtain their treatment. Each year Medicare will directly pay the premiums of the insurance plan that the member selects; any remaining funds are placed into the member's MSA. Remaining funds can then be used to pay for medical services that contribute to the high annual deductible. These annually contributed funds usually will not cover the cost of the high deductible unless they have accumulated in the account for a couple of years. If there are insufficient funds in the account, the member will pay out-of-pocket expenses toward their own uncovered medical care deductions until the full deduction has been incurred. Like Medicare Part B,

there is no cap on out-of-pocket expenses for MSA beneficiaries. Once the high deductible has been reached, the insurance policy will pay a significant portion, if not all, of additional health care costs for the year. At the end of the year members may carry forward any funds remaining in their Medical Savings Account. The account continues to accumulate in the member's name if he/she has not used all of their initial annual funding.

Congress is approaching MSAs with extreme caution. For a number of years Congress debated the pros and cons of MSAs, finally agreeing to an experiment that will allow 390,000 beneficiaries to have MSAs starting January 1st 1999. Enrollment for the program will begin in November 1998 and will end 1 January 2003. During this time, the effectiveness of this new program will be evaluated.

B. SCOPE OF THIS THESIS

This thesis will examine the political and fiscal pressures in the evolution of Medical Savings Accounts from their roots in the private sector to the enactment of the Balanced Budget Act of 1997 for the Medicare System. It will also examine how Medical Savings Accounts might ensure Medicare's solvency for future generations while at the same time providing the high level of medical care desired by its participants.

C. BENEFITS OF STUDY

This thesis will examine Medical Savings Accounts in order to understand how new, complex, and controversial proposals affecting Medicare are dealt with in legislation and how the Medicare Medical Savings Account test program has been implemented to this point.

II. MEDICAL SAVINGS ACCOUNTS IN THE PRIVATE SECTOR

John C. Goodman, president of the Dallas-based National Center for Policy Analysis (NCPA), a conservative think tank, came up with the idea of Medical Savings Accounts in the mid-1980's. The purpose of MSAs is to reduce health care costs across the board through competition and free enterprise by (1) allowing people the freedom to see the doctor that they want when they want, (2) provide a financial incentive to the employee to be fiscally responsible with their medical care costs while at the same time (3) providing a sense of security knowing that their out of pocket medical expenses are capped each year.

Basically, MSAs as follows. An employer pays for a high deductible catastrophic health policy with a low premium, immediately realizing savings compared to the cost of a traditional managed health care. All or part of the savings can be placed in the employee's MSA to help pay for the high deductible. If the amount contributed by the employer does not meet the high deductible, then the employee must pay the difference as necessary until the high deductible is incurred. Once the employee has incurred the deductible, the catastrophic insurance policy takes effect and pays for a significant portion, if not all, of additional covered medical expenses for the remainder of the year.

The MSA option provides the opportunity for the member/employee to take direct control of when, and more importantly, where they get their health care. Under an MSA, the employee is no longer restricted to a list of "participating" health care providers like in an HMO. Instead they can contract with any organization or private doctor to provide medical services. This new option provides the owners of MSAs leverage to activate market forces of supply and demand. As more and more people move towards MSAs,

competing provider organizations may be incentivized to reduce their rates and expenses to be more competitive and increase their share of the MSA market. No longer would the health care industry and insurance companies be the only groups to benefit from the health care business. Instead, the MSA consumer will now be an active participant; they can retain their unused annual health care system money, and also have a voice in selecting their coverage, thus driving market forces to become more efficient.

A. CORPORATE HEALTH CARE SPENDING CHANGES

In 1994, the National Center for Policy Analysis stated that "most health economists agree that the primary reason why health care costs are rising is that the money we are spending in the medical marketplace is usually someone else's. More than a decade ago, the Rand Corporation discovered that when people are spending their own money on health care they spend 30 percent less with no adverse effects on their health."

(NCPA, April 1994, p. 1) The center pointed out the following examples of successful health programs:

- Since 1982, Quaker Oats has had a high-deductible policy and paid an annual \$300 into the personal health accounts of employees, who get to keep any unspent balance; the result: over the past decade the company's health care costs have been growing an average of 6.3 percent per year while premiums for the rest of the nation have grown at double digit rates.
- Forbes magazine pays each employee \$2.00 for every \$1.00 of medical claims they do not incur up to a maximum of \$1000.00; the result: Forbes's health care costs fell 17 percent in 1992 and 12 percent in 1993.
- Dominion Resources, a utility holding company, deposits \$1,620.00 a year into a bank account for the 80 percent of employees who choose a \$3,000.00 deductible rather than a lower deductible; the result: the company has experienced no premium increase since 1989, while other employers faced annual increases of 13 percent.

- Golden Rule Insurance Company deposits \$2,000.00 a year into a medical savings account for employees who chose a \$3,000.00 family deductible; the result: in 1993, the first year of the plan, health costs were 40 percent lower than they otherwise would have been. (NCPA, April 1994, pp. 1-2)

By the end of 1995, over 3000 different companies provided their employees MSAs as a health care option. (Subcommittee on Civil Service of the Committee on Government Reform and Oversight, House of Representatives on December 13, 1995, p. 6) From this customer base came a movement to enhance the "savings" aspect of the accounts by allowing MSAs to accumulate contributions and interest earned tax free, to pay for future medical expenses.

B. FINANCIAL ASPECTS OF MSAs

Prior to 1997, the balance in a MSA at the end of the year was refunded to the employee as a bonus or refund. Contributions by the employer were considered taxable income for the employee and the "savings" aspect of the MSA did not exist. Any remaining funds rebated at the end of the year could be spent on anything the employee wanted, since it was considered taxable income.

Since 1997, the Health Insurance Portability and Accountability Act of 1996 permitted a four-year test program for up to 750,000 Medical Savings Accounts. These accounts would allow contributions from employers to be tax-free and carry forward to the next year. Participants in this program have to be (1) self employed (2) small businesses with fewer than 50 employees or (3) those individuals with no health insurance coverage available to them.

This law truly made the "savings" part of Medical Savings Accounts a reality. No longer will MSAs covered by the new law be zeroed out at the end of the year. Each year on January 1st the process for the old taxable and new tax free MSAs starts all over as the employer deposits an agreed upon amount into the employee's MSA, to be used for medical expenses incurred until meeting the deductible.

C. FINANCING MSAs

Since its inception, many different MSA financing methods have emerged. All plans call for the employer to pay for a high deductible, low premium catastrophic health policy. However, funding for the high deductible aspect differs among plans. Some employers may contribute 50 percent of the deductible to the employee's MSA, leaving the remaining 50 percent to be paid by the employee as incurred; others might contribute 75 percent of the high deductible each year.

The idea was slow to be accepted by many employers and employees prior to 1995. In 1995 proof of performance came from about 3000 different organizations that had started offering or participating in MSA health plans. Congressional testimony from Senators, Mayors, County Commissioners and Presidents of corporations and insurance companies on December 13, 1995 revealed savings for companies offering MSA's to their employees; local governments such as Jersey City, New Jersey and Ada County, Boise, Idaho also experienced immediate same year savings of millions of dollars to their health care plan. (Subcommittee on Civil Service of the Committee on Government Reform and Oversight, House of Representatives on December 13, 1995, pp. 9-41)

During this testimony, Mayor Bret Schundler of Jersey City, New Jersey testified that:

Jersey City was the first governmental entity to offer MSAs to its employees. In the past, Jersey City covered its management employees through the New Jersey State Health Benefits Plan. Most chose the traditional indemnity or ("fee-for-service") (sic) option, where employees had to pay a \$200 front-end deductible and a 20 percent co-payment on the next \$2,000.00 of medical expenses for each covered family member. That means a family of four had to pay up to \$1,800.00 in out-of pocket expenses annually.

Under the MSA plan, the city purchases a catastrophic insurance policy that covers 100 percent of a family's medical costs above a \$2,000.00 deductible. The city then places an additional \$1,800.00 in a medical savings account that the employee can draw upon for medical. Added together, this means that a family of four enrolled in the family plan would, at most, have to pay a \$200.00 back -end deductible. And if that same family's total health care costs fall below \$1,800.00, the money remaining in the MSA will be refunded to the employees at the end of the year.

Mayor Schundler went on to say,

The cost of family coverage under the State Health Benefits Plan is \$6,775.00 per year and rising (premiums have doubled in just the last five years). The cost of the MSA option is only \$6,500.00 --\$4,700.00 for the catastrophic insurance policy and \$1,800.00 for the cash contribution to the Medical Savings Account. Therefore, in the first year alone we save about \$275.00 for every management employee that chose the MSA over the traditional indemnity plan.

That's a great deal: better coverage for our employees, which maintains their ability to choose their own doctor and lowers their potential out-of-pocket expenses, combined with lower cost to the taxpayers of Jersey City! (Subcommittee on Civil Service of the Committee on Government Reform and Oversight, House of Representatives on December 13, 1995, pp. 13-16)

D. CONCLUSIONS

Medical Savings Accounts arose in the 1980's in response to double-digit cost increases to health care. Employers were looking for ways to balance the cost of health care benefits with the same need to provide an attractive coverage plan that would meet their employee's requirements.

By providing MSAs as an option, employers have allowed their employees to actively manage their own health care thus making them fiscally responsible for their

own health care. The benefits of this option allowed (1) companies and employees to cap out-of-pocket expenses, (2) produce immediate realized savings for the company, (3) potentially produce savings for employees if they do not have to incur the high deductible and (4) provide a sense of security to its employees by allowing them to get the health care that they feel is required at any time.

Opponents warn of potential economic and social problems due to MSA participation. They claim that people who own MSAs will forego necessary medical treatment in order to build up a cash balance. The argument here is that people would sacrifice or ignore their health problems for a bigger savings account. Another concern is that health care cost would actually increase due to additional administrative requirements rather than decreasing through competition as supporters of MSAs point out. Another argument against competition is that the individuals acting on their own lack the resources to become intelligent consumers in the medical marketplace. For more specific individual and national economic reasons, opponents point out that a high deductible may help people who are healthy but it may financially hurt people who are already sick and that the widespread use of MSAs would cause substantial loss of federal tax revenue.

III. CONGRESS, MSAs AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

During the early 1990s, President Clinton asserted that all Americans should have access to health care and receive it at a reasonable price. Following this call, Congress became entrenched in a bitter battle over how to reform the health care system. Two key areas of this reform were: (1) slowing the pace of health care cost growth and (2) providing health care coverage to all Americans.

A. THE BEGINNING OF CONGRESSIONAL ACTION

The President and Congress sponsored a number of proposals concerning health care reform. Numerous proposals came to the table in 1994 that included tax-exempt MSAs, from supporters such as Representatives Bill Archer (R-TX), Chairman of Ways & Means Committee, and Roy Rowland (D-GA), and Senators Judd Gregg (R-NH), GOP Whip, Bob Packwood (R-OR), Thomas Bliley (R-VA), Bob Dole (R-KS) and Phil Gramm (R-TX). (Medicine & Health, January 1995)

Two of the proposals that affected the evolution of congressional legislation for private and later Medicare MSAs were the measures from Representative Pete Stark (D-California) and the Bipartisan Health Care Reform Act.

1. Stark Bill

Representative Pete Stark's (D-CA) proposal centered on universal coverage. Individuals could buy private insurance or participate in a new plan called Medicare Part C. Participants of Medicare Part C would pay their premiums through payroll deductions not to exceed 20 percent of the full premium cost. The employer would incur the remaining 80 percent of the premium. Based on a 2400 dollar annual premium, a full-

time employee would have been faced with an annual premium cost of 480 dollars and an annual deductible of 500 dollars with no limit on out-of-pocket expenses. For prescription drugs, there would have been a 500 dollar deductible with a 1000-dollar out-of-pocket cap. (Rubin, 1994, p. 609)

2. The Bipartisan Plan

The Bipartisan Health Care Reform Act called for employers to offer at least two plans, one which did not limit the choice of doctors or health care providers and one that centered around a high-deductible catastrophic plan. Unlike Stark's proposal, employers would not be required to pay for either of the plans. Health care insurance costs incurred by the employee would have been partially tax deductible. In addition to these options, the bipartisan plan recognized MSAs in the private sector and proposed tax benefits for them. (Gieri, 1997, pp. 35-36)

None of the proposals submitted in 1994, including the two described above, became law. However, these two MSA proposals did foreshadow how Congress would finalize a working format for MSAs in both the private sector and for Medicare, in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997, respectively.

B. DRIVING FORCES OF MSAs

One of the largest MSA supporters in the private sector was the Golden Rule Insurance Company of Indiana. In 1993, it offered MSAs to its employees; 80 percent of its 1300 employees chose MSAs. Each year Golden Rule deposited 2000 dollars into a family designated MSA or 1000 dollars into a single member's MSA to help offset the high deductible of 3000 dollars for family accounts and 2000 dollars for single accounts.

Because of the large number of employees that accepted MSAs, Golden Rule reduced its employee health care costs by 40 percent. These savings were passed on to the average employee. During their first year, employees had nearly 470,000 dollars in their MSAs, or an average of 450 dollars per account. Other organizations, such as Spurwink School in Portland, Maine, the United Mine Workers of America and the public employees of Jersey City, N.J., joined Golden Rule in the MSA experiment. (Business & Health, October 1994, pp. 3-4)

While large employers were pushing for MSAs, HMOs and managed care programs were fighting the whole idea. They argued that if MSAs were available to everyone, then the majority of the population, which is healthy, would leave the managed care system. As result of this exodus, insurance premiums would have to go up for those who were sick and could not afford the high-deductible MSA option. The end result would have been the opposite of what was intended; there would be higher premiums for some beneficiaries and more uninsured individuals.

Supporters for MSAs fired back, using the same argument. They pointed out that MSAs would benefit the entire population because health care cost savings from large MSA participation would eventually reduce national health care costs and spending, while at the same time increasing the number of people who have health care insurance.

1. Unfavorable MSA Tax Laws

During the early 1990s, many companies discovered that they could reduce their health care cost through MSAs. But because of tax laws, employers were not allowed tax deductions for contributions made to MSAs and employees had to claim any funds remaining at the end of the year as taxable income. This combination of rules made it

impossible for small employers to offer MSAs; their employee base was not large enough to recoup a 10 to 40 percent savings on employee health care costs after taxes like the large companies. This hindered the growth of MSAs. Because the employee's remaining funds were taxable at the end of the year, the employee's prudent use of health care was in jeopardy if the employee did not want to incur more taxable income at the end of the year.

Some states addressed the tax problem early on by passing tax legislation favoring MSA participation. By April 1995, nine states had passed laws allowing employers and individuals to establish tax-free MSAs. (Inside Health Care Reform, April 1995) Funds contributed by the employer or individual to the MSA and the interest it earned would be exempt from state income tax.

a. Tax Legislation

By May 1995, congressional support for MSAs was beginning to weaken. During this period, the Joint Committee on Taxation (JCT) analyzed an MSA bill proposed by Bill Archer. In their report, they stated that the government could lose up to three billion dollars in tax revenue over five years from Archer's MSA proposals. (Inside Health Care Reform, May 1, 1995)

MSA supporters, such as Greg Scandlen, executive director of the Council for Affordable Health Insurance, pointed to a report issued by the American Academy of Actuaries (AAA) that was somewhat kinder to MSAs. In that report, AAA warned that MSA legislation would probably encourage young, healthy Americans to purchase low-premium, high-deductible plans and leave the traditional health insurance market, thus driving up regular insurance prices. It also stated that 75 percent of individuals with no

significant health expenses would select an MSA with a high-deductible plan. This would result in as much as a 61 percent increase in low-deductible premiums and a possible decrease of up to 56 percent for the high-deductible premium plans. Their report also found that health care and administrative costs could decline as much as 10 and 22 percent, respectively. (Inside Health Care Reform, May 1, 1995)

With these findings, employers would have to pay close attention to the mix of health care plans that they offered their employees. Increasing cost to their traditional HMO plans because of low participation could exceed the savings realized from MSAs. The fewer people enrolled in the HMO plan, the more expensive premiums would be.

2. Health Insurance Reform

In July 1995, Senators Nancy Kassebaum (R-KS) and Edward Kennedy (D-MA) sponsored legislation that ultimately led to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The bill guaranteed health insurance coverage for employees changing jobs or starting their own business at the lower premiums normally associated with group insurance programs. The bill was very popular and was unanimously approved by the Senate Labor and Human Relations Committee on August 2, 1995 and by the entire Senate on April 23, 1996. It was considered the last chance that the 104th Congress had at providing some kind of health care reform. (Gieri, March 1997, pp. 73-75)

C. THE CONGRESSIONAL BATTLE OVER HIPAA AND MSAs

By September 1995, the House Ways and Means Committee had marked up and approved Representative Archer's revised MSA plan. The resulting plan would cost the

government 1.7 billion dollars in tax revenues over a seven year period, because of the MSA tax relief. However, this would not turn out to be a winning situation for the either Archer's plan or MSAs. The plan would have allowed anyone with a catastrophic health plan and at least a 1500 dollar deductible for individuals, or a 3000 dollar deductible for families, to establish and keep an MSA. Contributions made to the MSA would have been tax deductible for the person or entity providing the funding. For example, if the employer made the contribution, then the employer would take the deduction; if an individual contributed to their own account, then they could take the deduction. Both parties would not have been able to contribute to the MSA. It had to be either the employer or the employee.

Furthermore, the annual MSA contributions could not exceed the high deductible, any interest earned in the account would have been considered taxable income, non-medical costs withdrawals would have been limited to premiums for long term care insurance, and any funds removed for non-medical purposes would have been taxed and assessed a 10 percent penalty. (Health Legislation & Regulation, September 1995)

A 1994 CBO study that found that tax exempt MSAs would increase the costs of traditional health programs because a large number of healthy people would enroll. As a result, many Democrats opposed the plan, including Representative Pete Stark (D-CA), ranking Democratic member of the Ways and Means Health Subcommittee. Stark argued that, "Medical savings accounts are potentially beneficial for some people – those who are both healthy and in a high tax bracket, but these benefits will come at the expense of people who are sick or have high health care costs." (Health Line, September 1995)

While the House was busy with Archer's bill, Senator Charles Grassley (R-IA), a member of the Senate Finance Committee, introduced a companion bill on September 15, 1995. (Medicine & Health, September 1995) The Senate Finance Committee approved the MSA package on October 19, 1995 as part of a seven year, 245 billion dollar tax cut. (Washington Health Week, October 23, 1995)

During this time, tax-exempt MSAs were becoming somewhat more popular at the state level. Between April and September 1995, six more states adopted tax-free MSAs, bringing the total to 15; eight states rejected similar legislation. (Medicine and Health, September 25, 1995)

On October 24, 1995, the American Academy of Actuaries released an analysis of MSAs. In their analysis, they anticipated slow growth in the MSA market and stated that large employers and high-risk and low-income people would more than likely not participate in MSAs. Because MSA growth would be slow there would be no adverse selection to raise rates of the health care plans currently available. (Medicine and Health, October 30, 1995)

By April 1996, a report by the Joint Committee on Taxation characterized the individuals they expected to choose an MSA: .9 percent would earn between 20 and 30 thousand dollars per year, 25.4 percent would earn 30 to 50 thousand dollars, 51.5 percent would have incomes between 50 and 75 thousand dollars, 10.2 percent would earn between 75 and 100 thousand and the last 12 percent would make over 100 thousand dollars a year. Their analysis also found that MSAs would have a small impact on the uninsured. MSA supporters, such as Rep. Bill Archer, used the report to reinforce their

position that MSAs would not be used by only the wealthy. (Medicine & Health, April 1996)

Also in April 1996, the House's top four GOP leaders outlined their reasons for supporting MSAs in a letter to the president. (Health Line, April 12, 1996) A few days later, Senate Majority Leader Bob Dole (R-KS) announced that he was going to introduce an amendment to the Kassebaum/Kennedy insurance reform bill to allow tax-exempt MSAs. (Health Line, April 18, 1996) This kind of support from the Senate GOP leader (also a presidential candidate) started the Senate battle between Dole and Kennedy over MSAs.

In May 1996, both sides presented news conferences trying to illustrate their view on MSAs. The Republicans "paraded satisfied middle class MSA holders, some of whom were sick, in an effort to refute Democrats' claim that MSAs were only for the healthy and wealthy" (Health Line May 2, 1996); the Democrats claimed that MSAs were a "payoff to the Golden Rule Insurance Co." (Health Line May 2, 1996) for their past large GOP contributions. Behind the scenes, negotiations with the White House were underway for a compromise on MSAs as a part of the Kassebaum/Kennedy bill.

Dole's support for MSAs was no coincidence. If the measure failed because the President could not help the House and Senate realize an agreement, then presidential candidate Dole could argue that the President could not produce health care reform and that he (Dole) strongly supported it for the American people. If the MSA provision was accepted and put into law, Dole could claim that it had his support and was his idea. Either way it was a win-win situation for him as a presidential candidate. However, the clock was running for Senator Dole; he was scheduled to leave the Senate June 11th to

campaign for president and he “vowed to enact the health bill (HR 3103) before he left Capital Hill. This goal was echoed by President Clinton and Senate Democratic Leader Tom Daschle (D-SD)”. (Washington Health Week, May 20, 1996)

By this time, talk was turning to the percent of the population to which MSAs should be offered and for how long. In June 1996, Kennedy believed that a compromise was possible and suggested a demonstration project involving tens of thousands of participants to determine the impact MSAs might have on health care costs and insurance premiums. Republican supporters said that Kennedy’s proposal was unacceptable and a non-starter. (Health Line, June 5 1996)

A few days later, Senator Kassebaum offered a different MSA compromise. To obtain more information about MSAs, she proposed a four-year MSA test period for employees of small businesses and the self-employed. She went on to say that this test would allow the “experts a chance to determine whether the accounts appealed mostly to healthy individuals, as some critics predict.” (Health Line, June 6 1996) Republicans did not think the proposal was strong enough.

On June 11th, Senator Bob Dole left the Senate and Senator Trent Lott (R-MS) replaced him as the Senate Majority Leader. A few days later White House Adviser George Stephanopoulos said: “The president has been willing to accept an experimental project on MSAs as a means of maintaining bipartisan support for passing health care reform.” (Health Line, June 17 1996) This statement placed a lot of pressure on both sides of Congress to compromise as soon as possible; health care reform was a bill in which both sides had a stake during the upcoming elections.

Throughout June, arguments between the two parties revolved around who would eventually determine if MSAs were working, how many people would be allowed to obtain MSAs, how much could be contributed, how long to allow a demonstration project, and the composition of the House-Senate conference. With regard to the House-Senate conference, Senator Kennedy consistently objected to the number of proposed members who supported MSAs.

By July 1, 1996, "sixty-eight days had gone by with Senator Kennedy refusing to allow the appointment of senators to a conference committee that would reconcile the health insurance bill he claimed to champion." (Health Line, July 1, 1996) At this point, Senator Lott could have asked the Senate for a unanimous consent to appoint conferees. If Senator Kennedy objected, then he would have been forced to conduct a real filibuster. Senator Lott could have politically forced Senator Kennedy to stand and continuously explain why he was blocking his own bill. (Health Line, July 1, 1996)

By mid-July, a MSA pilot program cap of 750 thousand people was proposed by the Democrats. The Republicans were not satisfied with that number. On July 17th Senators Kennedy and Lott agreed that once the MSA issues were ironed out, Senator Kennedy would not object to Senator Lott's conference appointments. (Health Line July 18 1996) By July 22, 1996, eighteen states had tax-exempt MSA laws. (Washington Health Week, July 22, 1996)

On July 25, 1996 Senator Kennedy and Representative Archer announced that they had agreed to a four-year demonstration project of up to 750 thousand MSAs for those who were self-employed and in businesses with fewer than fifty employees. That same day, "Senator Lott appointed himself, Finance Committee Chair William Roth (R-

DE), Finance Committee ranking member Daniel Patrick Moynihan (D-NY), Labor and Human Resources Committee Chair Nancy Kassebaum (R-KS) and Labor and Human Resources Committee ranking member Kennedy as conferees to the House-Senate conference committee on the Kassebaum/Kennedy bill.” (Health Line, July 26 1996) During the press conference, both Kennedy and Archer expressed their disappointment with the agreement. Kennedy said, “I think this is a fair test, though the number of participants is greater than I think was necessary.” Archer stated, “this number was too small for me”. (Health Legislation & Regulation, July 1996) Both statements reflected that neither side felt that they had won.

On August 2nd, 1996 the Health Insurance Portability and Accountability Act (HIPAA) passed the House and Senate; the President signed it into law on August 21st, 1996. The new law established an MSA demonstration project limited to 750 thousand accounts over a four-year program. These tax-exempt MSAs would only be available to employees of small companies (fewer than 50 employees) and self-employed individuals with a high-deductible health insurance plan. Contributions made to the MSA would be tax deductible for the individual making the contribution. Contributions made by the employer to the MSA would not count as income for the employee and they could not exceed 75 percent of the deductible for family coverage or 65 percent of the deductible for individuals. High-deductible plans are defined as at least 1500 dollars but not more than 2500 dollars for an individual, and at least 3000 dollars but not more than 5500 dollars for a family. Withdrawals for medical expenses would not be considered taxable income. Distributions that are not used for medical expenses would be subject to a 15 percent tax. (Health Legislation and Regulation, August 28, 1996)

The project began January 1, 1997 and will close December 31, 2000. Without further legislation, no more MSAs can be opened after December 31, 2000, or when the 750,000 account cap has been met, whichever occurs first. MSAs established prior to the deadline can be maintained indefinitely. (Health Legislation and Regulation, August 28, 1996)

D. CONCLUSIONS

MSAs were a GOP-driven proposal that focused on the American working family. It was held up as a program that could slow down health care cost growth through responsible individual spending, forcing efficiencies in the health care market, and as a secure health care program for individuals and families.

Critics opposed the idea because they were afraid that MSAs would splinter the health care insurance sector through adverse selection, leaving the poor and sick to either pay higher premiums, or be precluded from obtaining insurance because of unaffordable, skyrocketing premiums.

The compromise that resulted was a phenomenon that could only occur during an election year. A program so highly praised, while at the same time so vehemently disliked by its respective partisans would not normally pass through Congress. But because the programs (health insurance reform and MSAs) were so important to their respective parties and because no health care reform had been enacted since the president took office in 1992, there was great pressure for both parties to go to the American people during this election year with proof that they (Congress) had done what they were asked to do.

The Republicans political maneuvering to attach MSAs to the Kassebaum/Kennedy bill was a no lose situation for them. If the Democrats did not agree to the MSA provision, they would appear to oppose Americans making their own decisions and improving their own health care and financial security.

Following passage of HIPAA, the Government Accounting Office (GAO) provided a report to Congress in December 1997 about the status of MSAs. The report was based on a survey made during the summer of 1997. Subsequent reports will be made each December until the four-year program has expired. The GAO reported that "fifty-four insurers and three HMOs offered qualified plans and another fifteen insurers and eight HMOs reported that they were planning to do so." (GAO, December 1997) It also noted that MSA participation was significantly lower than expected. The Internal Revenue Service (IRS) reported that only 22,051 MSAs had been established by the end of July 1997. This was a participation number so low that it probably surprised proponents on both sides of the issue.

IV. MSAs AND MEDICARE: THE POLITICS OF THE BALANCED BUDGET ACT OF 1997

During the same period that Congress debated health care reform and MSAs for the private sector, they were also focused on controlling the federal deficit. After the election on November 8, 1994, the Republicans commanded a majority in the House and Senate for the first time in forty years. As a result of their position, the House Republicans pledged to approve their "Contract with America" within their first 100 days of session. One of the items in the contract was a pledge for a constitutional amendment to require a balanced budget. Although it passed in the House, it failed in the Senate. However, by proposing a way to balance the federal budget, Congress signaled the importance it attached to this issue. (New England Journal of Medicine, April 6, 1995)

One of the big problems with the federal budget was that Medicare and Medicaid benefits were becoming a spending run-a-way train. In 1994, Medicare and Medicaid accounted for 242 billion dollars, or 16.5 percent of the federal budget; the deficit was running 203 billion dollars and interest to service the total debt was another 203 billion dollars, or 13.8 percent of the budget. (CBO, Economic and Budget Outlook: Fiscal Years 1997-2006, January 1998)

By 1995, federal spending for domestic discretionary programs had become flat, representing 35.9 of the federal budget. (CBO, Economic and Budget Outlook: Fiscal Years 1997-2006, May 1996) The remaining 64.1 percent went to entitlement programs such as Social Security, Medicare, Medicaid and government retirement programs. Of these programs, Medicare and Medicaid were expected to grow by 10 percent a year, while the rest of the federal budget was growing at less than four percent a year. (Rubin,

April 22, 1995) Clearly the country could not financially afford to continue at this level of health care cost and consumption. The balancing act that Congress had to follow was to provide access to health care for seniors while at the same time reduce spending on entitlement programs in order to reduce the deficit.

A. MEDICARE SOLVENCY WARNINGS

Thirty years ago Congress wrestled with the growing problem of older people not having access to health care insurance. To resolve that social problem Congress established Medicare in 1965, an entitlement program that provides health insurance coverage to the elderly. While the program has been very successful in terms of providing coverage, it has created a significant financial burden for the federal government. The primary reasons for this problem are (1) more people are becoming Medicare beneficiaries while the number of younger tax contributors to the system is declining and (2) there are no restraints on the elderly to minimize their use of the Medicare system. Beneficiaries are required to pay for only 20 percent of their medical bills under Part B, and can get supplemental insurance to cover those costs. There are few incentives for the beneficiaries to be judicious in their use of Medicare. (New England Journal of Medicine, December 28, 1995)

Numerous times since 1970 the Annual Report of the Federal Insurance Trust Fund warned that without congressional intervention, the Medicare Trust Fund would be insolvent within ten years. On eight of those occasions Congress passed laws solving the trust funds problem for the short term. In 1995, this report stated that by 1996 the Medicare Trust Fund would start paying out more than it would take in and that the trust fund's reserves would be depleted by 2002. This problem was further compounded by

the fact that a huge demographic shift of Medicare recipients would occur in 2010 (retirement of the baby boomers), which would exacerbate the funding problem. (Rubin, 1995 pp. 1228-1229)

While the Republicans embraced the report because it supported their position of reducing Medicare spending, many economists pointed out that the situation was nothing new and that Congress would simply make more temporary fixes.

B. 1995 BALANCED BUDGET ATTEMPT

In February 1995, President Clinton submitted his fiscal year 1996 budget. His budget included 716 billion dollars for the Department of Health and Human services, a 7.5 percent increase over fiscal year 1995. Of the proposed 716 billion dollars, the majority would have gone to Medicare, Medicaid and Social Security. It also increased spending in programs for children and families, AIDS patients and substance abuse users. President Clinton's plan made no effort to balance the budget. Instead, it would have incurred annual deficits of 200 million for the rest of the decade. (New England Journal of Medicine, April 6, 1995)

That same year, the Republicans promised to balance the budget and provide tax cuts to the American people. Speaker of the House Newt Gingrich (R-GA) and Senate Majority Leader Bob Dole (R-KS) indicated that billions of dollars would have to be eliminated from Medicare and Medicaid in order to offset the Republican proposed income tax cut. (New England Journal of Medicine, April 6, 1995)

The Republican proposal, The Balanced Budget Act of 1995, would span seven years to balance the budget by 2002 and called for an 894 billion dollar reduction in spending. Of that 894 billion, 270 billion was to be realized by slowing down the growth

of the Medicare program by funding it at 12 percent below projected levels. (Congressional Quarterly, April 22, 1995) In order to help meet their Medicare cuts, the GOP felt that Medicare would do better if it moved more towards managed health care programs and allowed for MSAs like the private sector. They also wanted a "fail-safe" for Medicare spending. The "fail-safe" would reduce reimbursement rates if spending projections for Medicare started to exceed its budget. (New England Journal of Medicine, December 28, 1995) The problem for their plan was that it was unacceptable to the Democrats and the President.

The President responded to the Republican congressional proposal by suggesting a 520 billion dollar reduction over seven years. Of this reduction, 128 billion dollars was to come from Medicare, primarily by lowering reimbursement rates to hospitals and doctors and also offering an assortment of managed care programs to Medicare beneficiaries. However, these programs did not include MSAs. (Gieri, 1997, p. 61)

On November 20, 1995, the Republican-controlled Congress approved the Balanced Budget Act of 1995 (H.R. 2491), which would eliminate the federal budget deficit within seven years. On December 6, 1995, President Clinton vetoed the Balanced Budget Act of 1995 because of the 270 billion dollar reduction in Medicare. (CBO, The Economic and Budget Outlook: An Update, December 1995)

1. Continuing the Budget Battle

After vetoing the Balanced Budget Act of 1995, President Clinton submitted his new plan on December 7, 1995. According to the Congressional Budget Office (CBO), the President's new proposal would not balance the budget, while the vetoed Balanced Budget Act of 1995 would. (Gieri, 1997, pp. 62-65)

The President was adamant about not cutting Medicare too deeply and was concerned that if MSAs were integrated into Medicare, the costs for Medicare and those beneficiaries that might be affected by adverse selection would actually increase more. In February 1996, Bruce Vladeck, the Administrator for the Health Care Financing Administration (HCFA) said that "there was significant opportunity within the Medicare population for managed care plans, but that Medicare managed care must be pursued with the best interest of the beneficiaries at heart." (Health Line, February 28, 1996) Vladeck was not supportive of MSAs for Medicare because of a CBO study and a Lewin-VHI analysis. CBO reported that MSAs would increase Medicare spending by four billion dollars over seven years, while the Lewin-VHI analysis estimated that Medicare spending would increase by 15 to 20 billion dollars over seven years. (Health Line, February 28, 1996) Vladeck was concerned that MSAs would splinter the Medicare system, allowing the healthiest and wealthiest seniors to move into MSAs while the sickest and poorest were left in a weakened fee-for-service program. (Health Line, February 28, 1996)

2. Budget Impasse

Even though the President vetoed the Balanced Budget Act of 1995, he did acknowledge the need to either slow down Medicare spending or increase contributions to the program to preserve its solvency. By April 1996 the Clinton administration was willing to increase the cuts to Medicare from 97 billion dollars to 127 billion dollars, while at the same time the Republicans reduced the cut in their plan from 270 billion dollars to 168 billion dollars. (New England Journal of Medicine, April 18, 1996) The President's plan was beginning to look more like the Republican proposal and even

supported providing more choices for beneficiaries. MSAs, however, were still a point of contention.

The Balanced Budget Act of 1995 did not pass because of the strong disagreements between the Republicans and Democrats about how deep to cut Medicare. The Republicans carried the battle deep into fiscal year 1996 with no success and eventually retreated from their unpopular position on Medicare cuts. They did not include them in their budget proposal for fiscal year 1997.

C. 1997 BALANCED BUDGET AGREEMENT

In 1997, the Republican Congress returned to balance the budget and made Medicare the centerpiece once again. In April 1997, both Democrats and Republicans introduced budget proposals with large tax cuts. Again, both sides were different. The President's plan called for 100 billion dollars in tax cuts through 2002, while the Republican plan included 200 billion dollars in cuts during the same period. (American Institute of Certified Public Accountants Journal of Accountancy, April 1997) Neither proposal specifically addressed Medicare adjustments, nor would they for a couple of months. The GOP was still working on a plan and was seriously considering breaking Medicare out of the budget process and addressing the problem as a freestanding bill. Support for their position to cut Medicare came once again from the Medicare Trustees annual report. It reiterated the previous year's forecast that Medicare would be bankrupt by 2001. (Health Line, April 25 1997)

By May 1997, the President and Republican leaders agreed to a compromise that would cut taxes and balance the budget by 2002. Under the agreement, Medicare would be cut by 116 billion dollars over five years while at the same time extending the

Medicare Trust Fund's life to 2007. Savings from Medicare were to be realized by reducing payments to the health care industry and by requiring Medicare beneficiaries to pay an additional dollar a month premium on top of their expected increased premium of seven dollars a month. This would bring their total monthly premium increase to eight dollars. "Added to the regularly scheduled premium increases, the total increases for seniors over the life of the budget plan would be 18 dollars per month." (Health Line, May 5 1997)

Within a week, the health care industry weighed in with their opinion of the proposed plan. Of the 116 billion dollars cut from Medicare, the industry was expected to absorb 100 billion dollars. Health care industry leaders argued that the plan relied too heavily on cuts and very little on reform. They contended that without real reform the Medicare funding problem would not go away. Pamela Bailey, President of the Health Care Leadership Council, said, "The worst outcome of the budget deal would be that Congress and the President bypass this opportunity to reform Medicare and instead just impose price controls on doctors, hospitals and health plans." (Health Line, May 7, 1997)

By May 29, 1997, Chris Jennings, the President's top health care advisor, warned Republicans that the administration was against MSAs as a part of Medicare. Jennings was then asked if a Medicare demonstration project allowed under the Health Insurance Portability and Accountability Act of 1996 would be acceptable to the President. Jennings answered, "it's too premature to tell." (Health Line, May 30, 1997) With this press conference, Jennings sent a message to the GOP that the President was willing to negotiate.

On June 3, 1997, Mike McCurry, White House Press Secretary, reiterated the fact that the President was opposed to MSAs but that he might be willing to compromise with a pilot project that involved a limited number of people over a specific period of time. (Health Line, June 3, 1997) Later that same day, Bill Thomas (R-CA), Chairman of the House Ways and Means Health Subcommittee, revealed the details of his Medicare reform bill. His bill included an MSA demonstration project, allowing up to 500,000 participants over a four year period. (Health Line, June 3, 1997)

On June 4, 1997, Representative Pete Stark (D-CA) and Senator Kennedy (D-MA) voiced their opinions about the MSA provision in Thomas's bill. Stark said that he "could vote for the bill without the MSA thing." (Health Line, June 4, 1997) He went on to say that he might "offer an amendment that would strike Thomas's language and instead allow those under 65 who previously had MSAs to keep them when they became eligible for Medicare." (Health Line, June 4, 1997) Senator Kennedy said, "the MSA provision is a cynical device to attract only the healthiest and best-off senior citizens." (Health Line, June 4, 1997)

Thomas's plan was backed by a CBO report stating that his bill would produce the proposed 115 billion dollar savings required in the pending balanced budget agreement. Savings would be realized by slowing down payment growth rates to doctors, hospitals and HMOs. Beneficiaries would also pay an additional \$6.80 a month above their projected annual increases. (Health Line, June 4, 1997)

The House Ways and Means Committee approved the bill on June 9, 1997. (Health Line, June 10, 1997)

On June 1, 1997, the Senate Finance Committee approved changes to the Medicare program. In their bill, the eligibility age would be raised from 65 to 67 and means testing for beneficiaries would be established by charging higher deductibles for individuals who earn more than 50 thousand dollars a year and for couples who earn over 75 thousand dollars a year. The Senate bill also reduced the MSA demonstration project from 500,000 to 100,000 participants. (Health Line, June 19, 1997)

By the next day, the Congress heard from their elderly constituents. Max Richtman, executive vice president of the five million member National Committee to Preserve Social Security and Medicare said "the proposal is terrible and a deal breaker as far as seniors are concerned." (Health Line, June 20, 1997) The Medicare means testing issue was at the forefront of the controversy, just like it was in 1988 when Congress voted to expand Medicare financing with increased premiums on wealthier seniors. As a result, those retirees protested and the provision was repealed before it could even take effect. Now, nine years later, they were faced with the same proposal. (Medical Industry Today, June 20, 1997)

By July 28, 1997 the conference committee on the balanced budget bill announced that they had come to an agreement for the five year balanced budget plan. The controversial issues of means testing and increasing the Medicare eligibility age from 65 to 67 were removed from the bill. However, a four year MSA demonstration project that would allow up to 390,000 participants remained in the bill. (Health Line, July 29, 1997) That same week the House and Senate overwhelmingly approved the bill and sent it to the President. (Modern Healthcare, August 4, 1997)

As a result of these efforts, the Balanced Budget Act of 1997 was signed by the President August 5, 1997. In that bill, there was a new provision for Medicare, Medicare + Choice, more commonly called Medicare Part C. Part C offers seniors many different managed care options and a four year MSA demonstration project for 390,000 Medicare beneficiaries, to begin January 1, 1999 and end December 31, 2002.

D. CONCLUSIONS

The Balanced Budget Act of 1997 was the vehicle that allowed the GOP to introduce MSAs into the Medicare system. Like the battle for MSAs in the Health Insurance Portability and Accountability Act of 1996, the same arguments and down to the wire political tactics were used to get it established.

Based on the economic estimates at that time, the Balanced Budget Act of 1997 was designed to balance the budget by 2002. It was praised for its 500 dollar per child tax credit, providing health insurance for low income children ("kiddiecare"), expanding medical services to Medicare beneficiaries, and possibly eliminating deficits in the near future. But opponents point out that the 115 billion savings over five years will not save Medicare. The Balanced Budget Act of 1997 basically extended Medicare's life for a few years. Reforms to the program are still required if the trust fund is to be a solvent and viable plan when the baby-boomers retire in 2010.

The Medicare reforms sponsored by the GOP seem to be moving some of the costs of Medicare from the government to the beneficiaries. By establishing MSAs, Congress can determine if they will cause adverse selection as opponents suggest, or if MSAs will actually drive Medicare costs down because individuals would manage their

own funds. If the later scenario proves true, the GOP will have a strong argument to place more responsibility on the beneficiary during the upcoming Medicare reform battle.

V. IMPLEMENTING MEDICARE MEDICAL SAVINGS ACCOUNTS

The Balanced Budget Act of 1997 (BBA of 1997) produced a new set of Medicare options for seniors, called Medicare Part C. Medicare Part C offers seniors a choice between the traditional fee-for-service Medicare, a private indemnity plan, various managed care programs or MSAs.

As required by the BBA of 1997, Health and Human Services (HHS) will hold a national health fair for Medicare beneficiaries every November, beginning November 1998. These fairs will inform seniors about the plans that are available within their area. Medicare beneficiaries will be allowed to change plans and move in and out of the fee-for-service plan every month until the end of 2001. During the first six months of 2002, beneficiaries will be allowed to change plans once. After June 2002, beneficiaries will be allowed to change plans only during the November election period and the first three months of the new year. (Modern Healthcare, August 18, 1997) The only exceptions to these rules are for MSAs.

Beneficiaries who want to sign up for MSAs will only be allowed to sign up during the month of November, starting in November 1998. Beneficiaries who have end-stage renal disease (ESRD) are not permitted to establish MSAs. The only other sign up exception is if a person becomes eligible for Medicare benefits anytime during the year. At that time, the new beneficiary can choose to establish an MSA regardless of the month. If the new beneficiary does not establish an MSA during their first month of Medicare eligibility, then the beneficiary must wait until the annual signup period each November. (Telephone conversation with Cindy Mason of HCFA, September 24, 1998)

A. ESTABLISHING THE MSA SYSTEM

In June 1998, the Health Care Financing Administration produced written guidelines for Medicare Part C. In this document, the rules for MSAs were spelled out for the beneficiary and MSA providers. With the first sign up period scheduled for November 1998, HCFA required companies who wanted to offer MSAs to have their applications submitted by the end of August 1998. (Medicare+Choice Part C Statutory Requirements, June 1998)

As a result of the short lead-time provided to the insurance industry, not a single company submitted an application to provide MSAs by the August 31, 1998 deadline. The industry was still trying to digest the new rules and develop their marketing plans. Because no company was able to submit an application for HCFA review by the deadline, the first November sign up period has been cancelled. As soon as HCFA acquires approved applications, seniors who turn 65 will be eligible to sign up for MSAs during their first month of eligibility until the next annual November sign up period. At this time, all beneficiaries will have the option to sign up for MSAs. (Telephone conversation with Cindy Mason of HCFA, September 24, 1998)

B. EVALUATING MSAs

In order for Congress to determine the merits of the Medicare MSA demonstration project, HCFA must submit a report to Congress by March 1, 2002. The report will assess MSA's performance. Some of the issues required in the report are the fluctuation in program enrollment, costs incurred for beneficiaries and Medicare, cost comparisons between MSA contributions and funds for beneficiaries in other Medicare

programs, commercial and administrative problems providing MSAs and beneficiary satisfaction. (Telephone conversation with Cindy Mason of HCFA, September 24, 1998)

C. CONCLUSIONS

The MSA demonstration project is in place but cannot be utilized by Medicare beneficiaries until the insurance industry submits applications to offer Medicare MSAs. As of October 30, 1998, HCFA had not received any applications. The limited early interest in the program did not surprise HCFA; they fully expect to have approved insurance companies participating within the first couple of months of calendar year 1999. (Telephone conversation with Cindy Mason of HCFA, October 30, 1998)

As soon as companies start providing MSA policies, only seniors who turn 65 can enroll within their first month of eligibility for Medicare. All current Medicare beneficiaries will have to wait until November 1999.

VI. SUMMARY AND CONCLUSIONS

John C. Goodman, president of the Dallas-based National Center for Policy Analysis (NCPA) claims to have developed the idea of Medical Savings Accounts in the mid-1980's. They were envisioned to be a program that would help reduce health care costs for employers and insurers by providing their employees an annual contribution for their health care costs to manage as they saw fit.

Part of the original vision of MSAs was to encourage the prudent use of medical expenses by allowing the MSA owner to retain any unused funds in the MSA for future medical expenses. If the MSA owner removed the funds for non-medical uses they would have to pay income taxes on those funds. The management of the money was to be left up to the individual.

MSAs were also envisioned to allow the individual to receive their care where they felt the most comfortable. No longer would they be required to participate in a plan that did not fit their medical needs or maybe their personal preference of doctors.

From the beginning opponents feared that MSAs would cause adverse selection within the existing health care system, driving the healthiest people to MSAs where they could save some money for themselves, while the remaining sick population might see their insurance rates go up. Opponents also argued that MSAs would discourage people from seeking medical attention when they really needed it in order to accumulate money in their accounts.

MSAs were slow to take off in the private sector before the 1990's. By 1995, over 3000 companies offered MSAs to their employees. (Subcommittee on Civil Service

of the Committee on Government Reform and Oversight, House of Representatives on December 13, 1995, p.6) Even though MSA participation was growing, tax laws were retarding growth. All funds that were deposited into an MSA were considered taxable and any funds remaining at the end of the calendar year had to be removed from the MSA.

By 1994, MSA supporters saw their chance to make MSAs tax-free plans that could accrue contributions and interest each year. The GOP favored MSAs because they saw the potential to lower health care costs in the private sector through competition and an opportunity to provide workers with a new means of tax free savings.

The Democrats wanted nothing of the sort. They saw MSAs as costing the treasury billions of dollars in lost tax revenue, and argued that adverse selection would increase the health care premiums for everyone else. Participation rates and population characteristics in an insurance plan are very important because the costs of a plan are averaged and spread among the people enrolled in that plan. With adverse selection, non-MSA plans will be left with a smaller and less healthy population, increasing their insurance premiums.

In 1995, the Republicans brought MSAs back to the table on two fronts, the Balanced Budget Act of 1995 and to the Kennedy/Kassebaum bill. Their intent was to (1) permit Medicare beneficiaries to establish MSAs in order to reduce Medicare expenses and help balance the budget, and (2) to reduce medical expenses for American workers and companies in part by providing tax breaks for their MSA contributions.

The efforts of the Republicans to incorporate MSAs into Medicare during the BBA of 1995 negotiations proved to be a difficult battle with the President and no

changes to Medicare or the federal budget took place. The BBA of 1995 was vetoed because of the large cuts in Medicare, which were also in the BBA. Medicare MSAs were not the primary reason that congressional Democrats and the President opposed the BBA of 1995. Their primary issue was that they could not accept the large cuts in the Medicare program that would be required to balance the budget within the agreed upon time of seven years, even though they did not have a plan that would.

While the BBA of 1995 failed, the Kennedy/Kassebaum health insurance reform bill was still being negotiated. The Republicans used this bill to introduce tax exempt MSAs for the American worker. The Democrats, led by Senator Kennedy, opposed MSAs and did not want them in the insurance reform bill. However, it was a presidential election year; the Kennedy/Kassebaum bill was perceived as the only opportunity to reform health care after the President called for reform in 1992.

Unlike the BBA of 1995, the MSA concept was the primary issue for both sides in finalizing the Kennedy/Kassebaum bill. The Republicans in Congress would not approve the bill without tax exempt MSAs. The Democrats desperately fought the idea, until they ran out of time. In the end they had to choose between not producing health care reform legislation or compromising with the Republicans on an issue that they were strongly against right before a presidential election.

By July 1996, both sides agreed to a four year MSA demonstration project limited to 750,000 participants. Once this compromise was completed, Congress passed the new bill, known as the Health Insurance Portability and Accountability Act of 1996, and sent it to the President, which he signed on August 21, 1996.

A big problem with the experiment was that it only permitted employees of companies with fewer than fifty employees to participate. A large portion of the American work force was prohibited from taking advantage of the program.

The restriction makes it very difficult for a small company that offers health care benefits to provide MSAs. Any small company that does offer health care benefits will have to carefully determine what mix of health care plans to offer its employees. If a small company offers only MSAs they would probably see that their health care costs would be lower compared to the traditional managed health care plans available. However, if they offered a choice of either managed care plans or MSAs to their employees they could possibly see the effects of adverse selection because those employees that are very healthy might accept MSAs while the company's less healthy employees would choose stay in the managed care plans. The less healthy participants in the managed care plans could increase the company's premiums and possibly wipe out any savings realized from the MSA plan.

Each December the GAO is required to report the progress of the MSA demonstration project to Congress. In their December 1997 report, they reported that only 22,081 MSAs had been established by the end of July 1997. (GAO, December 1997) The participation level in the project proved unexpectedly low.

In 1997, Congress resumed its effort to produce a Balanced Budget Act. As in their 1995 effort, Medicare was central to this effort. The President and the GOP reached an agreement in May 1997 to cut Medicare by 115 billion dollars over five years. They did not, however, have an agreement to include Medicare MSAs in the new bill at this time.

The precedent for Medicare MSAs came from the Health Insurance Portability and Accountability Act of 1996, where Congress created an MSA demonstration project for the private sector. The Republicans wanted Medicare beneficiaries to have access to MSAs because they believed that they would help curtail the growing costs of Medicare expenses if the beneficiaries were responsible for their own medical expenses. The Democrats argued that MSAs would not help Medicare and in fact would hurt the Medicare system and beneficiaries because of adverse selection. In other words, the parties debated Medicare MSAs in much the same way that they debated MSAs for the private sector prior to passing the HIPAA of 1996.

By June 1997, the President and the GOP finally agreed upon a four year Medicare MSA demonstration project that permitted up to 390,000 participants effective 1 January 1999.

A. CONCLUSIONS

MSAs were originally conceived to help slow the growing costs of health care in the private sector in the mid-1980s. During the early 1990's, Congress was receiving pressure to make MSAs a tax-exempt plan. The GOP saw an opportunity to provide some tax relief to the American people while at the same time assist in the President's call for health care reform. The President and Democrats did not like MSAs because they saw them as seriously damaging the existing health care system.

Losing their first MSA round via the Bipartisan Plan in 1994, the Republicans had an opportunity to get their MSA legislation passed in the 1996 presidential election year via the Kennedy/Kassebaum health insurance reform bill. The compromise that followed was a matter of political survival for the President and Democrats. Without the

compromise they would have had to enter the elections failing to produce the health care reform that was promised by the President four years earlier.

While the HIPAA of 1996 was being negotiated, Congress was also working on a Balanced Budget Agreement. The BBA of 1995 coincided with the upcoming 1996 election and it addressed MSAs for Medicare. On this bill, however, the Democrats and the President would not look bad if an agreement could not be reached. In fact an agreement was not reached because of the large cuts in the Medicare program required by the GOP. The reality was that both sides wanted to balance the budget but neither side would be considered the villain for not succeeding.

The President and Democrats were isolated from political backlash because they were defending deep Medicare cuts and protecting the interest of senior citizens. The Republicans also were in a no lose situation because they could argue that their plan would balance the budget within seven years, an argument designed to appeal to the large voting population of age fifty and under.

Eighteen months after the President vetoed the BBA of 1995, which addressed Medicare MSAs for the first time, he signed the BBA of 1997. During that period both sides agreed to compromise on their position of Medicare cuts in order to balance the budget by 2002. The Republicans conceded more under the agreement by reducing their original Medicare cuts from 220 billion dollars to 115 billion dollars versus the Presidents modest increase in Medicare cuts from 97 billion dollars to 115 billion dollars. Medical Savings Accounts were still important to the Republicans as a part of Medicare and were the last sticking point in the BBA of 1997 negotiations. With the precedent of

private sector MSAs established by the HIPAA of 1996, both sides were willing to accept an MSA demonstration project for Medicare.

At the end of the demonstration project in 2002, the Democrats hope to have proof that MSAs will cause adverse selection and actually cost the Medicare system more. Lacking such evidence, they may be faced with new Republican measures that empower the senior citizen population to make their own choices of how to manage their own Medicare health care expenses.

The Republicans and supporters of MSAs hope the demonstration project supports their belief that MSAs will allow people to get the health care that they require while at the same time reduce Medicare expenses via competition in the market place for those independent Medicare dollars. This would be congruent with Republican hopes to return money to individuals and allow them to depend more on themselves and less on the government.

1. Legislative Attempts to Revise the HIPAA of 1996 MSA Project

While it is easy to see how MSAs progressed from the private sector to the federally funded Medicare system, it should be noted that during 1998 two Republican bills, one in the House and one in the Senate, were introduced that could have altered the MSA demonstration project that was established in the HIPAA of 1996.

a. *H.R. 4250, Patient Protection Act of 1998*

Representative Gingrich (R-GA) introduced the House's bill, H.R. 4250 on 16 July 1998, called the Patient Protection Act of 1998. This bill included an article to change the MSA rules established in the HIPAA of 1996. Specifically, it would have (1) reduced the minimum annual deductible for high deductible health insurance policies

from 1,500 dollars to 1,000 dollars for an individual and from 3,000 dollars to 2,000 dollars for a family, (2) increased the tax deduction for contributing to an MSA from its current range of 60 to 70 percent to 100 percent tax deductible, and (3) removed the 390,000 MSA demonstration project participation limit. (CBO Preliminary Cost Estimate, July 24, 1998)

On July 23, 1998 the Clinton Administration issued its opinion on H.R.4250. In that statement, the administration strongly objected to the bill because it did not cover many issues involving patient rights. With respect to MSAs, the statement read:

H.R. 4250 would subvert the MSA demonstration project enacted in the Health Insurance Portability and Accountability Act of 1996. Under H.R. 4250, the MSA tax break may accrue only to the healthiest and wealthiest individuals and attract them out of the general health insurance market, potentially raising premiums for all other people. There is no evidence that the claimed cost containment benefit of MSAs outweighs the cost of providing a tax break primarily for healthy and higher-income individuals. (OMB Statement of Administrative Policy, July 23, 1998)

On July 24, 1998, the CBO issued a preliminary cost estimate of Gingrich's bill. In that estimate they stated that the Joint Committee on Taxation estimated that the changes in the MSA provision alone would reduce income and payroll revenues 1.3 billion dollars between 1999 and 2003. (CBO, Preliminary Cost Estimate H.R. 4250, July 1998) That same day H.R. 4250 passed in the House and was sent to the Senate for consideration.

On July 28, 1998, the bill was read in the Senate for the first time. On October 9, 1998 the bill was tabled in the Senate, which effectively eliminated it from further consideration. (Congressional Bill Summary & Status for H.R. 4250 of the 105th Congress, as of November 17, 1998)

b. S. 2330, Patients' Bill of Rights Act of 1998

Senator Nickles (R-OK) introduced his bill, S. 2330 on July 17, 1998, called the Patients' Bill of Rights Act of 1998. Like the Patient Protection Act of 1998, this bill included provisions to expand the MSA rules established in the HIPPA of 1996. Specifically, it would have (1) eliminated the restrictions confining MSAs to employees of small employers, (2) reduced the minimal annual deductible for high deductible health insurance policies from 1,500 dollars to 1,000 dollars for an individual and from 3,000 dollars to 2,000 dollars for a family, (3) increased the allowable tax deduction for MSA contributions to 100 percent, (4) waived the additional tax on MSA distributions provided the balance in the MSA did not fall below the annual high deductible, and (5) established MSAs under the Federal Employees Health Benefits Program (FEHBP). (Congressional Bill Summary & Status for S. 2330 of the 105th Congress, as of November 17, 1998)

This bill is significant because it represents the next step in the MSA evolution. By introducing it, the Republicans tried to take MSAs to the next level by offering them to federal employees. The belief behind the proposal is if MSAs prove to be successful, allowing the large federal work force to have MSAs could reduce the government's health care benefit spending.

However, on September 24, 1998, the CBO issued a cost estimate for S. 2330. In their report, the CBO and the Joint Committee on Taxation estimated that the MSA provision alone would have reduced tax revenues by 8.1 billion dollars between 1999 and 2003. (CBO Cost Estimate, September 4, 1998)

This bill was placed on the Senate Legislative calendar under General Orders, Calendar No. 479 on July 20, 1998. The Senate did not vote on the bill before its

session ended. (Congressional Bill Summary & Status for S. 2330 of the 105th Congress, as of November 17, 1998)

B. RECOMMENDATIONS FOR FURTHER RESEARCH

MSAs are expected to either force the health care market to become more efficient and slow down the growth of health care costs or splinter the entire system through adverse selection. After sufficient data has been accumulated from both MSA demonstration projects, an analysis could be conducted to better estimate the long-term impact on the private sector and the Medicare program.

Future research may want to compare the current Medicare policy of offering many different managed health care plans and MSAs to providing only MSAs. This analysis could help determine if adverse selection would occur in the first scenario but not the second and if either scenario would reduce Medicare cost growth.

**APPENDIX - MEDICAL SAVINGS ACCOUNTS AND HEALTH CARE
POLICY: A CHRONOLOGY OF EVENTS**

- 1986 MSAs, advocated by National Center for Policy Analysis (NCPA), are introduced to the private sector.
- 1994 Tax status of MSAs addressed in health care reform bills but no legislation is passed.
- 1995 Legislation to permit Medicare MSAs is included in the Balanced Budget Act of 1995.
- 1995 Kassebaum/Kennedy Health Insurance Reform bill introduced July 1995.
- 1995 The Balanced Budget Act of 1995 is vetoed by the President on December 6, 1995.
- 1996 Senator Dole introduces an amendment to the Kassebaum/Kennedy bill to permit tax exempt MSAs in April 1996.
- 1996 The Kassebaum/Kennedy bill, which included a four year MSA demonstration project for small employers, is signed into law by the President on August 21, 1996 and is known as the Health Insurance Portability and Accountability Act of 1996.
- 1997 Balanced Budget Act of 1997, which included a four year MSA demonstration project for Medicare beneficiaries, is passed by Congress and signed into law by the President on August 5.
- 1998 On July 16, 1998, Representative Gingrich (R-GA) introduces H.R. 4250, Patient Protection Act of 1998, which included a provision to broaden the MSA demonstration project established in the Health Insurance Portability and Accountability Act of 1996.
- 1998 On July 17, 1998, Senator Nickles (R-OK) introduces S. 2330, Patient's Bill of Rights Act of 1998, which also included provisions expanding private sector MSAs and extending them to the Federal Employees Health Benefits Program (FEHBP).
- 1998 H.R. 4250 is tabled in the Senate, which eliminated it from further consideration.
- 1998 S. 2330 dies because the Senate did not get to vote on it before their session ended.

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